“WADING THROUGH SLUDGE”: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF PARENTAL EXPERIENCES OF CHILD FEEDING IN THE CONTEXT OF AVOIDANT EATING

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Abstract

Responsive feeding is an approach to feeding children that prioritises child autonomy and supports children’s ability to regulate their energy intake. Alongside innate and developmental factors, nonresponsive feeding practices - specifically pressure to eat - are associated with increased avoidant (‘picky’) eating, a common parenting challenge. Although much is known about associations between feeding practices and child eating behaviours, an in depth understanding of the parental perspective is lacking. This programme of research comprises a systematic review of the conceptualisation of pressure to eat and a qualitative study: an interpretative phenomenological analysis of maternal meaning making in relation to their feeding practices and their child’s eating behaviours. The study is unique in its methodology and its sample (UK mothers of nonclinical avoidant eaters seeking support from their health visitor). Ten participants were recruited and data were gathered using semi-structured interviews. It was found that current or past use of pressure to eat was ubiquitous in this sample. This was captured by the superordinate theme ‘Getting the food down the child’. Three further superordinate themes were identified. These concerned maternal agency, identity, and attempts to understand. It is argued that participants experienced child feeding as an unwinnable battle, their only options being to fight on in vain or submit completely. There may be several factors contributing to this. First, a lack of knowledge, both of responsive feeding and common causes of avoidant eating. Secondly, a misinterpretation of aspects of the feeding literature, embedded in the contemporary parenting canon. Finally, a sense of hopelessness - participants felt they had tried everything, nothing worked, and no one had any answers. These findings comprise an original, fine-grained insight into maternal meaning making in the context of avoidant eating. They have implications for research and practice, especially regarding screening and support provided in primary care.

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Glossary

	Definition / Explanation
ADHD	Attention Deficit Hyperactivity Disorder
AND	The US Academy of Nutrition and Dietetics
ARFID	Avoidant/Restrictive Food Intake Disorder (a clinical diagnosis for severe avoidant eating)
ASD	Autism Spectrum Disorders
Avoidant eating	Avoidant eating is used in this thesis as a synonym for 'picky' eating. This is not to be confused with Dovey's (2018) usage of *food avoidance* which refers to all the strategies employed by a child in order to avoid food. Neither is it to be confused with the range of eating behaviours (of which *food fussiness* is one) measured by the Child Eating Behaviour Questionnaire (Wardle et al., 2001).
BMI	Body Mass Index
EAS traits	Temperamental traits: emotionality, activity, and sociability
GP	General Practitioner (family doctor)
HRA	Health Research Authority
IPA	Interpretative phenomenological analysis
Lincolnshire NHS Trust	Lincolnshire Community Health Services NHS Trust
Moderatum generalisability	A pragmatic approach to generalising from idiographic work, highlighting its utility alongside its inherent fallibility
Neophobia	Wariness of eating unfamiliar foods
NHS	National Health Service
Nottinghamshire Healthcare NHS Trust	Nottinghamshire NHS Trust
NOFTT	Nonorganic Failure to Thrive
Obesity	The term *obesity* is considered problematic as it is viewed as stigmatising (Puhl, 2020). The more neutral term *weight dysregulation* is the preferred language in this thesis. However, the words obesity and *overweight* are used when they are necessary to an accurate representation of the research they refer to.
RDA	Recommended Dietary Allowance
RFT	Responsive Feeding Therapy
sDOR	The Satter Division of Responsibility in Feeding model
SDT	Self-determination Theory
Self-regulation	Self-regulation of energy intake and self-regulation are used interchangeably in this thesis
WHO	World Health Organisation

1 Introduction

1.1 The Context and the Problem

Approximately a quarter of parents of young children perceive their child to be a *picky eater* (Cardona Cano, Tiemeier, et al., 2015; Cole et al., 2017). Although recent data are lacking, both British (S. Moore et al., 2010; Wright et al., 2007)[1] and international (Goh & Jacob, 2012) research indicates that parents frequently approach their primary healthcare provider for help with this common challenge. However, the requisite help may not be forthcoming. This is both in relation to helping parents appreciate the origins of paediatric feeding problems and in helping them understand how to support the acceptance of a variety of nutritious foods (Mitchell et al., 2013). In this thesis, the terms *avoidant eater* and *avoidant eating* are henceforth used instead of picky eater and *picky eating* (see Glossary). Avoidant eating is held to be neutral language that encompasses childhood eating behaviours ranging from developmentally normal food rejection to clinically significant eating problems (see 0). It is defined as both the consumption of a limited variety of familiar foods and the rejection of unfamiliar foods (Dovey et al., 2008). In this thesis, unless otherwise specified, the term avoidant eating refers to child avoidant eating.

Parents in the UK are given information about nutrition but lack practical advice regarding feeding practices (Clark et al., 2007; Hayter et al., 2015), a gap often expressed as omitting the 'how' as distinct from the 'what' of child feeding (Chan et al., 2011; Fraser et al., 2021; S. Moore et al., 2010; Tartaglia et al., 2021), which has been identified at an international policy level (Schwartz et al., 2011). Indeed, parents of avoidant eaters risk having their concerns dismissed by healthcare providers via platitudes such as being told that children eat when they are hungry enough (L. Rogers et al., 2012), will "grow out of it" (Rowell & McGlothlin, 2015, p. 55) or "do not starve themselves" (Wright et al., 2007, p. e1070). The challenge for practitioners of responding appropriately to avoidant eating is compounded by inconsistent definitions of avoidant eating (see 2.2.2) and a large variance in the degree of the problem (see 0), which can be seen as a continuum (Dovey et al., 2019) ranging from developmentally

[1] In line with APA7th style, where multiple authors have the same surname, author differentiation by initial is used. The only exception to this is J. Smith, whose work is cited many times in Chapter 4 and elsewhere. To aid readability, initials are included for A.D.Smith and A.M. Smith but not J. Smith.

normal *neophobia (*wariness about unfamiliar foods) through to the clinical diagnosis of *avoidant restrictive food intake disorder* (ARFID; see Glossary and 2.7.2) .

It has been established that avoidant eating is bidirectionally associated with a specific maladaptive parental feeding practice: *pressure to eat* (P. Jansen et al., 2017a). Pressure to eat refers to adult attempts to induce children to eat. This could range from coercive practices such as the use of insistence or threats, to less forceful practices such as playing games to encourage eating, or persuading children to eat an extra mouthful (Daniels, 2019). Not only is there compelling evidence regarding pressure to eat contributing to, and being used in response to, avoidant eating (discussed in Chapter 3), much is also known about both adaptive parental feeding practices (Daniels, 2019) and the aetiology of childhood eating behaviours (Cole et al., 2017). Taken in conjunction with suggestions regarding a lack of evidence-based support for parents of avoidant eaters, this constitutes a striking research-practice gap, which has been highlighted by others (Mitchell et al., 2013; Powell et al., 2011).

Adaptive feeding practices are encompassed by the construct of *responsive feeding* (Black & Aboud, 2011). In this thesis, the following definition of responsive feeding is used: *Responsive feeding is an approach to feeding children which facilitates autonomous eating in the context of a warm, attuned relationship and appropriate structure. This is with a view to supporting the development of a positive relationship with food, characterised by effective self-regulation of energy intake, and optimised competence and eating enjoyment*. The rationale for this definition is provided in the next chapter (2.9) along with a description of how responsive feeding is recommended by multiple international organisations (Engle & Pelto, 2011).

As suggested by Black and Aboud (2011), the parental use of pressure to eat is incompatible with responsive feeding because it necessarily entails external motivation of eating as opposed to the facilitation of autonomous eating. For example, if a child is told to eat another mouthful before they may leave the table, their eating is no longer internally driven. As discussed later (2.1.2), parental attempts to control children's eating (whether by directing them to eat more or to eat less) have been the subject of research for some years. More recently, scholars exploring nonresponsive feeding practices such as pressure to eat have called for further investigation into the mechanisms that underpin them, in order to direct the development of interventions (H. Harris, Jansen, et al., 2018b). This need for a better understanding of parental feeding practices in the context of avoidant eating is foundational to the programme of research

presented in this thesis. Additional personal motivations are described in the subsequent section which, in line with a later reflective component of this thesis (5.9), is written in the first person.

1.2 Personal Interest and Motivations

With a background in counselling and psychotherapy, I have worked clinically in the field of avoidant eating for many years. Initially, this was directly with children, then in the last decade I have worked exclusively with parents of avoidant eaters, for the most part using a multidisciplinary telehealth approach. My specialism is feeding dynamics and the feeding relationship. I draw on psychological and psychotherapeutic theory, as well as the feeding literature, to undertake this work. Currently, my role is largely supervisory; I oversee case work in my practice which includes dietetic input, occupational therapy input where needed, and coaching from a specialist in paediatric feeding psychology. I take cases of children aged between 18 months and 12 years. These cases range from supporting parents through developmentally normal toddler eating behaviours through to working with extremely limited eating.

As a mother of three girls (aged 9, 13 and 15 years) I am often asked whether I became interested in child feeding because my daughters were avoidant eaters. The answer is "no". Unlike many professionals in my area, this was not my experience. My children all enjoy a varied diet. I take little credit for this - I am acutely conscious that many aspects of childhood eating behaviours are innate rather than environmental. My experience as a parent has, however, given me an awareness of the practicalities of child feeding as well as some of the broader challenges parents may face.

My interest in the field was kindled when my eldest daughter was a young toddler, despite her being a typical eater. I was undertaking a training placement at the local Child and Adolescent Mental Health Service (CAMHS) where I worked as a trainee psychotherapist one day a week. Most of my clients at CAMHS were adolescent girls with a diagnosis of *anorexia nervosa*. These girls seemed to be using food as a means of gaining control where they felt they had none. I was struck that my young daughter sometimes did the same, in her own way. In her case, it was developmentally normal autonomy-seeking behaviour. However, the parallel made me think about the psychological aspects of food and the role played by control.

My passing insight into the dynamics surrounding food and feeding piqued my curiosity and I began to delve into the feeding literature. What I found was compelling:

Researchers know so much about what constitutes adaptive and maladaptive feeding practices and yet, as far as I could tell, this information was not being made available to parents. Over the next few years, while working as a therapist in private practice, I continued to voraciously read the feeding literature in my spare time. Ultimately, I decided to bring this interest into my professional work and I set up in practice as a feeding consultant. I was able to use my skills as a therapist to help families work on the relational aspects of food and feeding as well as providing education and coaching on the adoption of responsive feeding practices.

Drawing on my early clinical experience and the feeding and psychotherapy literature, I developed my own treatment model: Emotionally Aware Feeding, which falls under the Responsive Feeding Therapy (RFT) umbrella. I now train professionals in Emotionally Aware Feeding and I speak regularly on RFT, mostly to US audiences. I recently co-authored a white paper summarising the values and practices associated with RFT, with a multidisciplinary team of clinical colleagues from North America. This has since been used by professionals in the US, Canada, the UK, and as far afield as Chile and Brazil. I provide clinical supervision for professionals working with avoidant eating and have an interest in child feeding in an educational context (Cormack, 2017, 2019).

Since its foundation in 2016, I and two colleagues (with help from parent volunteers) have administrated our large Facebook group (~56,000 members) for parents of avoidant eaters, my experience of which has added to my impression that many parents frequently struggle to get professional help for paediatric feeding problems when they need it. Furthermore, my work in this field has given me a strong sense that motivations driving parental feeding practices may be extremely complex and even contradictory. Conversely, in my experience, parents often reveal a high level of self-awareness and can be very articulate in how they talk about their child's avoidant eating and their own responses to it. These observations have all contributed to my interest in pursuing research in this area, especially qualitative research, which fits with my skill set as a therapist and my interest in the parental viewpoint.

Although I, and other professionals in this field, am able to help the minority of parents who can access specialist feeding services, I was interested in the experience of parents whose children's eating was not deemed clinically significant and who were reliant on support from frontline healthcare practitioners in the NHS. The high prevalence of avoidant eating in childhood, coupled with the distress it can cause

parents (see 2.8.2), renders it an important area for research. To summarise, if research evidence shows that nonresponsive feeding practices contribute to avoidant eating, it follows that a better understanding of parental interpretations of the feeding practices they use is essential.

1.3 The Programme of Research

This PhD comprises a systematic review of the literature on the conceptualisation of pressure to eat followed by an empirical component: a qualitative study exploring parental meaning making concerning their feeding practices. Both of these elements are carried out exclusively in relation to avoidant eating. The qualitative study was conducted in response to a perceived need for a nuanced insight into the parental perspective of feeding practices used in the context of avoidant eating. As discussed in the literature review (Chapter 3), there are many cross-sectional studies showing a correlation between avoidant eating and pressure to eat, most commonly based on parental report (C. Brown et al., 2016; Camfferman et al., 2019; Ek et al., 2016). However, qualitative research - which may be able to illuminate this relationship - is scarce (see 2.11).

The empirical component of the thesis represents a unique exploration of parental feeding practices and avoidant eating using *interpretative phenomenological analysis* (IPA; Smith et al., 2009), a methodological approach which strives for a particularly "*rich and detailed"* level of analysis (Pietkiewicz & Smith, 2014, p. 363). The UK primary healthcare context of the study is similarly unique and the purposive sample of parents of avoidant eaters (rather than a general sample) is very unusual. Not only has the need been highlighted for more qualitative research into how nonresponsive feeding practices and child eating behaviours relate to one another (Finnane et al., 2017), it has also been suggested that the complex nature of parental feeding practices makes them difficult to capture using quantitative measures reliant on parental report (Wolstenholme et al., 2019). Given the perceived need for a fine grained insight into the parental perspective, the aim of the study was as follows:

- to explore parental meaning making in the context of avoidant eating in early childhood

The study objectives, flowing from this aim, were:

  - to explore parental meaning making in relation to the feeding practices used and

- to explore parental meaning making in relation to the child's eating behaviours

This aim and these objectives can alternatively be phrased as a research question:

- How do parents of children they identify as avoidant eaters make sense of their feeding practices and of their child's eating behaviours?

The emphasis on the parental interpretation of child eating behaviours alongside parental feeding practices was included on the grounds that it is likely that the two are interconnected: What a phenomenon means to a person arguably influences how they respond to it.

1.4 The structure of the thesis

The current chapter, in which the thesis is introduced, is followed by two chapters comprising literature reviews. The first of these, Chapter 2, provides an overview of the field of paediatric avoidant eating. Food acceptance in childhood is complex and involves many diverse factors (Blissett & Fogel, 2013). On this basis, it was felt that a summary of the history of research into avoidant eating, coupled with an exposition of key parent-related and child-related factors associated with avoidant eating, would serve to contextualise the study. Similarly, given the potential ambiguity around definition and degrees of avoidant eating highlighted earlier in this chapter, an attempt was made to convey some of this complexity with a view to locating the thesis in relation to it. Both responsive and nonresponsive feeding practices relevant to avoidant eating are considered; the nonresponsive feeding practice of pressure to eat is the central focus of the thesis but it was felt that clarity regarding the nature of (and background to) responsive feeding would further elucidate the research.

Chapter 3 is a systematic review of the literature on the conceptualisation of pressure to eat in the context of avoidant eating. It is argued that pressure to eat lacks a clear and consistent definition. On this basis, tools assessing pressure to eat are examined, with a view to gaining insight into how researchers have historically delineated pressure to eat in a feeding context. Only studies which measured child avoidant eating alongside parental feeding practices were examined.

Chapter 4 is the methodology, in which the ontological and epistemological underpinnings of the empirical element of this programme of research (the IPA study) are set out. The main philosophical notions underpinning IPA (Smith et al., 2009) are considered. These are: phenomenology, idiography, and hermeneutics. The chapter

concludes with a discussion of the type of knowledge claims made by the study. *Moderatum* generalisability (Williams, 2002) is employed, which is a pragmatic approach to generalising from idiographic work, highlighting its utility alongside its inherent fallibility. Following the philosophical location of the study that takes place in Chapter 4, details on the method employed are provided in Chapter 5. Research design is considered and a chronological account of the research procedure is shared, including challenges surrounding recruitment and how these were surmounted. Ethics are discussed, as are Smith's (2011) quality criteria for IPA studies, in line with which the study is conducted.

Chapters 6 to 9 make up the findings section of the thesis, in which four superordinate themes are presented. The first of these (Chapter 6) includes a descriptive analysis of feeding practices used by participants, prior to the interpretative analyses shared later in that chapter and in the subsequent findings chapters (7,8, and 9). Each findings chapter culminates in a discussion of the findings presented. Chapter 10, the final discussion, explores how the superordinate themes interrelate and what the findings suggest for practice and research. Chapter 10 also includes a detailed exploration of how the findings expand upon existing qualitative evidence, and novel contributions are highlighted.

2 The Field of Paediatric Avoidant Eating

The aim in relation to this chapter was to review the literature in order to provide a broad background to the topic of paediatric avoidant eating. A further objective was to establish the historical and theoretical context of the concepts explored in this thesis. The chapter opens with a summary of the history of avoidant eating research and how it intersects with related areas of study. Next, there is a consideration of terminology used to describe childhood avoidant eating. The literature on the main parent and child factors contributing to avoidant eating is then examined, followed by an investigation of the classification of avoidant eating. There is a consideration of the impact of avoidant eating on both parents and children before the chapter concludes with a consideration of adaptive and maladaptive feeding practices relevant to avoidant eating and how these relate to the notion of responsive feeding.

2.1 Context

2.1.1 The History of Avoidant Eating Research

Avoidant eating in childhood is a relatively recent but burgeoning area of study. During the 1960s and 1970s there was a degree of academic interest in the predisposition of infants to prefer certain tastes (Birch, 1999). However, it was not until the late 1980s and early 1990s that the field saw an increased emphasis on research into childhood nutrition, following the realisation that paediatric diet was a factor in the development of heart disease (Wardle, 1995). This early work on diet led to a consideration of environmental as well as innate factors in relation to children's eating (Birch, 1987). In the latter decades of the last century, researchers began to understand more about the heritable components of childhood eating behaviours (Falciglia & Norton, 1994). The investigation of genetic factors primarily took place in the field of *preference formation*, an area in which the development of food likes and dislikes in infancy and childhood are explored (Drewnowski & Rock, 1995; Falciglia & Norton, 1994; Rozin & Vollmecke, 1986). Individual difference in the perception of taste was central to the study of preference formation (Hayes & Keast, 2011). For a review of the preference formation literature, see Savage et al. (2007).

Also in the latter decades of the last century, research was being carried out into the related construct of *food neophobia*, henceforth referred to simply as *neophobia* in this thesis. Neophobia is a wariness about the consumption of unfamiliar foods (Pliner & Hobden, 1992). Neophobia - and how it differs from avoidant eating - is examined

later in this chapter (2.2.1). The need to offer children multiple exposures to novel foods to aid acceptance and counter neophobia was highlighted in early research in the field of paediatric feeding. Birch was a key influence in this nascent exploration of the role of exposure (Birch, 1979, 1987; Birch & Marlin, 1982) and is arguably one of the most significant and prolific contributors to the scholarship of childhood eating behaviours.

Although the majority of early child-feeding studies considered typical eaters, researchers were also beginning to explore avoidant eating in both clinical and nonclinical populations (Chatoor, 1989; Pelchat & Pliner, 1986). This latter body of work continues to grow: In their review investigating the state of research into avoidant eating, Cardano Cano et al. (2015) concluded that childhood avoidant eating had recently enjoyed a greater research focus. There is now a rich corpus in the field, encompassing a wide age range (Samuel et al., 2018). Cardano Cano et al. (2015) identified three primary areas of study in relation to avoidant eating: the characterisation of avoidant eating, factors contributing to the development of avoidant eating, and effective management of avoidant eating. This thesis is primarily concerned with the third area, specifically the role played by parents.

2.1.2 Related fields

Many studies exploring childhood eating behaviours consider both obesity[2] and avoidant eating (Ek et al., 2016; Farrow & Blissett, 2008; Haszard et al., 2015; Haycraft et al., 2017; Jani et al., 2015). This can be explained by the focus on the parental feeding practices pressure to eat and *restriction*, both of which are classified as *controlling feeding practices* (Birch & Fisher, 1998; see 2.10.1). Pressure to eat is associated with parent-perceived avoidant eating (McPhie et al., 2011) and parent-perceived underweight (Francis et al., 2001). Restriction refers to adult attempts to curtail consumption of foods, usually those with a high sugar and fat content (J. Fisher & Birch, 1999), and is associated with parent-perceived child overweight (Rollins et al., 2015). Thus, both pressure to eat and restriction can be said to reflect parental attempts to influence children's food consumption in order to optimise health. In the majority of studies examining parental feeding practices, parental use of restriction and pressure to eat are assessed with the same validated instrument, the Child Feeding Questionnaire

[2] See Glossary for a commentary on the term *obesity*

(CFQ; Birch et al., 2001). This further explains the simultaneous consideration of the two constructs and the overlap in the obesity and avoidant eating literature.

As previously stated, the literature on the parental use of pressure to eat is the focus of the next chapter. However, the relationship between parental feeding practices and child overweight is not examined as it is beyond the scope of the study. Similarly, in keeping with current societal concern about childhood nutrition and weight, numerous studies examine how the social environment influences child eating behaviours in the general population, often with a focus on increasing fruit and vegetable consumption, see Pearson et al. (2009) for a systematic review. This topic, although related, is also beyond the remit of the study because the programme of research centres upon parental responses to food avoidance as opposed to how parents feed children who are typical eaters.

2.1.3 Self-regulation of Energy Intake

Children's capacity to regulate their own energy intake is fundamental to an understanding of the relevance of controlling feeding practices (discussed further in this chapter in section 2.10.1). It is also foundational to responsive feeding (see 2.9). Birch et al.'s (2001) development of the CFQ rested on the assumption that children are able to regulate their own energy intake, and so adults do not need to use restriction or pressure to control their food intake. This goes back to the work of Davis in the 1930s. Davis challenges the dominant view at their time of writing, that parents needed to feed babies set amounts of food on a schedule. Their work involved children being allowed to help themselves to a variety of foods and their conclusion was that children were able to thrive, given control over their intake in this manner. In other words, Davis suggested that children eat according to their bodies' needs, given the opportunity (Davis, 1928, 1934, 1939). Birch and colleagues then revisited the notion of children's self-regulatory capacity, and demonstrated that children are indeed able to regulate their energy intake both over a single meal and a 24 hour period (Birch et al., 1991; Birch & Deysher, 1985, 1986). This early work has arguably had a large degree of influence in the field. Parents use practices like pressure and restriction to control children's intake, but it has long been known that this is neither necessary nor adaptive.

2.2 Terminology

Following the provision of some historical context for research into avoidant eating, there is now a focus on terminology. In this section, the constructs of avoidant eating and neophobia are defined and differentiated.

2.2.1 Avoidant eating and neophobia

Neophobia, in relation to child eating behaviours, has been distinguished from avoidant eating on the basis that neophobia describes a lack of willingness to consume unfamiliar foods, whereas avoidant eating additionally encompasses a lack of willingness to consume foods which are not novel (Tharner et al., 2014). Thus there is a difference concerning precisely when the food rejection happens. A simplistic summary of neophobia offered by Dovey et al. (2008) suggests that neophobia involves a rejection prior to tasting because once a food has been tasted it is no longer novel. By this rationale, a rejection after a single tasting would be avoidant eating. However, the picture is a more nuanced one because, as reflected in Dovey's later work (Dovey, 2018), a neophobic child may simply need more exposures than a typical eater before accepting an initially unfamiliar food, with the severity of the neophobia being reflected in the number of exposures ultimately required.

A theory based in evolutionary psychology has been put forward in relation to neophobia: Caution regarding unfamiliar but potentially edible plants may have played an adaptive role for the human species (Pliner & Hobden, 1992). When children become physically mobile (in early toddlerhood), in order to reduce the risk of temptation to eat poisonous items, a wariness about eating brightly coloured and unfamiliar foods may have been protective (Birch, 1999; Dovey et al., 2008). The negative reaction to bitterness often seen in young children (Beauchamp & Mennella, 2009) fits with this theory because bitterness signals toxicity in the natural world (Shi et al., 2003). Indeed, 'Beige food' (Merritt et al., 2019) is a term used colloquially to denote a stereotypical toddlers' diet, low in colourful fruit and vegetables.

Following a history in experimental studies with animals (Archer & Sjoden, 1979; Barnett, 1958, as cited in Pliner & Hobden, 1992), neophobia has been researched extensively with human subjects; a review of instruments used to measure neophobia identified 255 studies pertaining to neophobia (Damsbo-Svendsen et al., 2017). Seven instruments in Damsbo-Svendsen et al.'s review related to children. The first study exploring how neophobia relates to avoidant eating appears to be by

Galloway et al. (2003). These researchers found that, although avoidant eating and neophobia were related to a small extent, the two constructs had different predictors. Neophobia was linked to innate characteristics (including anxiety) and avoidant eating was largely influenced by environment.

Galloway et al.'s (2003) findings were not replicated in a later study in which it was concluded that neophobia was significantly related to avoidant eating (Finistrella et al., 2012). In concurrent research (Rigal et al., 2012), it was found that the two constructs were highly correlated, and they were described as "overlapping but distinguishable" (p.634). Arguably, this debate was settled in a large-scale twin study (A.D. Smith et al., 2017), designed to ascertain to what degree genetic and environmental factors can explain the variation in neophobia and food avoidance in young children. A. D. Smith et al. found that, although avoidant eating was more influenced by environment than neophobia was, the two constructs had a shared origin and both were highly heritable.

2.2.2 Towards a definition of avoidant eating

This examination of the nature of avoidant eating is now extended to consider its definition. It is widely agreed that there is a lack of a consistent approach to the delineation of avoidant eating in the literature (Cardona Cano, Hoek, et al., 2015; Chatoor, 2002; Estrem et al., 2016; Kerzner et al., 2015; Tharner et al., 2014). Further confusion arises from the frequent use of synonyms. The most commonly used term appears to be *picky eating* (Boquin, Moskowitz, et al., 2014; C. Brown et al., 2018; Cardona Cano, Hoek, et al., 2015) but many other appellations are also employed. Examples of these are as follows: *fussy eating* (Dovey et al., 2008) *selective eating* (Zucker et al., 2015), *faddy eating* (Taylor et al., 2015), *problem eating* (Sanders et al., 1993), *irregular eating* (McDermott et al., 2008) and *finickiness* (Kreipe & Palomaki, 2012).

The majority of definitions of avoidant eating fall into two groups. The first group simply refers to the acceptance of a narrow range of foods (Carruth & Skinner, 2000; Ekstein, Laniado, & Glick, 2010; Galloway, Fiorito, Lee, & Birch, 2005; Nederkoorn, Jansen, & Havermans, 2015; Örün, Erdil, Çetinkaya, Tufan, & Yalçın, 2012). The second group includes a reference to both the rejection of known and unknown foods, thus including neophobia as an element of avoidant eating (Dovey et

al., 2008; Lafraire et al., 2016; Nicholls & Bryant-Waugh, 2009; Powell et al., 2011; Rigal et al., 2012; Steinsbekk et al., 2017; van der Horst, 2012).

From a clinical perspective, avoidant eating has been defined as the rejection of both novel and familiar foods which is of sufficient severity to "interfere with daily routines to an extent that is problematic to the parent, child or parent-child relationship" (Lumeng, 2004, p. 265) so that the degree of the problem forms part of the definition. This formulation was also espoused by Taylor et al. (2015) in their review of definitions. The emphasis on the relational and experiential aspects of paediatric feeding problems is valuable. However, it also highlights the difficulty of objectively assessing the degree of the problem. This is because food rejection managed effectively may not interfere with a family's quality of life as described but could nonetheless entail the consumption of a very limited diet. In addition to the rejection of familiar and unfamiliar foods, *strong food preferences* have been included in some definitions of avoidant eating (Mascola et al., 2010; Taylor et al., 2015). This is ambiguous because it is very hard to establish whether a strong food preference is in fact distinct from a powerful need to reject nonaccepted foods. In other words, a strong preference for an accepted food could be a manifestation of anxiety about eating nonaccepted foods.

Two qualitative studies specifically exploring parental understanding of the term 'picky' eating (Boquin, Moskowitz, et al., 2014; Trofholz et al., 2017), suggested that parents' definitions may be divergent, although in both studies it was found that neophobia and the consumption of a narrow range of foods were instrumental to parental usage of the term 'picky' eating. Additionally, Boquin, Moskowitz, et al. (2014) found that some parents included the consumption of a limited quantity of foods in their definition. Trofholz et al. (2017) found that the most extensively used definition in their sample was the dislike of just a few foods, yet other participants were referring to the rejection of an entire food group or the acceptance of a very limited diet. Taken together, these qualitative findings indicate that parental definitions of avoidant eating resonate with those in the literature in their inclusion of neophobia and an emphasis on limited dietary variety, while also revealing some divergence in relation to typology and degree. In this thesis, avoidant eating is defined as the consumption of a limited variety of familiar foods and the rejection of unfamiliar foods. This draws on the definitions used by researchers, the way in which parents themselves conceptualise avoidant eating, and an acknowledgement of the somewhat different developmental pathways of the rejection of familiar and unfamiliar foods.

2.3 The Prevalence of Avoidant Eating

When examining the merit of researching avoidant eating, the frequency of its occurrence is a relevant consideration. In this section, several reviews of the literature encompassing prevalence are considered (Cole et al., 2017; Samuel et al., 2018; Taylor et al., 2015), as are studies that were conducted after the period covered by these reviews (see Appendix A). Taylor et al. (2015) identified a wide range of prevalence findings in the studies they considered, with 5.6% being the lowest prevalence rate and 50% being the highest. Cole et al.(2017), via a meta-analysis of 11 studies, found the prevalence rate to be 22%. Like Taylor et al. (2015), Samuel et al. (2018) found a wide range of prevalence rates, in their case extending from 6.6 to 59.3%. These authors pointed out that when avoidant eating was assessed more carefully to include some indication of degree (i.e., "very picky eater" as opposed to a "yes / no" answer to a single question about 'picky eater' status) the prevalence level dropped to <15%. In the five studies located which were not included in these reviews (Chao, 2018; Kutbi, 2020; Machado et al., 2021; Steinsbekk et al., 2017; Zohar et al., 2020) prevalence rates were divergent and samples varied greatly in age. In relation to clinically significant avoidant eating, the prevalence of ARFID is not currently known (Bourne et al., 2020).

Particular attention is given to the findings shared by Taylor et al. (2015) from the UK Avon Longitudinal Study of Parents and Children (ALSPAC). This is because the location and age range make them relevant to the current study. Furthermore, the design of the study adds weight to its findings; data were gathered at multiple time points (24, 38, 54 and 65 months of age) and the sample was extremely large (n=13,988) and population-based. It should be acknowledged, however, that the data are not current, dating from the1990s. At each time point, the prevalence of avoidant eating was between 9.7 and 14.7%. Taylor et al. reported that 3.5% of children were avoidant eaters at all time points, a finding consistent with Zohar et al.'s (2020) data, which showed 3.94 % of children to be persistent avoidant eaters.

On the basis of all the studies considered in this section, including Cole et al.'s (2017) meta-analysis, it is argued that, as highlighted by Taylor et al. (2015), prevalence data is difficult to compare because of divergence in measures, ages of samples and definitions of avoidant eating. However, it seems reasonable to estimate that between 10 and 25% of children are perceived by their parents to be avoidant eaters. Furthermore, there seems to be a distinction between remitting and persistent avoidant eating, the latter affecting a smaller subgroup of children. Evidence

concerning the trajectory of childhood avoidant eating is considered further in the next section.

2.4 The Trajectory of Avoidant Eating

Using the Child Eating Behaviour Questionnaire (CEBQ; Wardle et al., 2001) at two time points (4 and 11 years of age) with a UK sample (n=322), Ashcroft et al. (2008) found that, although there was a reduction in scores on the *food fussiness* subscale of the CEBQ over time, scores at both time points were highly correlated. A conclusion drawn by these authors was that food fussiness[3] (and other eating behaviours) may have a trait-like nature given this evident stability. Similarly, Powell et al. (2018) found avoidant eating rates at the age of 3 years to be significantly associated with those measured at the age of 4 years. It is possible that the small (and low) age range in this latter study explains the lack of remittance; the authors recommended further longitudinal work extending into middle childhood. In contrast, other research suggests that avoidant eating is largely remittent: In the ALSPAC cohort, 3.5% of the children were avoidant eaters at all time points (see 2.3) versus between 10.3% and 15.4% of the sample who were avoidant eaters at individual time points. The highest incidence of avoidant eating was at 38 months (Taylor et al., 2015). This indicates that being an avoidant eater at some point in early childhood is common, whereas persistent avoidant eating is less common.

Likewise, Cardano Cano et al. (2015), in a large-scale population-based study, found that at the highest rate of incidence of avoidant eating was at the second time point used, when the children were aged 3 years (27.6%). This contrasts with the lowest rate of incidence (13.2%), at the third time point used, when the children were aged 6 years. Of the children identified as avoidant eaters at the first two time points (1.5 and 3 years of age) approximately two thirds were no longer avoidant eaters at the third time point, thus remittance was high. Given the sample sizes in the ALSPAC and Generation R cohorts, which were ~14,000 and ~4,000 respectively (Taylor et al., 2015; Cardano Cano et al., 2015) these findings are perhaps more compelling than those of Ashcroft et al. (2008), mentioned at the beginning of this section (2.4).

Distinct trajectories of avoidant eating have been identified, with Cardano Cano et al., (2015) describing three: *remitting* (0-4 years); *late onset* (6 years only) and

[3] 'Food fussiness' rather than 'avoidant eating' is used here to avoid confusion arising from the latter term due to its distinct use in relation to the CEBQ (Wardle et al., 2001).

persistent. In recent research with a low income US sample (Fernandez et al., 2020), three trajectories were similarly identified: *persistently low*, *persistently medium*, and *persistently high*. This was in the context of data collected at multiple time points between the ages of 4 and 9 years of age. It seems clear that there is not a simple pathway that all children follow in relation to avoidant eating and research exploring its prevalence and trajectory would benefit from a more nuanced consideration of degree. In fact, it has been suggested that there may be a connection between the trajectory and degree of avoidant eating (Mascola et al., 2010) but further research is needed in order to establish how the intensity of feeding problems is connected to their remittance. The question of degree is considered later in this chapter (0). First though, child factors, parent factors and environmental factors associated with avoidant eating are examined.

2.5 Child Factors Associated with Avoidant Eating

There are several factors which have been linked to avoidant eating in childhood. Some concern innate individual differences, some are environmental (including relational factors), some pertain to developmental disorders, and some are physiological. Developmental and physiological causes of picky eating such as Autism Spectrum Disorders (ASD), gastrointestinal issues or physical problems with chewing or swallowing are not examined because children with a pre-existing diagnosis explaining their eating behaviours are not a group of interest regarding this programme of research. By way of considering innate individual differences, this section covers child characteristics which have been linked to nonclinical avoidant eating: sensory processing, temperament, and genetically driven differences in taste perception. In the subsequent section (2.6), environmental factors are considered.

2.5.1 Sensory Processing

In the latter half of the last century, Ayres (1974) developed *sensory integration theory*, in the context of which they talked about *tactile defensiveness* and later, *oral defensiveness*. Ayres (1964) posited that humans have a protective system which responds to stimuli and a discriminative system which allows the brain to interpret stimuli for cognition. These systems work together to keep humans from harm. In some individuals, there is an imbalance between the protective and discriminative systems whereby the latter dominates, resulting in a negative reaction to certain types of sensory stimuli. This early work (Ayres, 1964, 1974) led to the development of a model

designed to aid the processing of sense data in children with sensory integration challenges (Ayres & Robbins, 2005).

This area of scholarship was developed by Dunn (1997), who proposed a conceptual model of sensory processing in young children which drew on the fields of both neuroscience and behavioural science. This model describes a relationship between two continua: the *behavioural response continuum* and the *neurological threshold continuum*. Children who are low on both continua are described as *sensation avoiding*. They may have low thresholds for certain aspects of sense data (e.g., the tactile experience of food in the mouth) and may exhibit avoidant behaviour in response to this. Dunn's sensory profile (1994) includes several measures which refer to eating and, in a later factor analysis of the revised sensory profile (Dunn & Brown, 1997), the factor grouping *oral sensitivity* was proposed. This features items from the domains of touch, taste and smell. For example, "limits self to particular food textures /temperatures" (p.493). Much of the research exploring sensory processing and children's eating behaviours has used Dunn's revised sensory profile, exploring the domains of gustatory, olfactory, tactile, auditory and visual sensitivity (Blissett & Fogel, 2013). However, in the avoidant eating literature, both Dunn and Brown's (1997) and Ayres' (1974) terminology is used (with references to sensory sensitivity, oral sensitivity, oral defensiveness, and tactile defensiveness) which is potentially confusing.

Parents themselves seem to recognise the role played by sensory sensitivity in child eating behaviours, considering it to be an important aspect of avoidant eating (Boquin, Moskowitz, et al., 2014). Scholars, however, have only recently established the connection between sensory sensitivity and avoidant eating. In Dovey et al.'s (2008) review of the literature, just a single paper (A. M. Smith et al., 2005) was cited in which this link was suggested. In a later review, considering influences on children's acceptance of new foods, it was found that sensory sensitivity (usually assessed via parental report) was an important factor in children's inclination to eat certain foods (Blissett & Fogel, 2013). Later still, in another review, Lafraire et al. (2016) highlighted a clear connection between tactile defensiveness and avoidant eating emerging from the literature. It can be inferred, therefore, that sensory processing has increased in prominence in the study of avoidant eating over recent decades.

There is some question about how the sensory aspects of avoidant eating relate to the degree of the feeding challenge. In relation to clinically significant feeding problems, Chatoor (2009) proposed a specific category of dysfunctional eating termed

sensory food aversion. More recently, Kerzner et al. (2015), in their paper offering guidance for paediatricians, classified children with the most limited diets (less than 10 or 15 foods) as *highly selective*. The authors claimed that these are the children Chatoor (2009) found to have sensory food aversions, describing rejection with a sensory basis, of entire food categories. This would include rejection based on texture, smell, temperature or the visual aspects of the food (Kerzner et al., 2015). Although other sources (G. Harris & Shea, 2018) support the assertion that the majority of children whose food rejection is at the severe end of the spectrum display some atypical sensory processing, research evidence concerning how the degree of sensory over (or under) responsiveness relates to the degree of avoidant eating is lacking. In fact, it has been shown that both children with moderate and severe avoidant eating are more likely to be hypersensitive to texture and taste (Zucker et al., 2015).

What is clear, however, is that sensory sensitivity influences eating. In what the authors claimed to be the first study of the food choices of tactile defensive children and the extent of avoidant eating in this population, it was stated that the incidence of eating vegetables "without fuss" in these children was half that of nontactile defensive children (A.M. Smith et al., 2005, p. 17). In the same study, it was asserted that (according to maternal report) tactile defensive children rarely ate the same foods that the rest of the family were given. In the first study, according to the authors, to establish that sensory sensitivity prospectively predicts avoidant eating (Steinsbekk et al., 2017), it was found that the children most likely to become avoidant eaters were those who were not only highly sensory sensitive themselves, but also had parents who measured high on sensitivity and low on structuring. This illustrates the interplay between parent and child factors inherent in avoidant eating.

2.5.2 Temperament

Temperament refers to the innate predispositions governing how humans respond to the world around them (Rothbart, 2007). A growing body of evidence points to the important role of temperament in children's relationship with food. A comparison of findings in this area is challenging due to inconsistencies in which model of temperament is used. However, in many of the studies considered, temperament was conceptualised using Buss and Plomin's (1984) three dimensions: *emotionality*, *activity*, and *sociability* (EAS). Of these dimensions, the research into emotionality and avoidant eating is by far the least ambiguous, a clear link having been established

(Hafstad et al., 2013), underscored by findings connecting high emotional lability and poor emotional regulation with more severe manifestations of avoidant eating (Fernandez et al., 2020). Buss and Plomin (1975) used the term emotionality to describe the intensity of a person's reactions. A person with a high degree of emotionality experiences extreme affect and is easily aroused. Emotionality appears to be similar to *difficultness* as used in Thomas et al.'s (1968) model of temperament, where it is said to be characterised by intense reactions and the frequent expression of negative affect. In the paediatric feeding literature, both the terms emotionality and difficultness are used. Emotionality is felt to be a preferable term, based on its greater neutrality.

It has been suggested that the relationship between child eating behaviours and parental feeding practices may be bidirectional (Haycraft et al., 2011) and it seems that this could be the case in relation to emotionality and avoidant eating. A challenging child temperament may contribute to maladaptive parental feeding practices (Blissett & Fogel, 2013) which could, in turn, negatively affect child eating behaviours. This chimes with early research (Chatoor, 1989) suggesting a connection between parenting, child temperament and eating behaviours. Chatoor described how a *willful* child temperament, coupled with a maternal lack of sensitivity, can give rise to dysfunctional feeding practices. Chatoor's term *willfulness* has been linked to the concept of difficultness (Hagekull et al., 1997) and also appears to map onto Buss and Plomin's (1975; 1984) notion of emotionality. While the connection between emotionality and eating is clear, findings on sociability and shyness are mixed. Haycraft et al.(2011) found that, in their sample of young children, eating behaviours were not connected to the EAS traits. Conversely, Pliner and Loewen (1997) found that children with greater levels of shyness were more likely to be neophobic.

2.5.3 Taste Perception

The perception of taste involves a complex interplay of senses and is influenced by both innate and environmental factors. See Beauchamp and Mennella (2009) for a comprehensive overview of the mechanisms involved. It is well established that children and adults react differently to certain flavours (Mennella & Bobowski, 2015). It is also known that there is variation among individuals, regardless of their age, in terms of how tastes are perceived. In some instances, this has been linked to a specific gene or group of genes (Bufe et al., 2005). Individuals who experience taste more intensely than the majority of people have been termed *supertasters* (Bartoshuk et al.,

1992). This concept has evolved over recent years, initially referring to how bitter and sweet tastes are perceived, but latterly encompassing *acuity* (the ability to accurately identify flavours) and other categories of taste (Hayes & Keast, 2011). It is not clear whether being a supertaster is connected to being an avoidant eater although the intense experiencing of bitterness has been linked to avoidant eating; despite a comparatively small number of studies exploring this link, in a review of the literature Blissett and Fogel (2013) found that children's sensitivity to bitterness was connected to the rejection of certain foods.

As alluded to above, there seems to be an interaction between children's eating behaviours, children's intrinsic qualities and the feeding environment. Child factors have an effect on the degree of influence of some parental feeding practices, such as exposure and modelling (Coulthard & Blissett, 2009). Furthermore, child factors have been shown to affect how parents approach feeding, which in turn affects how children relate to food (Blissett & Fogel, 2013). The bidirectional influence of child eating behaviours and certain parental feeding practices is considered in Chapter 3. In the next section, however, research exploring relevant parent factors other than feeding practices is considered.

2.6 Environmental Aspects of Avoidant Eating

Several environmental factors have been shown to have a bearing on child feeding. In this section, these along with maternal mental health, are examined. The relational aspects of child feeding are also considered because feeding dynamics can be seen as an aspect of the feeding environment.

2.6.1 Demographic Factors

Demographic factors considered in this section are parental income and ethnicity. Other demographic factors such as maternal age and parental gender (Cardona Cano, Tiemeier, et al., 2015) have been examined but are not considered here. This is because space constraints dictated the prioritisation of factors which have been more widely researched.

2.6.1.1 *Parental Income*

Although there are several studies exploring the impact of demographic factors on parental feeding practices in general (Berge et al., 2018; Hoerr et al., 2009; Musher-Eizenman et al., 2009; Vereecken et al., 2004), few specifically consider a correlation between demographic factors and avoidant eating, and of those that do, findings are

sometimes contradictory. In a study of parental feeding practices in the USA (Evans et al., 2009) the authors concluded that, while there were not many significant differences between parental feeding concerns and practices due to demographic factors, there was a correlation between high parental income and a perceived difficulty with avoidant eating. This relationship was not found in two Dutch studies, both embedded in the same large-scale longitudinal study (Generation R; Cardona Cano et al., 2015; Tharner et al., 2014) showing that children who were avoidant eaters were more likely to be part of a low income family than children who were not avoidant eaters. However, previously, Carruth et al., (2004) stated that the prevalence of avoidant eating did not change according to household income. A more recent study (H. Harris et al., 2019) found that food insecurity influenced feeding practices in the context of avoidant eating. Yet other research (C. Brown et al., 2018) with a relatively large sample (n=506) found food insecurity and avoidant eating to be unrelated. As called for by Harris et al. (2019), it seems that further research with food insecure families is needed, in order to better understand the relationship between child-feeding practices, food insecurity and avoidant eating. It is possible that associations differ according to cultural context.

2.6.1.2 Parental Education Level

In terms of parental education, Evans et al. (2009) stated that little research exists into inter-relationships between parental education, child eating behaviours and parental feeding practices. Their study, exploring avoidant eating in an ethnically diverse US sample, found no associations between parental feeding practices and education level. This finding has since been echoed in a study with a similar sample (Fernandez et al., 2020), in which significant associations between parental education and the level of child avoidant eating were not found. Similarly, longitudinal work did not show that maternal education level predicted child avoidant eating (Hafstad et al., 2013). Although one study (Vereecken et al., 2004) revealed a difference in child diet according to maternal education level, this was entirely explained by maternal diet and parenting practices. This was in the context of a general sample in which avoidant eating was not assessed. These findings, taken together, suggest that maternal education level is not associated with child avoidant eating.

2.6.1.3 Ethnicity

Ethnicity has been found to impact parental feeding practices (Fries et al., 2019; Sherry et al., 2004). However, this may be part of a complex and contradictory picture.

Despite finding that the degree of acculturation for US Hispanic participants was associated with feeding practices used, Evans et al. (2009) concluded that ethnicity did not seem to be associated with child eating behaviours or diet. They speculated that perhaps socio-economic factors, such as access to fresh food, had a greater role to play. More recent work (Berge et al., 2018), also exploring parental feeding practices in various ethnic groups in the US, showed differences connected to ethnicity in the use of pressure to eat but not restriction.

In relation to avoidant eating specifically rather than feeding practices in general, researchers in the Netherlands (Cardona Cano, Tiemeier, et al., 2015) found that in their sample, having a mother who was not of a Western ethnicity increased the chances of a child being an avoidant eater. However, a cross-sectional study with a random US national sample (Carruth et al., 2004) found that ethnicity did not predict avoidant eating. Given the size of the samples in these studies (Cardona Cano, Tiemeier, et al., 2015; Carruth et al., 2004), which were n4018 and n3022 respectively, this divergence is noteworthy. It is possible that the difference in the study dates or the cultural context impacted the data.

Only one study was identified (Wright et al., 2007) in which ethnicity and avoidant eating in a UK sample were examined, and this study reported 100% White respondents. Similarly, only one (Korani et al., 2018) examining ethnicity and parental feeding practices in a UK sample was identified. Although it included measures of both restriction and pressure to eat, the focus of this research was on weight rather than avoidant eating. However, these authors found that South Asian mothers used the most pressure to eat, then Chinese, Black and White mothers, in descending order. South Asian mothers also used the most *instrumental feeding* (making a desired activity or food contingent on eating or trying another, nondesired food) and Chinese mothers used the least. It should be noted that Korani et al.'s sample comprised parents of children aged 5 to 11 years. These findings should, therefore, be applied with caution to parents of younger children.

2.6.2 Maternal Mental Health

Multiple studies - a selection of which are referred to in this section - have shown that both maternal mood and maternal mental health are related to paediatric feeding problems (no studies relating to paternal mood or mental health were identified). The notion that there may be a positive relationship between maternal

psychopathology and child-feeding problems is not a new one, having been suggested by Chatoor (1989) in the 1980s. The findings of a longitudinal study conducted in the UK (Coulthard & Harris, 2003), in which the role of maternal mood in avoidant eating in infants was examined, supported the notion that maternal mood may give rise to maladaptive approaches to child feeding. However, the authors suggested that maternal affect was potentially reactive as opposed to causal. It is possible that when feeding is problematic, mothers experience elevated negative affect, which in turn exacerbates feeding problems. It should be noted that these findings cannot necessarily be extrapolated to mothers of children over the age of 11 months. Equally, the authors recommended a cautious interpretation of their data because it is based on maternal report alone.

In relation to early childhood as opposed to infancy, it has been found that negative maternal mood when a child is 18 months old predicts feeding problems both at that point and when the child is of preschool age (Hafstad et al., 2013). Similarly, there is evidence for a link between maternal anxiety and young children's avoidant eating (Katzow et al., 2019; Zucker et al., 2015). A study from the UK in which maternal mental health symptomatology and the use of responsive and controlling feeding practices (Haycraft, 2020) indicated a connection between maternal anxious and depressive symptoms and the employment of controlling feeding practices. These findings, as the author pointed out, underscore previous research connecting both clinical and nonclinical maternal mental health problems with nonresponsive feeding practices. Furthermore, these findings give rise to a question about whether mothers may be less engaged with child feeding if they are experiencing negative affect.

It has been suggested that child gender impacts the relationship between maternal mental health and feeding problems: Anxious and depressive symptomatology predicted problematic feeding dynamics in mothers of boys but maternal eating psychopathology did not (Blissett et al., 2007). Conversely, in the same study, it was found that symptomatology associated with depression and *bulimia nervosa* predicted food refusal in mothers of girls, but anxiety did not. Lewinsohn et al. (2005) referred to several studies that link maternal disordered eating and child-feeding problems. Their own data did not show a connection but the authors acknowledged the limitation that, unlike the studies they had cited, their community sample did not contain many mothers whose eating was in fact disordered.

2.6.3 The Relational Nature of Paediatric Feeding Problems

The notion that feeding is inherently relational is not a new one (Satter, 1986) and is implicit in the ongoing research focus on parental feeding practices alongside child factors, as illustrated in the next chapter. However, it has been argued that this understanding has historically been missing from the field (Walton et al., 2017). Walton et al. suggested that researchers have habitually interpreted avoidant eating in relation to the adult agenda and that consequently, children's rejection of foods has been wrongly viewed as noncompliance rather than as an expression of autonomy. Similarly, Davies et al. (2006) made the case for conceptualising clinically significant childhood avoidant eating as a relational disorder. They argued for a systemic interpretation of paediatric feeding problems. The notion that child feeding is relational and that avoidant eating needs to be understood through a systemic, relational lens is intrinsic to responsive feeding (Black & Aboud, 2011; Cormack et al., 2020), outlined at the end of this chapter (2.9). A fundamental tenet of Davies et al.'s (2006) argument is that child eating behaviours and parental feeding practices are bidirectional. The literature on parental use of pressure to eat in the context of avoidant eating is considered at the end of this chapter (2.10.3.3) and the direction of the association between pressure to eat and avoidant eating is considered in the next chapter (3.1.2).

2.7 Classifying Avoidant Eating

Along with inconsistencies in definition (see 2.2.2) variance in the degree of avoidant eating contributes to the complexity of the field. In this section, both developmentally normal and clinically significant avoidant eating are considered, culminating in the notion of avoidant eating as a continuum.

2.7.1 Avoidant Eating as Developmentally Normal

In their literature review, Cardano Cano et al. (2015a) described how avoidant eating is widely acknowledged to be a developmentally normal stage in early childhood, reflected in the high prevalence rates and the frequency of remittance as children approach middle childhood (see 2.3 and 2.4). This fits with the evolutionary argument in relation to neophobia, introduced above (2.2.1). Alongside the evolutionary argument, there is another possible explanation of why avoidant eating can be seen as a normal aspect of early childhood: children's natural urge for autonomy and concurrent parental misperceptions.

The striving for autonomy is a key aspect of psychologically healthy development (Ryan et al., 2016). Developmentally normal boundary testing often takes place during mealtimes, as described by Chatoor (2002), who stated that the tension between autonomy and dependency is a daily concern in the context of child feeding. Autonomy-seeking behaviours may manifest as avoidant eating (Horodinski et. al, 2010) and, as already alluded to in relation to Walton et al.'s (2017) work, viewing this as dysfunctional potentially constitutes the problematisation of child agency. It should be noted that the evolutionary argument and the autonomy-seeking argument are not necessarily mutually exclusive.

As seen in the previous chapter (1.1) parental concerns about avoidant eating can be dismissed by healthcare professionals. Factors concerning remittance and prevalence presumably contribute to this; many children do 'grow out of' avoidant eating and its high rate of occurrence renders it a developmental norm. Nonetheless, it does not follow that paediatric feeding problems are always normal and will always remit with age. This thesis is concerned with nonclinical avoidant eating. However, avoidant eating may be a continuum (see section 0 for a detailed examination of this idea). On this basis, a brief history of the clinical classification of avoidant eating is offered, with a view to bringing greater clarity to bear regarding the - sometimes blurred - lines between clinical and nonclinical paediatric feeding problems.

2.7.2 Clinical Classification of Avoidant Eating

It has long been recognised that for some children, very limited eating may merit a clinical diagnosis. The form of that diagnosis has been through many iterations. In the latter half of the last century, the term *nonorganic failure to thrive* (NOFT, NOFTT or NFTT) was used to describe a young child who was not growing as expected despite an absence of discernible physiological problems (Breunlin et al., 1983). The term NOFT was often used alongside *feeding disorder*, the two terms being synonymous (Chatoor, 2002). NOFT was linked, in part, to dysfunctional parent-child feeding dynamics (Heffer & Kelley, 1994). Deprivation and other social factors were thought to contribute to NOFT (Albon & Mukherji, 2008). In the UK, what would previously have been classified as NOFT is now termed *faltering growth* (NICE, 2017).

The dysfunctional eating associated with NOFT was initially thought of as a separation disorder (Chatoor & Egan, 1983). It was later termed *infantile anorexia nervosa* (Chatoor, 1989) to capture the control-seeking behaviours associated with this

type of food rejection in early childhood, thought to be reminiscent of *anorexia nervosa*. Ultimately, this was changed to *infantile anorexia* (Chatoor et al., 1998).

Although NOFT was historically linked to dysfunctional attachments, later research (Chatoor et al., 1998) indicated that most children with infantile anorexia were securely attached to their mother. This research did, however, show a higher level of disordered attachments in the children with a diagnosis of infantile anorexia than in the children in the control groups.

Further to NOFT and infantile anorexia, a variety of diagnostic labels have been used in an attempt to classify childhood food rejection. These were outlined by Lask and Bryant-Waugh (2007). *Food avoidance emotional disorder* (FAED) applied to children with a diagnosis of an emotional disorder, a key aspect of which was the avoidance of food, resulting in weight loss or underweight; *selective eating* related to children who usually ate a very small number of foods but had no problems with faltering weight or growth; *restrictive eating* described children who ate a normal variety of foods and were of a healthy weight but had very small appetites and low food enjoyment; *food refusal* referred to inconsistent rejection of food across settings, people, and food items, such as children who may eat well with one parent but not another or who may enjoy carrots at daycare but refuse them at home. Finally, *functional dysphagia* related to children who avoided food due to a fear of swallowing difficulties or choking. These categories are included in what have been called *The Great Ormond Street Criteria* which constituted an attempt to classify and describe childhood eating disorders (Nicholls et al., 2000). Another important diagnostic subcategory proposed in relation to childhood feeding problems was sensory food aversions, mentioned above (2.5.1). This label was intended to capture the role of sensory sensitivity in food rejection (Chatoor et al., 2000). Ultimately, Chatoor (2002) proposed a classification system comprising six categories, in which sensory food aversions and infantile anorexia were included.

Turning now to the classification of clinical paediatric feeding problems in internationally used manuals, in the 1990s the category *feeding disorder of infancy and early childhood* was included in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; DSM-4; American Psychiatric Association, 1994). This category represented an attempt to classify paediatric feeding problems consistently. Nonetheless, the classification remained vague and did not include disorders where weight and growth were normal (Chatoor, 2002). Reflective of this vagueness, the

diagnostic category *eating disorders not otherwise specified* (EDNOS), also in the DSM-4, has been used to diagnose clinically significant avoidant eating. EDNOS covered all disordered eating beyond early childhood which merited a diagnosis but failed to meet the criteria for anorexia nervosa or bulimia nervosa (Fairburn & Bohn, 2005). The equivalent category in the ICD-10 Classification of Mental and Behavioural Disorders (10th ed.; ICD-10; World Health Organisation, 1992) was *Eating disorder, unspecified*.

In response to the recognition that the classification system was not fit for purpose, the *Work Group for Classification of Eating Disorders in Children and Adolescents* was convened to review the extant system and explore alternatives (WCEDCA, 2007). This work culminated in the inclusion of a new disorder: avoidant restrictive food intake disorder (ARFID), in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013) (M. Fisher et al., 2014) and more recently, in the International Statistical Classification of Diseases and Related Health Problems (11th ed.; ICD-11; World Health Organisation, 2019). ARFID arguably has many benefits in relation to the diagnoses it sought to replace. It is not limited to childhood but can be used to describe adults who only eat a narrow range of foods. Unlike EDNOS, it does not require a person to be significantly underweight or nutritionally compromised in order to meet the criteria for diagnosis. As seen in section 2.8.1, even severe avoidant eating does not necessarily result in underweight or nutritional deficits. Thus, ARFID represents a recognition of the - sometimes sizeable - psychosocial challenges that severely avoidant eating may result in. Even when a child is physically healthy, if their limited eating is causing them distress in social situations and their problematic relationship with food is causing them and their family distress, they may meet the criteria for ARFID. In the US, a further diagnosis, *pediatric feeding disorder* (PFD) has been proposed (Goday et al., 2019). According to Goday et al., by encompassing medical, nutritional, skill-based, and psychosocial aspects of paediatric feeding problems, PFD offers an alternative to discipline specific diagnostic conceptualisations of clinically significant paediatric feeding problems. The implication here is perhaps that ARFID comprises an excessive focus on the psychological. However, ARFID remains the diagnosis used in the NHS (NHS, 2021) although it should be noted that there is not yet a NICE guideline relating to ARFID.

Children with a diagnosis of ARFID are not included in the current study. This is because the diagnosis would theoretically enable them to access professional support

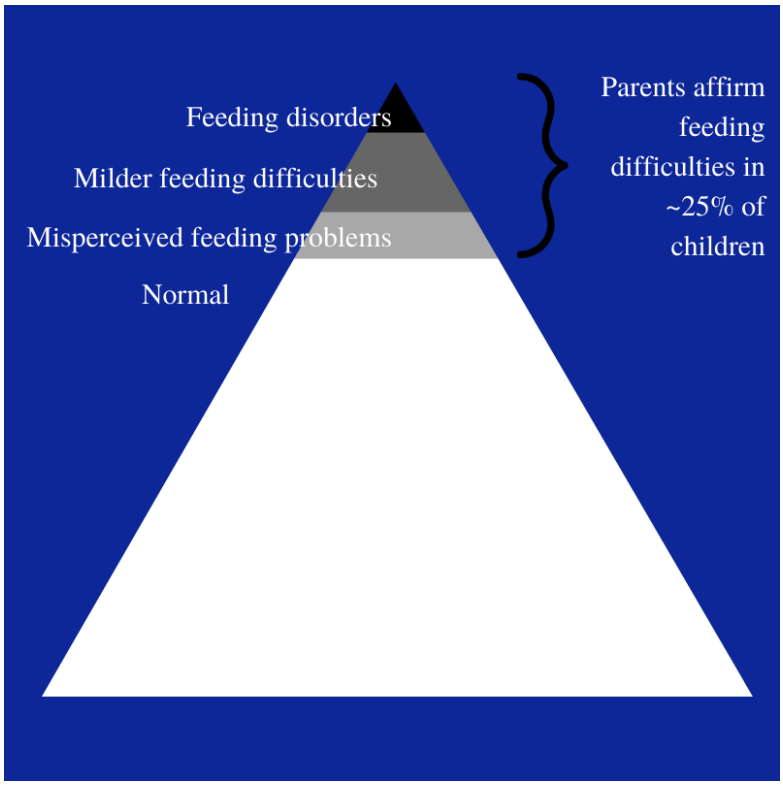
(perhaps input from their paediatrician or their local Child and Adolescent Mental Health Services (CAMHS) Eating Disorders Team[4], which would not be as accessible for children who do not meet the threshold for diagnosis or remain undiagnosed. This study is concerned with the experiences of parents who are receiving support from their health visitor for their child's eating challenges, rather than those who have received an onward referral. It should be noted though, that both clinical experience and opinions expressed in the literature (Cardona Cano, Hoek, et al., 2015; Dovey, 2018) suggest that professionals are often unable to distinguish between ARFID and developmentally normal avoidant eating due to a lack of specialist knowledge.

2.7.3 Avoidant Eating as a Continuum

Attempts to distinguish degrees of avoidant eating in guidance for professionals employ divergent approaches. Kerzner et al. (2015) used a pyramid loosely based on prevalence data (Figure 2.1). Three categories of paediatric feeding problem are presented: misperceived feeding problems, milder feeding difficulties and feeding disorders.

[4] This is what would happen in ideal circumstances. Clinical experience suggests that the referral, assessment, and treatment pathway for ARFID is not clearly established in the UK and that services are frequently overstretched.

Figure 2.1 *Pyramid Depicting Degrees of Avoidant Eating (redrawn)*



(Kerzner et al., 2015, p. 345)

In a chapter contributed to a book on neophobia, Dovey (2018) described 'picky' eating as a midpoint on a continuum between neophobia and ARFID, all of which they included under the umbrella term, avoidant eating.[5] This is potentially confusing; as stated previously (2.2.2), neophobia is often understood to be a component of what is commonly called 'picky eating', as opposed to a milder presentation of it. Dovey (2018) challenged this perspective, instead positing a continuum of avoidant eating ranging from developmentally normal neophobia to ARFID. However, they do not provide reasoning for this stance, simply putting it forward it as an alternative model.

A later study (Dovey et al., 2019) using various validated measures to compare groups of children (with ARFID, with ASD, who were 'picky eaters', or who were typical eaters) offers more robust support for the notion of a continuum. Findings revealed no differences between the 'picky eater' and ARFID groups using the Behavioral Pediatrics Feeding Assessment Scale (BPFAS; Crist & Napier-Phillips,

[5] See Glossary for an explanation of the nuanced difference in usage between Dovey's employment of the term avoidant eating and its use in this thesis.

2001). The only discernible difference between these two groups (assessed with the CEBQ; Wardle et al., 2001) was in level of *food responsiveness*, referring to the degree to which children respond to preferred foods. Dovey et al., (2019) speculated that the higher food responsiveness in the 'picky eating' group could be explained by more engagement with, and consumption of, preferred foods compared to the ARFID group. Thus, children with ARFID may have a more pronounced negative reaction to eating in general. It could also be the case that the ARFID group simply had fewer preferred foods which may relate to lower engagement. Alternatively, mealtimes could be more aversive for children with ARFID due to parental distress in response to their very limited diet. Notably, both groups scored high on emotional problems and their sensory hypersensitivity scores were also comparable. This casts further doubt on the idea that children with ARFID are experiencing something that is qualitatively rather than quantitatively different from what Dovey et al. term 'picky eating', supporting the notion of a continuum.

It is felt that the proposal of a continuum of paediatric feeding problems (Dovey, 2018; Dovey et al., 2019) is useful and is not incompatible with a definition whereby neophobia is understood to be a component part of 'picky eating',[6] as well as a normal response to food in young children, when mild and not associated with a very limited diet. To summarise, counter to Dovey's (2018) suggestion, it is asserted in this thesis that a continuum model does not logically contradict the following view: Developmentally normal neophobia is the least severe presentation of feeding challenge, with problems here necessarily being misperceived because the eating behaviours are, in fact, normal. These are likely to be transitory (Dovey et al., 2008). Then milder feeding difficulties (to use Kerzner et al.'s term; 2015) fit the definition of avoidant eating endorsed above (2.2.2), whereby neophobia is present alongside the rejection of familiar foods. This may manifest to varying degrees, the most extreme of which constitutes disordered eating.

The picture is further complicated by parental subjectivity. Perception is key to classification at both ends of the continuum. For example, a toddler may be exhibiting developmentally normal neophobia, the parent may be highly anxious about this, therefore the neophobia constitutes a feeding problem. Similarly, misperceptions that concern parents can give rise to nonresponsive feeding practice like the use of pressure

[6] Here, Dovey's (2018; 2019) term is used to aid clarity

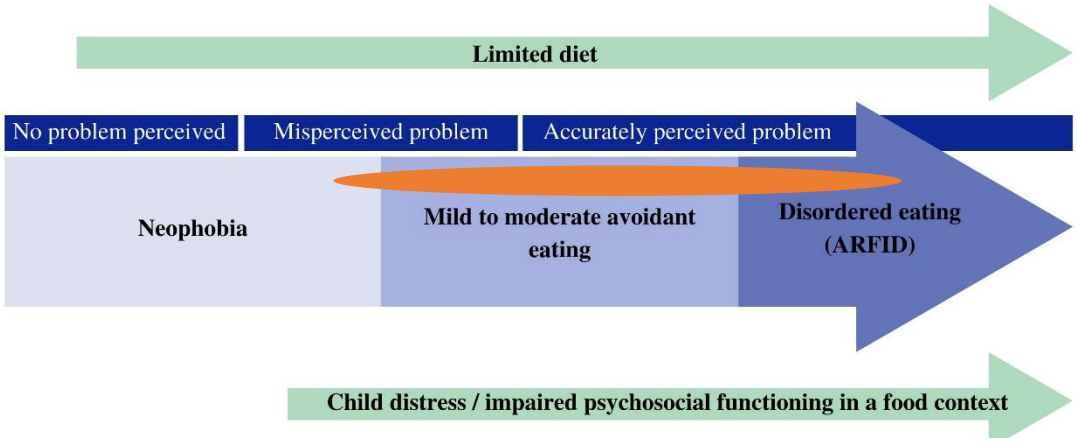
to eat and restriction (H. Harris, Jansen, et al., 2018b), so what began as a misperceived problem may develop into a problem located further along the continuum. As referred to in relation to Lumeng (2004) and Taylor (2015) above (2.2.2), even with milder challenges, parental and child distress regarding the child's eating contributes to whether or not feeding is classified as problematic. This can change over time, through experience (Wolstenholme et al., 2019) or potentially with professional support. Equally, at the disordered end of the continuum, a child who was meeting their nutritional and energy needs but had an ARFID diagnosis on the basis of impaired psychosocial functioning alone, may cease to experience psychosocial difficulties in relation to eating, perhaps through skilled professional intervention. This child's diet may still be limited but they would they move down the continuum and out of the disordered segment. It should also be noted that ARFID assessment is in its infancy in the UK and it is possible that many children remain undiagnosed. Lack of a diagnosis alone is not therefore insufficient evidence that a child's eating is not at the severe end of the continuum.

Diagnostic challenges, then, coupled with the subjective nature of paediatric feeding problems (for both parent and child) make assessing the degree of feeding problems difficult for nonspecialist clinicians and researchers. The fluidity implicit in the continuum model is useful in relation to this and it allows for the complexity involved. The following diagram reflects an attempt to capture these nuances and draws on both Kerzner et al.'s (2015) and Dovey's (2018; 2019) work. In concordance with others (C. Brown et al., 2018), it is argued that further research is needed to more accurately describe the continuum of paediatric feeding problems and to assist with the differentiation between developmentally normal and clinically significant avoidant eating.

For the purposes of this thesis and with reference Figure 2.2, it is assumed that children of participants in the empirical study presented later may fall at any point on this continuum between the *disordered eating* segment and the *no problem perceived* segment. This range is indicated in orange. This is firstly because children included in the study have not been referred back to their GP by the health visitor and so they theoretically do not merit an ARFID diagnosis. If a health visitor felt further that further assessment was warranted, they would signpost the parent back to the GP who would consider onward refer to CAMHS or a paediatrician. Secondly, inclusion in the study was decided, in part, by whether the parent perceived the child to be a 'picky eater' and

no quantitative assessment of the child's eating behaviours or diet was undertaken. On this basis, parental perception of the existence of a problem rather than child diet or eating behaviours determined inclusion.

Figure 2.2 *Degrees of Avoidant Eating as a Continuum*



2.8 The Impact of Avoidant Eating

Having established that avoidant eating in childhood is a common problem but is often an aspect of normal development, a consideration of the effects it has on families is relevant to the justification of its selection as the focus of this thesis. This is now discussed in respect of children's weight, growth, and nutritional status, as well as the impact it has on parents.

2.8.1 How Avoidant Eating Affects Children

Avoidant Eating and Weight and Growth. The impact of avoidant eating on children has historically been a contested issue in relation to weight and growth. Although it perhaps receives less media attention than overweight, underweight in childhood is seen as a public health concern because it is both a long term condition and predictive of future health problems, including coronary heart disease (P. Jansen et al., 2012). The connection between avoidant eating and underweight has historically not been well established due to inconsistent findings. In their review of the literature, Dovey et al. (2008) highlighted some of these. They cited a study (Marchi & Cohen, 1990) in which it was found that, although avoidant eaters have a lower body mass index (BMI) than typical eaters, they would not be classified as underweight. Dovey et al. (2008) contrasted this with the work of Carruth and Skinner (2000) who found no

meaningful difference in the weight or height of avoidant eaters. Conversely, Dubois et al. (2007) found that at 54 months of age, the chance of an avoidant eater being underweight was double that of their nonavoidant counterparts. This was a longitudinal study with a large sample size (n=1498) and so this finding is important. It was echoed by Ekstein et al. (2010) who found that the risk of underweight increased for avoidant eaters. However, this latter study had the limitation of a small sample size (n=34 children who were avoidant eaters and n136 controls).

In a study in which avoidant eating and BMI were investigated as a secondary research question, it was found that childhood avoidant eating and underweight were not connected (Werthmann et al., 2015). Again, this research used a small sample (n=32) and so its findings should be treated with caution. In the context of clinically significant avoidant eating, children with a diagnosis with ARFID were found to be significantly underweight (M. Fisher et al., 2014). Conversely, Hendy et al. (2010) found that avoidant eaters in a clinical context are often not underweight. This was attributed to the consumption of a diet high in calories and starches coupled with nutritional supplements. Whether a child is accessing dietetic support and has been prescribed supplements clearly has a bearing on how their eating behaviours affect their physical health.

Growth is a separate but related construct. In a review (Taylor et al., 2015) it was found that, based on the literature considered, the impact of avoidant eating on how children grow throughout childhood and beyond was unknown. It seems that growth has historically been considered less by researchers than weight, although sometimes the two areas are discussed simultaneously. For example, Wright et al. (2007) explored eating behaviours in toddlerhood and how these related to various outcomes, including growth. No significant associations between avoidant eating and growth were identified. Taylor et al. (2018) subsequently addressed the gap in knowledge identified previously (Taylor et al., 2015). Their latter findings (Taylor et al., 2018) showed that, although avoidant eaters were often thin, they were not underweight. Furthermore, the average (mean) heights, weights, and BMIs of avoidant eaters were consistently above the 50th centiles. This was a large-scale, population-based, longitudinal study (n=14,000). It could therefore be argued that - at least in a UK context - this study has settled the debate on how avoidant eating in childhood impinges on weight and growth.

A potentially counterintuitive area to be considered in relation to how avoidant eating affects children, is overweight. Finistrella et al. (2012) claimed to be the first

researchers looking specifically at how overweight and obesity cross-sectionally relate to both the constructs of neophobia and avoidant eating. They found that children who they classified as obese and overweight were more avoidant and more neophobic than those who were not so classified. Similar to Hendy (2010), they speculated that this phenomenon could be attributed to children eating more processed foods and less fruit and vegetables due to a limited eating repertoire. It would be illogical to infer from these findings that children who are overweight are more likely to be avoidant or that avoidant eaters are more likely to be overweight, and neither is this evident in Taylor et al.'s data (2018). It has been suggested that avoidant eating should not necessarily be seen as negative given the apparent protection it confers against overweight (Berger et al., 2016a; Fernandez et al., 2020). This claim exemplifies the current onus on weight status at the expense of a consideration of other factors, such as the stress caused by a dysfunctional parent-child feeding dynamic (see 2.6.3 and 2.8.2).

2.8.1.1 Avoidant Eating and Nutritional Status

There is agreement in the literature that avoidant eating has a negative impact on the variety of foods eaten by children (Lafraire et al., 2016). Nevertheless, this observation is of questionable value given its tautological nature; as shown previously (2.2.2), limited dietary variety is a key element of the definition of avoidant eating. The question of whether avoidant eating affects children's nutritional status is a complex one, as children may be meeting their needs for some nutrients but not others. For example, avoidant eaters in an all-female sample were found to have adequate levels of numerous (but not all) micronutrients. This result was surmised to be due to the fortification of accepted foods. However, this sample did not consume enough fibre (Galloway et al., 2005). Dovey et al. (2008) explored patterns in the food groups accepted and rejected by avoidant eaters, in their review. They described a reduction in fresh fruit and vegetables and a corresponding increase in foods with a high hedonic value (i.e., foods which are easy and enjoyable to eat due to high levels of fat, salt and sugar).

In a large-scale study of infants and toddlers (Carruth et al., 2004), it was found that both avoidant and nonavoidant eaters met their *recommended dietary allowance* (RDA). However, it was also found that some avoidant eaters barely consumed foods from some of the main food groups, including vegetables and meats. It is clear that the intake of fruit and vegetables is lower in avoidant eaters' diets (Coulthard & Blissett,

2009; Taylor et al., 2015) but not necessarily to a degree that impinges upon wellbeing. It has been suggested (C. Brown et al., 2018) that food avoidance at a moderate level is not associated with micronutrient deficits in the way that it may be at a clinically significant level. C. Brown et al. made a distinction between avoidant eaters meeting their immediate needs for bodily functioning (as evidenced in their sample) versus the acceptance of a varied diet which may confer protection against long term negative health outcomes. Nonetheless, they concluded that professionals can reassure parents about micronutrient deficits in the diets of avoidant eaters.

2.8.1.2 Avoidant Eating and Child Mental Health

Zucker et al. (2015) found that avoidant eating not only predicted concurrent, but also future, psychopathology, both at moderate and severe levels. The more extreme the problematic eating behaviours, the more severe the mental health challenges were found to be. This was in relation to attention deficit/hyperactivity disorder (ADHD), depression, and anxiety in children. It should be noted that ADHD is an example of neurodiversity rather than a mental health problem (Armstrong, 2010). However, these findings support the earlier suggestion that avoidant eating predicts anxiety disorders (Blissett, 2011).

Many studies claim that there is a link between avoidant eating in childhood and later eating disorders, specifically bulimia nervosa and anorexia nervosa (Ellis, Galloway, Webb, Martz, & Farrow, 2016; McDermott et al., 2008; Nicholls & Bryant-Waugh, 2009). However, all such studies only refer to the same original study (Marchi & Cohen, 1990). Indeed, later research examining retrospective accounts of childhood eating and feeding did not find any links between anorexia nervosa and paediatric feeding problems (Dellava et al., 2012) and none were found in a sibling study (Micali et al., 2007) either. More work exploring whether paediatric feeding problems predict anorexia nervosa and bulimia nervosa is needed. It is possible that the alleged connection has become part of 'received wisdom' in the field but lacks a strong research basis. The association between avoidant eating and psychopathology does not imply causality. However, it highlights the importance of recognising the potential vulnerability of avoidant eaters and prioritising them as a group in need of support.

2.8.2 How Avoidant Eating Affects Parents

As previously highlighted (1.1) avoidant eating is often regarded as a phase that children will naturally move out of and parents are reassured that it should not be a

cause for concern. However, this perspective is somewhat at odds with the negative emotions reported by parents themselves. For example, they may worry about how their child is developing physically in terms of their weight and growth (Boquin, Moskowitz, et al., 2014). They may also worry about the quantity and quality of the child's diet, even where the child's health is not itself concerning (H. Harris, Ria-Searle, et al., 2018). In the context of avoidant eating, mothers in particular demonstrate high levels of concern which are associated with nonresponsive feeding practices (H. Harris, Jansen, et al., 2018b), a relationship that is considered further in the following chapter (3.1.1). Such levels of concern are unlikely to be addressed effectively through brief reassurance.

Kerzner et al. (2015), however, argued that the primary impact of feeding problems on parents is not to do with concerns about their child's health as much as the mealtime conflict and disharmony that avoidant eating gives rise to. This was a speculative claim in the context of practical clinical recommendations. However, there is evidence supporting this view in the literature (Trofholz et al., 2017; Wolstenholme et al., 2019). The main areas where children's avoidant eating appears to affect parents are mealtime conflict, challenging behaviour associated with avoidant eating, and parental stress due to the child's eating behaviours. There follows an exploration of these areas.

Mealtime conflict is typified by power struggles over what and how much a child is eating. Such battles for control are strongly associated with externalising behaviour (Lewinsohn et al., 2005), so parents are not only having to respond to their child's eating decisions, but also the problematic behaviours that may go hand in hand with them. Not only can avoidant eating lead to discord between parent and child, it can also negatively affect the parents' couple relationship, especially where there is disagreement about how best respond to problematic eating behaviours (Jacobi et al., 2003). Similarly, in a study conducted in Singapore (Goh & Jacob, 2012), researchers found that, as well as being significantly associated with parental stress, avoidant eating had a negative effect on family relationships. It has also been shown to be associated with arguments between parents regarding the child's eating behaviours (Mascola et al., 2010).

It seems that feeding young children may be a particularly difficult aspect of parenting. In a study exploring how mothers manage young children's eating habits, feeding preschool children was characterised as "challenging and stressful" (Jarman et

al., 2015, p. 470). This was in relation to a sample taken from the general population rather than specifically avoidant eaters, although the prime mealtime challenges expressed by participants were avoidant eating and children's behaviour. Similarly, Gilmore (2006) found that a significant percentage of mothers of children aged between 2 and 4 years described conflict-related mealtime stress, with approximately one in five stating that they experienced their child's refusal to eat certain foods as upsetting. Indeed, parents can become frustrated as they endeavour to deal with their child's avoidant eating (Carruth et al., 1998).

Emotional reactions such as these appear to go beyond an 'in the moment' response to a child's eating, potentially impacting parents' wider sense of self-efficacy (Wolstenholme et al., 2020). Similarly, it has been found that parents who feel that their feeding strategies are effective are more likely to experience positive emotions, whereas parents with children whom they perceive to be difficult to feed are more likely to experience negative emotions (S. Hughes & Shewchuk, 2012). Unfortunately, Hughes and Shewchuk did not report the time scale over which they measured parental affect, making these associations hard to interpret. They used the Brief Measure of Positive and Negative Affect (PANAS; Watson et al., 1988) which is recommended for use over a variety of time periods ranging from *the present moment* to *the past year* as well as *in general* (Watson et al., 1988, p. 1070).

Parental help-seeking behaviours provide further evidence for the genuine challenge that avoidant eating may represent for them. According to Goh and Jacob (2012), almost one in three parents seek help from a doctor regarding avoidant eating. This finding was in the context of the general population in Singapore. In an earlier American study focusing solely on parents of avoidant eaters, it was found that the majority of them sought help from their healthcare provider (Carruth et al., 1998). According to a British study, (Wright et al., 2007) 13% of parents of avoidant eaters sought help from a medical professional, most commonly their health visitor. It is reasonable to assume that help-seeking behaviours vary across cultures, due to divergent healthcare systems and social norms. Nonetheless, these findings show that many parents of avoidant eaters consider the problem to be serious enough to warrant approaching healthcare professionals for support. There is clearly a mismatch between levels of parental concern and the dominant narrative that reassurance is a sufficient professional response in cases of nonclinically significant food avoidance.

This dissonance between parental support needs and the support available touches upon a paradox inherent in nonclinical paediatric feeding problems. Children are not at immediate risk of compromised weight, growth or nutritional status. Although the acceptance of a varied diet including more fruit and vegetables is a reasonable aspiration, parental concern regarding weight, growth and nutrition may actually result in nonresponsive feeding practices (such as pressure and restriction; see 2.1.2 and 3; H. Harris, Jansen, et al., 2018b) which then exacerbate feeding problems. This leaves clinicians with a conundrum: How can parents be supported in optimising children's health, while reducing the parental focus on the very things they (parents) are concerned about regarding child health - weight, growth and nutrition? Responsive feeding offers an answer to this. It is outlined below.

2.9 Responsive Feeding

The concept of responsive feeding has been talked about in relation to the feeding of young children for many years (Birch et al., 1995). It is often discussed in the context of milk feeding (American Academy of Pediatrics, 2017; A. Brown & Arnott, 2014) and was advocated by the World Health Organisation (WHO) in relation to complementary feeding in 2003 (WHO, 2003; as cited in Aboud et al.,2009). Its profile was raised in the field in an influential paper published in 2011, (Black & Aboud, 2011). This paper was one of a series (Bentley et al., 2011; Black & Aboud, 2011; Engle & Pelto, 2011; Hurley et al., 2011) centred upon responsive feeding, included in a supplement of the *Journal of Nutrition* and presented at a symposium on responsive feeding[7]. In their introduction to the supplement, Hurley and Black (2011) framed responsive feeding as a response to global health concerns about child growth, with a focus on how parental feeding practices interact with outcomes for children.

To preface a definition of responsive feeding, a discussion of its origins is offered, in recognition of the light they shed on its core principles. Black and Aboud (2011) described how responsive feeding emerged from the field of *responsive parenting*. They set out the steps central to attuned, reciprocal communication as characterised in the responsive parenting literature: The child attempts communication with the parent, the attuned parent receives the communication, interprets it accurately,

[7] Symposium: Responsive Feeding - Promoting Healthy Growth and Development for Infants and Toddlers, given at the Experimental Biology meeting, April 25, 2010, in Anaheim, CA, USA. The symposium was sponsored by the International Nutrition Council.

and then responds accordingly. For example, a child may articulate a need for physical comfort by raising their arms to be held. The parent sees and understands the gesture, picking the child up and meeting their expressed need. This takes place in an environment created by the parent, which is conducive to parent-child interaction. Black and Aboud (2011) argued that feeding children in a way that supports their ability to regulate their energy intake (2.1.3) can be underpinned by this theoretical framework, which is characterised by emotional connection and attention to child cues.

Black and Aboud (2011) did not offer a comprehensive definition of responsive feeding. However, they described certain characteristics of it, grouping them into three categories. These are shown in Table 2.1, with modified categories. The category labels are extrapolated from Black and Aboud's work rather than being taken directly from it.

Table 2.1 *Characteristics of Responsive Feeding*

Parent-established environment	A pleasant feeding context
	Minimal distractions
	Appropriate seating
Content of meals / snacks	Food is healthy
	Food tastes good
	Food is appropriate to the child's developmental stage
Structure of meals / snacks	Food is offered on a consistent schedule
	The structure supports appetite (i.e., intervals between eating opportunities are appropriate)
Parental attunement and communication	Responses are prompt
	Responses are emotionally supportive
	Responses relate to the child's communication (are contingent)
	Responses are appropriate to the child's stage of development

In a systematic review of instruments assessing responsive feeding (Heller & Mobley, 2019) the following items were considered across multiple instruments: food rewards, pressure to eat, parental control of intake, emotional feeding, responsiveness to cues, and responsiveness to child autonomy (p. 23). This approach reflects the way in which the evidence base for responsive feeding often focuses on how nonresponsive practices make eating worse or exacerbate weight dysregulation. It also highlights the importance of child-autonomy support alongside responsivity to cues. Given the maladaptive nature of controlling feeding practices (restriction and pressure to eat; see 2.1.2) this is implicit: If a child is being directed to stop eating or to eat when they do not want to, their autonomy is being thwarted. Further to autonomy, recent papers

(Cormack et al., 2020; Tartaglia et al., 2021) have highlighted the value of incorporating the basic needs proposed by self-determination theory (SDT; Ryan & Deci, 2002, 2017) in the conceptualisation of responsive feeding, these being autonomy, relatedness and competence.

In a commentary on findings from a US National Academies of Sciences, Engineering, and Medicine consensus study report investigating feeding guidelines from birth to 24 months in high income countries, Pérez-Escamilla et al. (2017, 2021) made the case for incorporating recommendations about responsive feeding in dietary guidelines for this age group as a matter of course. They offered this definition of responsive feeding: "feeding practices that encourage the child to eat autonomously and in response to physiological and developmental needs, which may encourage self-regulation in eating and support cognitive, emotional and social development" (p.1). An alternative definition is offered here (also shared in the previous chapter), giving greater prominence to relatedness and competence, and applicable beyond infancy and toddlerhood. It draws on the work involving SDT mentioned above as well as Black and Aboud's (2011) paper. In line with the goal of ensuring its relevance across childhood, it reflects an attempted shift from an emphasis on the development of self-feeding skills implicit in Pérez-Escamilla et al.'s (2021) definition, towards a focus on a positive relationship with food: Responsive feeding is an approach to feeding children that facilitates autonomous eating in the context of a warm, attuned relationship, and appropriate structure. This is with a view to supporting the development of a positive relationship with food, characterised by effective self-regulation of energy intake, and optimised competence and eating enjoyment.

2.9.1 Official Guidance on Responsive Feeding in the US and the UK

In the US, responsive feeding has a much higher profile than it does in the UK. It is hoped that this section (2.9.1) will facilitate a comparison of the status of responsive feeding in the US and the UK. When considering parenting practices in response to a common parenting challenge, especially in relation to parents who are seeking help from their healthcare provider regarding that challenge, guidance at policy level is relevant. First, the US context is examined. This includes the question of how the *Satter Division of Responsibility in Feeding* model (sDOR; Satter, 1986, 1990) is included in official guidance and how the sDOR relates to responsive feeding. Next, a

summary of official recommendations regarding responsive feeding in the UK is offered.

2.9.1.1 Guidance in the US

In relation to a review of child-feeding guidelines up to the age of 24 months, the inclusion of responsive feeding in the latest US guidelines (up to 2025) for this age group was welcomed (Pérez-Escamilla et al., 2021). Beyond infancy, multiple US bodies, both federal and professional, advocate responsive feeding and have done for some time. A selection is considered in this section. The US Academy of Nutrition and Dietetics (AND) published a position paper advocating responsive feeding as best practice (Ogata & Hayes, 2014). In this paper, responsive feeding was defined as child feeding whereby the child's hunger and satiety cues are recognised and responded to. The AND recommended that practitioners: "develop and implement programs for educating parents and caregivers on how to foster healthful lifestyles in home, childcare, and school environments, based on positive feeding relationships, a responsive feeding approach, and regular family/family-style mealtimes." (Ogata & Hayes, 2014, p.1272). This paper also highlighted the opposite of responsive feeding - nonresponsive feeding - referring specifically to the use of restriction or pressure to eat, or alternatively the adoption of a permissive or uninvolved approach to feeding. Arguably, the focus on relational aspects of feeding and regular family meals are aspects of responsive feeding rather than additional aspirations but this is, of course, dependent on how responsive feeding is defined.

The *Start Healthy Feeding Guidelines* published by the American Dietetic Association (Butte et al., 2004) advocate responsive feeding, both as general good practice and in response to avoidant eating. The *American Heart Association* published a statement on child feeding (Wood et al., 2020) that does not explicitly refer to responsive feeding but describes responsive feeding practices as an ideal in relation to weight regulation and child health. The *Head Start* programme is a longstanding federal initiative in the US (see Hinitz, 2014, for a history), providing support to low income children and families. It refers specifically to responsive feeding in its web-based resources (USDHHS, 2021), offering webinars and written information to health professionals to help them support responsive feeding practices. These are largely made up of practical advice centred around the sDOR (Satter, 1986, 1990). The intersection between the sDOR and responsive feeding is discussed in the next section.

2.9.1.2 Responsive Feeding and the sDOR

The sDOR (Satter, 1986, 1990) is a child-feeding model that is distinct from, but connected to, responsive feeding. It involves clarity around mealtime roles for both parent and child: The parent provides food on an appropriate and consistent schedule determined by themselves (not the child) and the parent also decides what to serve. The child is responsible for deciding how much of the foods provided to eat, or indeed, whether to eat them at all. This is with a view to supporting child autonomy in a feeding context, thus facilitating effective self-regulation of energy intake. There is an emphasis on the *feeding relationship*, a term first used in Satter's paper of that name (Satter, 1986). The sDoR is recognised as best practice by several US bodies, such as the United States Department of Agriculture (USDA, 2014), the AND (Ogata & Hayes, 2014), and the American Academy of Pediatrics (Lohse & Satter, 2020).

The sDOR (Satter, 1986, 1990) has been said to operationalise the principles of responsive feeding (Engle & Pelto, 2011) whereas the AND suggested that the foundational concepts of the sDOR incorporate responsive feeding principles (Ogata & Hayes, 2014). A further perspective, communicated in a letter to the editor responding to Engle and Peltos' (2011) paper, is that the objectives of the sDOR and responsive feeding are the same and that the sDOR should form the basis for the promotion of responsive feeding (Danaher & Fredericks, 2012). Indeed, the terms have been used as though they are synonymous (Cole et al., 2017). It is the current contention that - in line with Engle and Pelto (2011) - an accurate and constructive way to describe the conceptual relationship between the sDOR and responsive feeding is that the sDOR provides parents with a practical way of implementing responsive feeding. However, responsive feeding can be seen as an overarching theory, which, as highlighted by Hurley and Black (2011), straddles disciplines and involves multiple constructs.

2.9.1.3 Guidance in the UK

In contrast to the US, in the UK, there is only a limited number of resources providing information for parents about responsive feeding, and these come from charities and academics rather than government agencies. *The Infant and Toddler Forum* is a not for profit organisation supporting child health (Infant & Toddler Forum, n.d.). *The Child feeding Guide*, created by academics, specifically focuses on helping parents of avoidant eaters. It provides tools for parents, professionals and childcare professionals (Haycraft et al., 2020). Both of these platforms describe responsive

feeding practices in their resources but do not use that term. This is not it itself problematic as nomenclature is less important than the provision of evidence-based guidance for parents and professionals.

There is scant government guidance on child feeding beyond nutrition. Feeding information was previously included in the *Birth to Five* guidelines (Department of Health, 2009). This publication is partially in line with responsive feeding but largely contains nutrition information in the section on child feeding. These guidelines are now only a current document in Northern Ireland, having been archived in 2012 and not replaced in the rest of the UK[8]. The NHS website, in relation to 'fussy eating' (NHS, 2020b), features a short video of parents talking about child-feeding challenges, and a list of disparate tips apparently taken from the withdrawn Birth to Five guidelines (Department of Health, 2009) that do not communicate a coherent feeding approach. For example, they include suggestions such as inviting other children who are good eaters to come to tea. It should be acknowledged that the NHS *Health for Under Fives* website (NHS, 2020a) provides links to the two good quality resources described above (the Child Feeding Guide; Haycraft et al., 2020 and the Infant and Toddler Forum) but the dominant focus - even on the page entitled *Tackling Fussy Eating*, seems to be portion size. This is an illustration of the emphasis, highlighted in the previous chapter (1.1), on the 'what' of child feeding at the expense of the 'how'.

Schwartz et al. (2011) reviewed feeding guidelines relating to young children up to the age of 3 years, examining international, European, US, UK and French guidelines. They claimed that, in relation to self-regulation support, only the US guidelines provided specific information. The sole UK guidance referred to was the withdrawn Birth to Five guidelines (Department of Health, 2009). Schwartz et al. specifically called for a greater emphasis on responsive feeding in guidelines generally, with a focus on practical advice for parents enabling them to feed responsively. Although, as mentioned, there has been a review of international feeding guidelines up to 24 months of age with a focus on responsive feeding (Pérez-Escamilla et al., 2021), no review more recent than that conducted by Schwartz et al. (2011) has been identified

[8] See: https://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107303 . Withdrawal was also confirmed by telephone (21/04/21) by the Department of Health public enquiries office. Note - The N. Irish version is revised (2021)

in relation to older children. In conclusion, it seems clear that the UK - especially in comparison with the US - is lacking in robust, comprehensive guidance supporting the adoption of responsive feeding at policy level.

2.10 Parental Feeding Practices in the Context of Avoidant Eating

In order to examine the notion of responsive and nonresponsive feeding more closely, in this section, the literature pertaining to parental feeding practices and avoidant eating is considered. In their review, Ventura and Birch (2008) stated that feeding practices include strategies employed to direct the content, quantity or timing of a child's eating. Such practices may constitute practices said to be nonresponsive, such as pressure to eat and restriction (Pérez-Escamilla et al., 2017). Other practices, such as parental structuring of the feeding environment (Finnane et al., 2017), eating together as a family (Christian et al., 2013), or modelling positive eating behaviours (Palfreyman et al., 2015), are also known to be adaptive and are encompassed within contemporary conceptualisations of responsive feeding (Davison et al., 2020; Tartaglia et al., 2021).

2.10.1 Controlling Feeding Practices

When considering responsive feeding, the notion of influence is key: Where parents' goal is to motivate consumption directly, a thwarting of the child's self-regulation of energy intake is logically implied because the child's eating has become externally rather than internally driven (see 2.1.3).This distinction is reflected in the language used in relation to feeding practices, which fall into two main categories. These are: *controlling*, whereby adults attempt to directly influence children's eating decisions, and *noncontrolling*, whereby parents do not attempt to overtly modify the child's consumption (Haycraft et al., 2017). Others have used the term *directive* as a synonym for controlling feeding practices (Gregory et al., 2010a). In summary, the distinction between controlling and noncontrolling feeding practices can be said to rest upon the question of whether or not the child's eating decisions are intrinsically motivated.

2.10.2 Food Provision

Harris et al. (2019) proposed a model of the family food environment whereby a further distinction is made between what foods are offered (*food provision*) and how foods are offered (feeding practices). Parental behaviours relating to food provision include modelling, exposure to a varied diet, and the level of child control over the content of meals. It is known that exposure to a wide variety of foods aids the

acceptance of a broader diet (Birch & Marlin, 1982; Carruth et al., 2004; Galloway et al., 2003; Pelchat & Pliner, 1986). This fits with the evolutionary argument about the adaptive function of neophobia (see 2.2.1) because repeated exposure to once novel foods gradually renders them familiar. Parental modelling is an important mechanism for the facilitation of exposure; parental consumption of foods is the strongest predictor (in relation to parental feeding practices) of child consumption of those foods (Coulthard & Blissett, 2009). Issues around food provision in relation to avoidant eating can be very complex and may include socio-economic factors. For example, it has been shown that economic constraints may be connected to a parent's unwillingness to buy foods that are unlikely to be accepted, thus limiting the potential for exposure (Daniel, 2016; H. Harris et al., 2019).

A positive correlation between avoidant eating and the exclusive parental offering of preferred foods has been found (Finistrella et al., 2012). As with the impact of parental modelling, this relationship may be explained by the lack of exposure to a broader range of foods that this provision strategy necessarily entails. Another element of food provision sometimes explored in relation to avoidant eating is the preparation of a separate meal for the avoidant eater (Mascola, Bryson, & Agras, 2010) or an alternative meal being provided following food rejection (H. Harris et al., 2019), both of which may have implications for exposure. The relevance of what food is provided, how it is provided and how the parent then behaves in the feeding context all contribute to why parental feeding behaviour has been called a "complex construct" (Lohse & Satter, 2020, p. 11).

In a study exploring associations between parental use of responsive feeding practices and child eating behaviours (Finnane et al., 2017) it was found that the employment of less structure correlated with greater levels of avoidant eating. An example of a parent-led structural decision would be the child requesting a snack and the parent responding that "it isn't snack time but we'll be having lunch soon". A child-led structural decision in the same scenario would involve the parent giving the child a snack on request, regardless of the timings of past or planned eating opportunities. As summarised previously (2.9), responsive feeding entails an autonomy supportive approach employed against the backdrop of parent-driven structure and content decisions. Such logistical aspects of child feeding are relevant to family feeding dynamics, especially in relation to the mealtime locus of control.

The term controlling feeding practices is sometimes used synonymously with nonresponsive feeding practices (McPhie et al., 2014). Arguably though, given the role of structure, exposure, and modelling discussed above, as well as the emphasis on attunement and the provision of a positive feeding environment (Black & Aboud, 2011), controlling feeding practices can be seen as a subcategory of a nonresponsive feeding approach rather than an equivalent term. Similarly, the notion of responsive feeding encompasses - but is not limited to - adaptive feeding practices.

2.10.3 The Influence of the Child Feeding Questionnaire

As mentioned previously (2.1.2), the wide ranging use of the CFQ (Birch et al., 2001) has shaped research into parental feeding practices and an examination of the literature on parental feeding practices would be incomplete without a consideration of it. The study of controlling feeding practices was first mentioned in Birch's early work (Birch, 1998; Birch & Fisher, 1998). Birch et al. (2001) described how the concept emerged from experimental research into children's ability to regulate their energy intake (Birch, 1987) and into the effect of contingencies on consumption (Birch et al., 1982, 1984). An example of a contingency would be a child being told that if they eat a particular food, they will be rewarded with another food. Birch had noticed (attributed to informal observation) that parents often seemed to use feeding practices that involved a contingency in order to induce children to eat nonpreferred foods (Birch et al., 1982). Importantly, Birch and colleagues began to establish that contingencies had a negative impact on preference (Birch, 1980; Birch et al., 1984). This influential work provided the basis for the development of the CFQ (Birch et al., 2001), whereby controlling feeding practices are divided into three categories: restriction, pressure to eat and *monitoring*.

The CFQ (Birch et al., 2001) is used extensively (Shloim et al., 2015). It is a validated instrument employed in several contexts, including childhood weight dysregulation (Birch et al., 2003) and feeding challenges, both clinically significant (Gonçalves et al., 2019) and nonclinical (Antoniou et al., 2016). It is generally acknowledged to have a high level of reliability, although this was not found to be the case in one recent study (Camfferman et al., 2019). The almost ubiquitous influence of the CFQ (Birch et al., 2001) in feeding research has been criticised on the grounds that it has historically limited researchers to the investigation of restriction, monitoring, and

pressure to eat, at the expense of other significant feeding practices (Haszard et al., 2015; Musher-Eizenman & Holub, 2007).

Birch acknowledged a debt of gratitude to the ideas of Costanzo and Woody (1985) in relation to the conceptual framework underlying the CFQ (Birch et al., 2001). In a single paper, Costanzo and Woody (1985) presented the findings of several empirical studies, drawing on these to suggest a novel theoretical stance whereby parental feedings styles (in relation to child weight) were dynamic and domain specific rather than static and consistent across domains. They argued that there was value in looking for correlations between parenting practices and child outcomes but that specific areas - like feeding - may involve complex beliefs and feelings. Their stance was that such complexity may be missed by a focus on oversimplified relationships between variables that are assumed to be consistent across diverse areas. Their emphasis on the "cognitive and affective perspectives of parents - the goals, values, beliefs and attributions that parents wittingly or unwittingly employ in rearing their children" (Costanzo and Woody, 1985, p.426) has arguably been returned to in the form of the recent qualitative lens through which the field is now being examined alongside traditional quantitative research (see 2.11). The legacy of Costanzo and Woody (1985) can be seen in the implicit focus on parental beliefs and attitudes in the CFQ (Birch et al., 2001; see 2.10.3.3). Prior to a consideration of how pressure to eat is assessed by the CFQ, the relationships between the other practices it taps (restriction and monitoring) and avoidant eating are summarised.

2.10.3.1 Restriction and Avoidant Eating

As stated previously (2.1.2) restriction refers to parental limitation of access to food (Vereecken et al., 2010). It has been subdivided into *overt* and *covert* restriction (Ogden et al., 2006). Overt restriction refers to limitation of which the child is aware, such as the instruction to stop taking biscuits from the plate. Covert restriction refers to limitation of which the child is not aware, such only buying certain foods infrequently. According to a systematic review of the literature on restriction (Rollins et al., 2015), it has been demonstrated extensively that restricting a desired food counterintuitively serves to increase its desirability and that overtly limiting a child's eating makes weight dysregulation worse.

Whereas the association between weight dysregulation and restriction is established, findings in relation to restriction and avoidant eating are less clear.

According to Harris et al. (2016), most cross-sectional studies (with samples of older children) showed that if a child was an avoidant eater, mothers were more likely to use restriction. For example, they may tell them they could not have a second helping of a preferred food. Conversely, these authors found that the use of restriction correlated negatively with avoidant eating in their sample. They speculated that the young age of their participants (16 months) may have contributed to this discrepancy. Restriction was found to be associated with avoidant eating in a sibling study (Farrow et al., 2009). Farrow et al. suggested a possible explanation for this relationship, whereby the parent might restrict preferred foods (seen as unhealthy) in the hope that the child would be more likely to want the other available foods. It should be noted that, although avoidant eaters are less likely to classified as overweight than their nonavoidant peers (Taylor et al., 2018), avoidant eating may nonetheless be prevalent among children classified as obese (Sandvik et al., 2018).

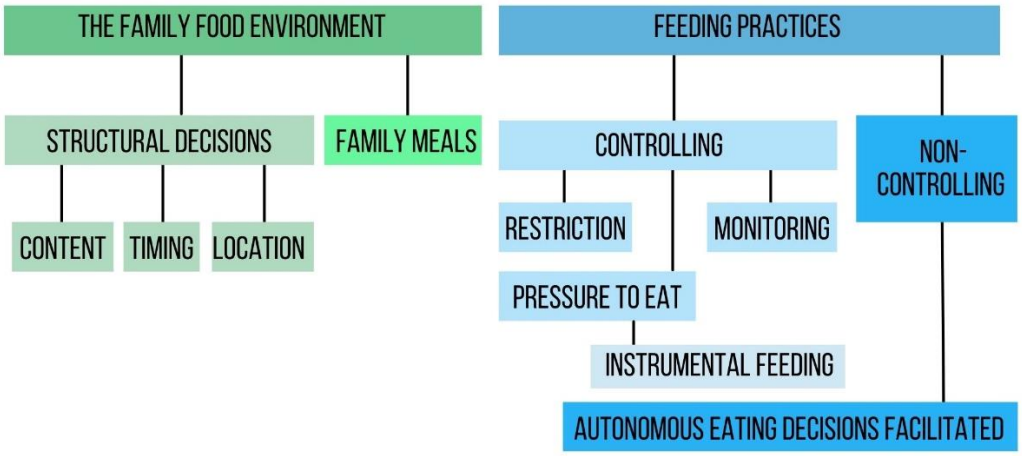
2.10.3.2 Monitoring and Avoidant Eating

Monitoring refers to the practice of keeping track of how much highly palatable food a child has consumed, that is, sweet foods, snack foods, and foods with a high fat content (Birch et al., 2001). Monitoring has been linked to both positive and negative outcomes for children in relation to dietary intake (Gubbels et al., 2011) but studies exploring monitoring and avoidant eating are scarce. Those identified pointed to a negative association between monitoring and avoidant eating (Haszard et al., 2015; Jani et al., 2015; Tharner et al., 2014). The same direction of association has been found in relation to monitoring and neophobia (Tan & Holub, 2012). On the assumption that monitoring represents a parental sense of responsibility for the child's food consumption, it is possible that these associations can be explained by a lack of monitoring indicating the use of a responsive approach to feeding.

Despite being classified as a controlling feeding practice by Birch et al. (2001), monitoring, alongside parental modelling, has been referred to as an example of *indirect control*, as distinct from the more directly controlling practices of pressure to eat and restriction (Gregory et al., 2010b). It has also been suggested that monitoring is perhaps an antecedent of pressure to eat and restriction because a parent needs to have a sense of what a child is consuming before the decision is made to attempt to exert control over consumption via pressure to eat or restriction (Jani et al., 2015). However, given the specific categories of foods that monitoring refers to in the CFQ (Birch et al., 2001),

seeing monitoring as a precursor to pressure to eat and restriction requires a broader definition of monitoring which extends to all types of food. Figure 3.1 represents an attempt to diagrammatically summarise the categories of parental feeding practices discussed so far in this chapter, and to locate pressure to eat (abbreviated in Figure 2.3 to PTE) in relation to the concepts considered.

Figure 2.3 *Categories of Feeding Practices*



2.10.3.3 Pressure to Eat

The nature of pressure to eat was introduced previously (2.1.2), where it was defined as adult attempts to induce children to eat. No explicit definitions of pressure to eat were located in the literature; here, its meaning is inferred from the questions used to assess it in the CFQ (Birch et al., 2001). In the CFQ, pressure to eat is measured using a five point scale in relation to the following four statements:

- my child should always eat all of the food on her plate
- I have to be especially careful to make sure my child eats enough
- if my child says ``I'm not hungry'', I try to get her to eat anyway
- if I did not guide or regulate my child's eating, she would eat much less than she should (Birch et al., 2001, p.210)

On the basis of these items, pressure to eat can be said to refer to inducing the consumption of any type of food because its measurement centres on an assessment of parental beliefs about a child's ability to regulate their own energy intake (Birch et al., 2001; see 2.1.3).

More than any other feeding practice, pressure to eat has been repeatedly shown to correlate with avoidant eating (Blissett & Fogel, 2013; Cardona Cano, Hoek, et al.,

2015; Dovey et al., 2008; Lafraire et al., 2016). However, given the lack of a clear definition, some questions remain regarding precisely what is meant by it. Although there is agreement that coercive feeding practices have a negative influence on child eating behaviours (Daniels, 2019), the concept of pressure is arguably nebulous, with certain parental feeding practices, such as praise and encouragement, sometimes framed as adaptive (Vaughn et al., 2016) and sometimes maladaptive (E. Jansen et al., 2014). In order to examine the construct of pressure to eat, the next chapter comprises a systematic review of its conceptualisation via the tools used to assess it in the context of avoidant eating. It is felt that a greater understanding of how pressure to eat is conceptualised in the avoidant eating literature will further the core aim of this programme of research; to gain insight into how parents make sense of the feeding practices they use. First though, there is an examination of qualitative research exploring parental feeding practices relevant to avoidant eating.

2.11 Qualitative Research

Increasingly, a qualitative lens has been employed to investigate aspects of child feeding such as child feeding in the context of ASD (Ausderau et al., 2019; Ismail et al., 2020) and complementary feeding (Norlyk et al., 2019; Spyreli et al., 2019). However, qualitative research investigating parenting practices in relation to avoidant eating is relatively scarce. In a search of the literature, seven such studies were identified. This search drew on two sources. The first of these was Wolstenholme et al.'s (2020) systematic review and synthesis of qualitative studies exploring parental perceptions of childhood avoidant eating. Four out of the ten studies in their review concerned parenting practices and avoidant eating. The remainder either examined neophobia or did not assess parenting practices.

The second source was a search of the qualitative literature encompassing the period following Wolstenholme et al.'s (2020) systematic review. This yielded three results. Details of results from both these sources, as well as the search process, are documented in Appendix B. Following Wolstenholme et al. (2020), studies conducted prior to 2008 were not considered. This was on the basis that none were identified by these authors in relevant literature reviews, and their searches suggested a marked increase in research into avoidant eating post 2008.

The seven studies identified were all published within the last five years, indicating that qualitative research on the topic of parenting practices and avoidant

eating is a relatively recent addition to the literature. Only three had samples made up exclusively of parents of avoidant eaters (Fraser et al., 2021; H. Harris, Ria-Searle, et al., 2018; Trofholz et al., 2017). Of these, the first two were analyses of help-seeking via an online forum (Reddit) and a hotline for parents, respectively. Qualitative research is therefore a new and growing area of focus for scholars interested in avoidant eating and parenting practices, but it is clearly still in its infancy. The next section considers the use of pressure to eat, as reported in qualitative research. It includes findings from the studies identified in the search of the qualitative literature described in this section, as well as findings from other relevant qualitative work.

2.11.1 Pressure to Eat in Qualitative Work

In line with the many cross-sectional studies showing that pressure to eat correlates with avoidant eating (see 2.10.3.3) it was found in several qualitative studies that parents reported using pressure in response to food refusals (Berge et al., 2016; Carnell et al., 2011; S. Moore et al., 2010; Trofholz et al., 2017). Russell et al., (2015) reported many nonresponsive practices used to induce consumption in their neophobic group (including negotiation, bribery, and tricking) but did not find that enforced trying was employed. Perhaps this is an outcome of the small sample (n=20) or the focus on neophobia as opposed to avoidant eating, which, as outlined previously (2.2.1) is a related but distinct construct.

Other qualitative studies (Goodell et al., 2017; S. Moore et al., 2007) reported the use of pressure in response to children rejecting foods or not finishing their meals but the authors did not connect this to parental classification of the child as an avoidant eater. These findings lend weight to the notion that employing pressure to eat may be a cultural norm, even in the absence of a perceived eating problem. It should be noted that Goodell et al. (2017) were researching feeding practices in the US in the context of low income African American and Hispanic families. However, Moore et al., (2007) used a sample of 12 parents in the UK. Eleven of these participants employed moderate pressure to get their children to eat familiar foods and half of the sample used rewards to induce their child to finish their meal. Given that this study was carried out with parents from the general population rather than specifically parents of avoidant eaters (who are arguably more likely to use pressure to eat) these findings are striking.

Some studies mention the use of pressure to eat but the focus of the work is slightly different. For example, Wolstenholme et al. (2019) closely examined how

feeding practices change over time, and Berge et al. (2016) were more concerned with food provision but reported parents using force, bribes, or "strongly encouraging" children to eat (p. 6). The feeding situation in which pressureful practices are reported is frequently characterised by parental concern and stress (H. Harris, Ria-Searle, et al., 2018; Rubio & Rigal, 2017; Trofholz et al., 2017) and pressure was used in a sample of fathers (H. Harris et al., 2020) despite an acknowledgement that it was ineffective. Fraser et al. (2021) mentioned the use of coercive practices in their sample, but by the nature of the study design (an analysis of parental help-seeking on an online forum) their findings primarily concerned parents seeking strategies rather than reporting them. Overall, the qualitative literature paints a picture of mealtimes as very stressful, parents as concerned, and the use of pressure to eat taking place in an environment characterised by conflict. Pressureful practices were either merely described, or referred to as pressure or pressure to eat, with the exception of H. Harris et al. (2020), who talked of *ensuring food intake*, expressed in their data as 'getting' the child to eat (p. 5).

Alongside attempts to induce consumption, some studies included the enforcement or encouragement of food-trying in the practices they described (Rubio & Rigal, 2017; Trofholz et al., 2017). This raises a question regarding whether such practices should be encompassed within the construct of pressure to eat, which is examined in the next chapter. It should be noted that many studies also described the use of permissive practices such as giving a child an alternative meal (Berge et al., 2018; Rubio & Rigal, 2017; Trofholz et al., 2017), thus parental strategies, as reflected in qualitative work, can be said to be varied, contradictory, and complex.

2.11.2 The Parental Perspective

When attempting to understand parental use of pressure to eat, an emphasis on the parental perspective is called for (see 1.3). However, it has been said that it is difficult to ascertain what parents think about the controlling feeding practices they use (Lafraire et al., 2016). Further complexity is introduced by the way in which practices may be in flux, in line with Costanzo and Woody's (1985) viewpoint described above (2.10.3). Qualitative research (Wolstenholme et al., 2019) has shown that families who experienced high levels of mealtime stress and conflict when their child was younger (and used practices akin to pressure to eat) seemed to shift their approach to a more accepting or resigned stance as the child got older. Conversely, families who reported remaining consistent in their feeding practices over time were less concerned about

child eating behaviours in the first place. Thus parental experience may interact with the practices they use, and so a key task for researchers is to better understand this experience. The empirical element of this thesis - an interpretative phenomenological analysis (IPA; Smith et al., 2009) of parental feeding practices - was undertaken with this goal in mind. In Chapter 4, the methodological underpinnings of the study are presented, followed by a description of the method, and the presentation and discussion of the findings. First though, there is a systematic review of the conceptualisation of pressure to eat in quantitative research. It is felt that an examination of the quantitative literature on pressure to eat can, in line with IPA conventions (Smith, 1996) precipitate a dialogue with qualitative inquiry into the same topic (see 4.3.4).

3 A Systematic Review of the Conceptualisation of Pressure to Eat

In this chapter, a systematic review of the conceptualisation of pressure to eat in relation to avoidant eating is presented. This is undertaken via an examination of the tools and measures used to assess it. The problem addressed by the review is a lack of clarity regarding the conceptualisation of pressure to eat, highlighted in the last chapter (2.10.3.3). This is investigated via two inter-related questions: How is pressure to eat first, defined, and secondly, assessed, in the avoidant eating literature? Fifty-three studies meeting the inclusion criteria (see 3.3.2) were located. The results section (3.4) comprises an analysis of the tools and measures used to assess practices mapping onto the notion of pressure to eat in these 53 studies, including observational methods. Finally, there is a discussion of the implications of how pressure to eat is conceptualised in the literature in the light of the tools and measures examined.

3.1 Background

In this section, the relationship between pressure to eat and avoidant eating is explored. This exploration begins with a consideration of possible influences on the use of pressure to eat and closes with a consideration of the role of eating enjoyment as a possible mechanism by which pressure to eat may affect avoidant eating.

3.1.1 Drivers of Pressure to Eat

Research suggests that mothers may employ pressure to eat in the context of avoidant eating, due to concern: In a cross-sectional analysis of observational data (C. Brown et al., 2016), it was found that mothers used pressureful strategies, including bribery, in response to concerns about child wellbeing. This related to perceived problems, including low volume of food intake, poor nutrition, and underweight. Similarly, other researchers (Gregory et al., 2010a) concluded that maternal concern for child underweight partially mediated the positive association they identified between pressure to eat and avoidant eating. Notably, they also found that child body mass index (BMI) did not predict maternal use of pressure to eat, which implies that maternal perception of child weight was inaccurate. This fits with findings that the weight of avoidant eaters is largely not problematic (Taylor et al., 2018).

In a study exploring the role of concern in relation to nonresponsive parental feeding practices (H. Harris, Jansen, et al., 2018b), concern was found to mediate both the use of rewards to incentivise eating and what was termed *persuasive feeding*. Persuasive feeding is a category of feeding practices discussed below in relation to the

Feeding Structure and Practice Questionnaire (FSPQ; E. Jansen et al., 2014). Perceived avoidant eating status has itself been shown to be associated with maternal use of pressure to eat (Jani et al., 2014), suggesting that maternal concern about the child being an avoidant eater may influence feeding practices even in the absence of specific concerns about weight or growth. This would go some way towards explaining why parents of avoidant eaters are more likely to use pressure to eat. Perhaps if parents classify their child's eating behaviours as problematic, they then feel a need to take responsibility for influencing the child's food consumption. Such associations are now considered in more detail.

3.1.2 Associations Between Pressure to Eat and Avoidant Eating

Many studies have identified an association between avoidant eating and pressure to eat (Carruth et al., 1998; Farrow et al., 2009; Pelchat & Pliner, 1986) although it is worth noting that this has not been universally identified. Kutbi et al. (2019) cited A. Brown and Lee (2015) as an example of research in which it was found that pressure to eat and avoidant eating were not associated. However, the only parental feeding practices measured in this study (A. Brown and Lee, 2015) were in the context of weaning approach during infancy (6-12 months). These findings cannot, therefore, be generalised to older children. In a longitudinal study, Mascola et al. (2010) concluded that parents of avoidant eaters were no more likely to use pressure to eat (or restriction) than parents of typical eaters. However, there is a question about whether some of their findings, not categorised as pressure to eat, may in fact indicate the presence of mealtime pressure. For example, frequent struggles over food, as measured by the Stanford Feeding Questionnaire, were reported by 62% of parents of avoidant eaters, as opposed to only 12% of their peers (Mascola et al., 2010). It seems highly likely that some of these struggles would have been centred around the parent using pressure to encourage eating and the child resisting that pressure. How pressure is assessed in the Stanford Feeding Questionnaire is considered in Table 3.2.

The majority of studies (see Appendix D) identified a positive association between pressure to eat and avoidant eating. However, as most of these are cross-sectional, the direction of causation is not clear. In a rare experimental study investigating the impact of pressure to eat on food consumption (Galloway et al., 2006) it was found that telling children (in a general population sample) "finish your soup, please", four times in a neutral tone, both significantly reduced soup intake and

increased negative child comments, relative to the control group who received no prompts. This implies a causal pathway whereby pressure to eat affects eating rather than the other way around, as the researchers were not using pressure to eat in response to child eating behaviours. Conversely, other research suggests a model whereby feeding practices are used in response to child behaviours or characteristics. For example, in a study using a sibling design (Farrow et al., 2009) the authors highlighted differential feeding practices based on child eating behaviours in an otherwise shared environment. This finding was echoed in a large-scale study of 16 month old twins, in which mothers used more pressure to eat with the twin perceived as being the more avoidant eater (H. Harris et al., 2016).

Researchers who conducted longitudinal studies (Gregory et al., 2010b; Lumeng et al., 2018) failed to find a prospective relationship between pressure to eat and avoidant eating, having controlled for child eating status at the outset. Their findings support the view of pressure to eat as a practice used in response to avoidant eating. Both sets of authors discussed the contrast between their results and those of Galloway et al. (2006). They (Gregory et al., 2010b; Lumeng et al., 2018) suggested that either the differences in the age of their respective samples, or the fact that Galloway et al. (2006) did not control for initial levels of avoidant eating, could explain the divergent findings. In contrast, other researchers (Camfferman et al., 2019) found that models featuring a child responsive and a feeding practice responsive causal pathway fitted their data equally well.

Indeed, authors of many cross-sectional studies in which a correlation between the use of pressure to eat and avoidant eating was identified, have speculated that the causal relationship was likely to be bidirectional (Camfferman et al., 2019; Farrow et al., 2009; Jani et al., 2015; Moroshko & Brennan, 2013; Pelchat & Pliner, 1986; Powell et al., 2011; Tharner et al., 2014; Webber et al., 2010). There may also be multiple factors involved; according to Moroshko and Brennan (2013), researchers exploring feeding practices and child eating behaviours have historically looked for an excessively simplistic causal pathway.

As regards longitudinal work, unlike Mascola et al.'s (2010) study mentioned above, in two relatively small-scale (n=181 and n=173) longitudinal studies in which parental use of pressure to eat in the context of avoidant eating was explored (Berger et al., 2016b; Galloway et al., 2005) a bidirectional relationship between pressure to eat and avoidant eating was suggested. While not claiming to have established a causal

pathway, Galloway et al. (2005) inferred that the relationship between pressure to eat and food avoidance was bidirectional. Berger et al. (2016b) found that mothers of girls who were avoidant eaters were more likely to use pressure, also presuming that this relationship was bidirectional.

Authors of a large-scale, population based longitudinal study (n=4845; P. Jansen et al., 2017a) set out specifically to examine the direction of association of maternal use of pressure to eat and child food avoidance. A bidirectional causal pathway was identified; pressure to eat seemed to be used in reaction to avoidant eating but also seemed to exacerbate it. The significant bidirectional relationship between pressure to eat and avoidant eating identified in this study included even the use of gentle pressure. This is important in relation to the question of how pressure is conceptualised, discussed later on in this chapter (3.5).

3.1.3 Potential Mechanisms Connecting Avoidant Eating and Pressure to Eat

Several studies have highlighted the potentially important role of child eating enjoyment in explaining the positive associations repeatedly identified between avoidant eating and pressure to eat. Child eating enjoyment has been shown to correlate negatively with maternal pressure to eat (Farrow et al., 2009; Farrow & Blissett, 2012; E. Jansen et al., 2014; Webber et al., 2010) and with avoidant eating (Finnane et al., 2017; Sandvik et al., 2018). Van der Horst et al. (2012), building on Webber et al.'s work (2010) showed that eating enjoyment mediated the relationship between pressure to eat and avoidant eating. This was possibly due to the negative eating environment resulting from the use of pressure.

Research into autonomy and child enjoyment of activities (that do not concern food) has shown that autonomy support enhances the positive emotions a child experiences while carrying out an activity (Froiland, 2015). Parental autonomy support and its link to intrinsic motivation has been researched extensively in the context of self-determination theory. (SDT; Deci & Ryan, 2013; Ryan & Deci, 2002). It is plausible that the mechanism through which pressure to eat reduces eating enjoyment is rooted in thwarted autonomy. More research is needed to elucidate this potential connection. Alternatively, a child's lack of eating enjoyment due to the experiencing of pressure to eat in the context of avoidant eating could contribute to negative feelings about food (and by extension, to negative feelings about the feeding environment). Negative feelings about food have been put forward as a factor in food rejection

(Lafraire et al., 2016). Conflict too, may play a role. If a child resists the parental use of pressure to eat, this may give rise to conflict between parent and child, which is associated with avoidant eating (Gilmore, 2006) and may reduce the child's enjoyment of the meal.

Research into food enjoyment, thwarted autonomy, or any other potential mechanism by which pressure to eat exacerbates avoidant eating (or vice versa) is arguably hampered by a lack of clarity and consistency in how pressure to eat is conceptualised. This review represents an attempt to address this problem via the scrutiny of the tools and measures used to examine it in relation to avoidant eating. The review encompasses an extensive time period in order to capture early assessment of pressure to eat when the concept of controlling feeding practices were in their nascence.

3.2 The Scope of the Review of Tools Used to Measure Pressure to Eat

Initially, searches of studies published between 1985 and 2019 were carried out. These searches were then repeated in 2021 to bring the review up to date. Given the scale of the field of paediatric feeding, strict inclusion and exclusion criteria were employed (see Table 3.1). It should be noted that extensive research has been carried out into the overlapping area of feeding practices and styles in relation to fruit and vegetable consumption in childhood (Blissett, 2011; Hoerr et al., 2009; Vereecken, Rovner, & Maes, 2010; Wardle, Carnell, & Cooke, 2005). Vegetables are a category of food which is frequently rejected by avoidant eaters (Tharner et al., 2014). However, this work was not examined unless avoidant eating was assessed. Studies examining the optimisation of fruit and vegetable consumption predominantly focus on typical eaters, consequently findings cannot be extrapolated to children with feeding challenges. Furthermore, it was felt that, given the sheer volume of work on this topic, its inclusion would dilute the focus of the review.

A decision was taken not to include qualitative research in this review. This is because qualitative inquiry is inductive (Donalek & Soldwisch, 2004) and as such, rarely begins with a priori categories. In the qualitative studies considered in the previous chapter (2.11), aside from the reference to *ensuring food intake* (H. Harris et al., 2020), practices mapping onto the notion of pressure to eat were not so much conceptualised as identified and described. Following their identification, they were often then discussed in relation to pressure to eat as it is used in the quantitative literature (Berge et al., 2016; H. Harris, Ria-Searle, et al., 2018; Wolstenholme et al.,

2019). On this basis, a close examination of the assessment of pressure to eat in quantitative research is felt to be a sound basis for the consideration of its conceptualisation in the field as a whole.

3.3 Method

In this section, the search strategies and inclusion and exclusion criteria used in the review are set out.

3.3.1 Search strategy

Two search strategies were used in this review: a conventional database search and a novel *systematised snowball citation search*. The goal was to locate all the papers published during the period considered that examined parental feeding practices and avoidant eating. These were then assessed to ascertain whether pressure to eat (or an equivalent or overlapping concept) was measured and, if this was not the case, they were excluded. The search comprised full text searches in the following databases: CINAHL, PsychInfo, and Pubmed. Additionally, a search of key words, abstracts, and titles was carried out in Scopus. See Appendix C for details of these searches.

The systematised snowball citation search was a manual approach to searching that was employed alongside the database searches. Although manually checking reference lists as part of a literature search is a standard recommendation (Horsley et al., 2011), this was systematised for this review rather than being employed in an ad hoc manner. It is thought that systematising manual searches in this way is a novel strategy. It was carried out as follows: Beginning with one (recent at the time) study centred on the topic of interest (Steinsbekk et al., 2017), all abstracts of studies in its reference list were checked if the studies potentially met the inclusion criteria on the basis of their title. This generated a second level of possibly relevant studies. All abstracts of second level studies were then checked on the same basis. If a second level study were found to meet the inclusion criteria, its reference list was similarly checked, generating a third level, and so on. This method gave rise to an exponentially increasing list of studies.

The same inclusion and exclusion criteria were used for both the database search and the systematised snowball citation search (see Table 3.1). When studies that had already been identified earlier in this process were manually located as described, they were coded accordingly. Once the majority of studies generated were already in the list, it was decided that saturation - a concept borrowed from qualitative research methodology (Saunders et al., 2018) - had been reached. In other words, the manual

reference list checks were largely no longer producing new studies. It has been argued that saturation is a vague concept (Bowen, 2008) and this was the case here; the decision that saturation had occurred was an intuitive one. However, it was felt that this was methodologically acceptable in this context because a rigorous conventional search of academic databases was also being employed.

3.3.2 Inclusion and Exclusion Criteria

Table 3.1 *Inclusion and Exclusion Criteria for the Review*

Inclusion Criteria	**Exclusion Criteria**
Avoidant eating (or a synonym) is assessed	Avoidant eating (or a synonym) is not referred to at all or is only referred to by way of background
Pressure to eat (or an equivalent concept) is assessed	Not English language
Date of study is between January, 1985 and November, 2019. (search 1) Date of study is between November, 2019 and June, 2021 (search 2)	Exclusively qualitative methodology
The study explores mothers', fathers', or mothers' and fathers' feeding practices	Studies solely examining neophobia (on the basis of the differential aetiology of neophobia and avoidant eating, see 2.2.1)
The sample includes children aged older than 12 months and younger than 12 years (on the basis that feeding infants and adolescents is qualitatively different from feeding children in this age range).	Theoretical studies or literature reviews
Empirical studies	

Key aspects of the studies identified were noted. This information is tabulated in Appendix D, in which a summary is provided, including:

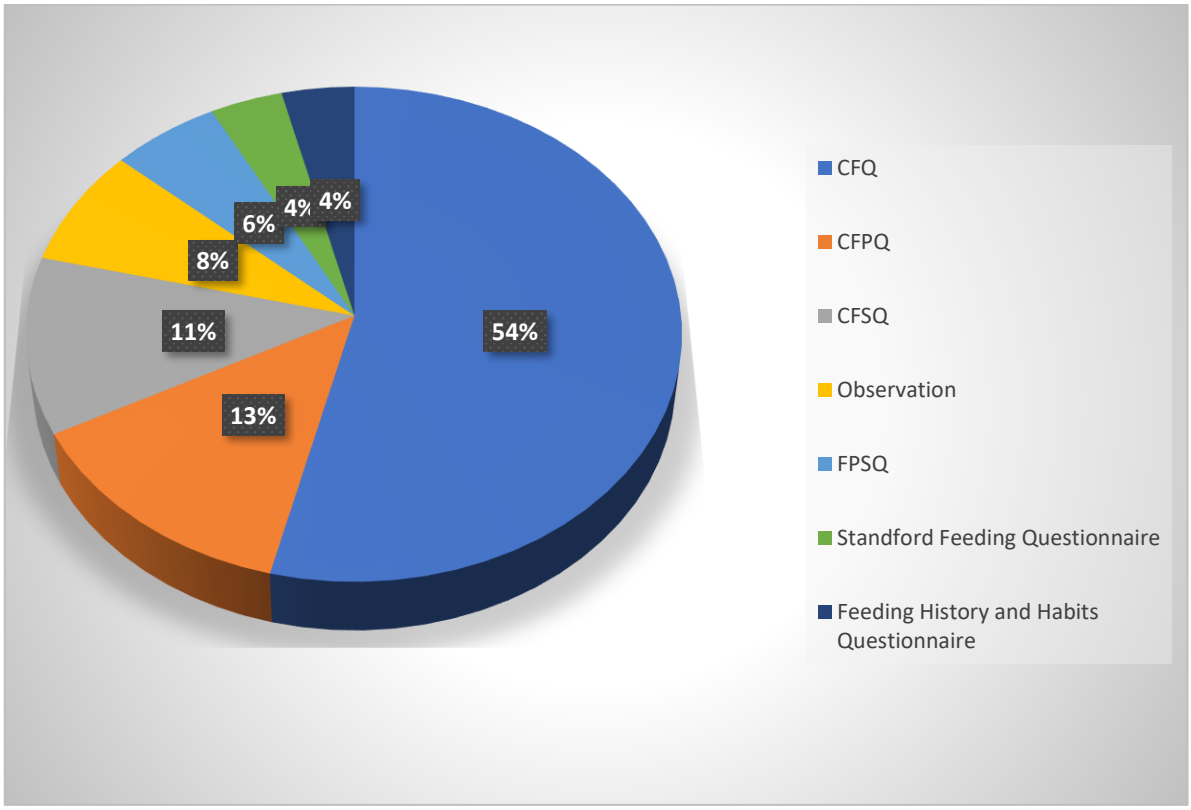
- study aims relevant to the review question
- the nature and size of the sample
- the country where the study was conducted
- basic methodological details
- instruments or methods used to measure pressure to eat
- instruments or methods used to measure avoidant eating
- relevant findings

3.4 Results

Fifty-three studies meeting the inclusion criteria were located. In the majority of studies (60%), avoidant eating was assessed using the Child Eating Behaviour Questionnaire (CEBQ; Wardle, 2001). Almost all studies (88%) relied on parental report of child eating behaviours alone. Occasionally, other methods were employed, usually alongside parental report. These were: observation (Fries et al., 2017; Powell et al., 2018), dietary recall (Berger et al., 2016a; Carruth et al., 1998; E. Jansen et al., 2014), and child self-report (Zohar et al., 2020). It should be noted that, in relation to the *food fussiness* subscale of the CEBQ (Wardle et al., 2001) maternal report of child avoidant eating has been shown to be reliable (Powell et al., 2018; Rendall et al., 2020), as it has in relation to other instruments (Boquin, Smith-Simpson, et al., 2014; Jacobi et al., 2003).

Figure 3.2 shows the distribution of tools and measures used to assess parental use of pressure to eat. It should be noted that often, multiple tools and measures were used, so the pie chart does not represent one tool or measure per study. In four studies, tools or measures were used that were only employed once across the studies identified. In a further three studies, study-specific questionnaires were employed. These seven questionnaires are not represented in Figure 3.2, which is designed to convey a sense of the relative usage of the more widely employed measures. Instead, they are summarised in Table 3.2. The use of observation is also shown in the pie chart; observation as a data collection method is felt to be important because the assessment of parental feeding practices, like that of child eating behaviours, largely relies on parental report.

Figure 3.1 *Measure of Pressure to Eat*



3.4.1 The Conceptualisation of Pressure to Eat

In this section, tools and measures shown in Figure 3.2 are discussed, with a view to ascertaining how pressure is measured and conceptualised in each. They are considered in order of frequency of usage, with the exception of observation, which is examined last.

3.4.1.1 The Child Feeding Questionnaire

As discussed above (3.1.1), Birch et al.'s (2001) simple questions making up the pressure to eat subscale of the CFQ assess parental beliefs and attitudes regarding children's self-regulatory ability. They can be said to quantify the degree to which the parent feels responsible for ensuring the child eats enough. This is very different from an assessment of specific practices and a positive response to any of the five questions could indicate parental feeding practices ranging from gentle persuasion through to coercive practices such as physically feeding a child when they did not wish to eat.

3.4.1.2 The Comprehensive Feeding Practices Questionnaire

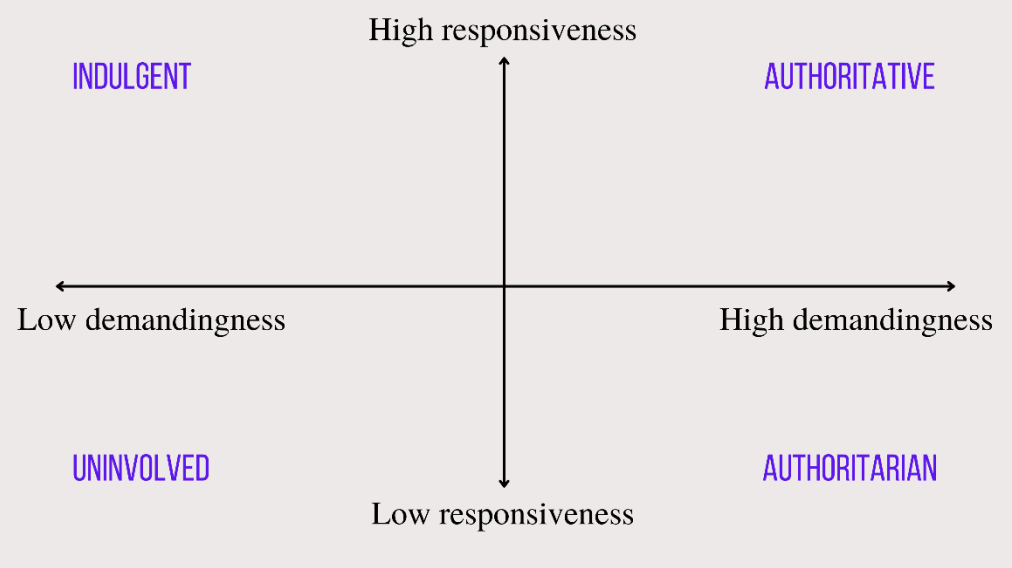
The Comprehensive Feeding Practices Questionnaire (CFPQ; Musher-Eizenman & Holub, 2007) is a validated measure developed with the express intention of

expanding the evaluation of parental feeding practices beyond those concerning parental control (pressure to eat, restriction and monitoring) as measured by the CFQ (Birch et al., 2001). The 12 subscales of the CFPQ (Musher-Eizenman & Holub, 2007) include practices relating to food provision such as modelling and involvement in food preparation. In the CFPQ, pressure is described in a way that echoes the CFQ (Birch et al., 2001). This concerns parental attempts to induce the child to eat more at meals and is therefore focused on quantity. Indeed, the pressure subscale in the CFPQ (Musher-Eizenman & Holub, 2007) contains two questions which are identical to those in the pressure to eat subscale of the CFQ (Birch et al., 2001), alongside two further questions also tapping the use of pressure to make the child eat more than they initially chose to.

3.4.1.3 The Caregiver's Feeding Styles Questionnaire

In developing the Caregiver's Feeding Styles Questionnaire (CFSQ; Hughes et al., 2005)**,** Hughes et al. drew on the CFPQ (Musher-Eizenman & Holub, 2007) and the notion of parenting styles from the wider parenting literature. The parenting styles model originated in the work of Baumrind (1967, 1971) and was extended by Macoby and Martin (1983). It is a measure of parenting control and attunement whereby approaches to the modification or maintenance of child behaviour are grouped according to where they sit in relation to two linear spectra: *responsiveness* and *demandingness.* Hughes et al.(2005) took the items from the CFPQ (Musher-Eizenman & Holub, 2007) and allocated them to one or other pole of the responsiveness and demandingness dimensions. Thus four feeding styles - equivalent to parenting styles - were demarcated. These styles are: *authoritarian, authoritative, indulgent*, and *uninvolved.* Figure 3.3 is an adapted diagram, showing how the styles relate to the dimensions. Indulgent and uninvolved styles are sometimes collectively labelled *permissive* (Blissett & Haycraft, 2008) as they were in Baumrind's (1967) original typology.

Figure 3.2 *Feeding Styles*



Hughes et al. (2005) conceptualised demandingness as any parental behaviour intended to influence child eating, either encouraging or discouraging it. In their model, demandingness is, in and of itself, seen as neither adaptive nor maladaptive; it includes both *child-centred* and *parent-centred* practices. Hughes et al. did not define the terms parent-centred and child-centred, but the implication is that they reflect the location of the practice on the responsiveness dimension. The authors frame child-centred practices, such as "reasoning and praising", as high in responsiveness, and parent-centred practices, such as "warning and physically struggling" with the child, as low in responsiveness (S. Hughes et al., 2005, p. 87). In their data, an authoritarian feeding style was associated with high levels of pressure to eat as measured by the CFQ (Birch et al., 2001). Hughes et al. (2005) positioned an authoritative feeding style as the ideal. Although pressure to eat is not a standalone factor in their model, the implication is that an authoritarian feeding style can be viewed as a proxy for parental use of pressure to eat.

3.4.1.4 The Feeding Practices and Structure Questionnaire

Along with the identification of a need for validated measures of feeding practices with young children, the *Feeding Practices and Structure Questionnaire* (FPSQ; E. Jansen et al., 2014) was developed in response to the same problem that Musher-Eizenman and Holub (2007) identified, namely the need to assess a broad range of practices relating to feeding. The FSPQ (E. Jansen et al., 2014) includes the evaluation of structure in feeding, referring to where meals happen, when they happen, and who is eating (family

meals). In developing the FSPQ, E. Jansen et al. used items from existing measures, including the CFQ (Birch et al., 2001) and the CFSQ (Hughes et al., 2005). E. Jansen et al. (2014) also introduced concepts from Satter's (1986, 1990) *Division of Responsibility* model (sDOR) regarding whether the parent or the child determines the content of meals and the quantity consumed.

Practices assessed by the FSPQ that map onto the concept of pressure to eat are captured by three of the nine final factors: *distrust in appetite*, *reward for eating*, and *persuasive feeding*. Distrust in appetite relates to beliefs about a child's self-regulatory ability and ensuing practices, similar to those tapped by the pressure to eat subscale of the CFQ (Birch et al., 2001). For example, there is a question regarding the belief that without guidance, the child would not eat enough. Reward for eating covers the use of food and nonfood incentives (or threats) to induce eating. Persuasive feeding is a broad factor encompassing measures that range from the use of praise and nutrition-based reasoning through to insistence on eating.

3.4.1.5 Other Measures

In Table 3.2, measures used less than three times in the studies identified in this review are summarised.

Table 3.2 *Other Measures Relevant to Pressure to Eat*

Study	Measure	Assessment of pressure
(Jacobi et al., 2003; Mascola et al., 2010)	Stanford Feeding Questionnaire	Includes items which imply pressure but do not directly assess it, such as struggles over food and not eating enough. Also includes items which map onto pressure to eat: verbal encouragement of eating, rewarding for eating, and using threats.
(Carruth et al., 1998; Pelchat & Pliner, 1986)	Feeding History and Habits Questionnaire	The *contingency* factor includes assessment of prodding, rewarding and punishing.
(Lumeng et al., 2018)	Infant Feeding Styles Questionnaire	Uses the IFSQ (Thompson et al., 2009, as cited by Lumeng et al., 2018) *pressuring to finish* subscale).
(Evans et al., 2009)	Preschooler Feeding Questionnaire	Includes assessment of *pushing child to eat.*
(Podlesak et al., 2017)	Mealtime Assessment Survey (MAS; (Boquin, Smith-Simpson, et al., 2014)	Besides the nine strategies which correlated with an authoritarian, permissive or authoritative parenting style, full details relating to the 25 feeding strategies assessed by the MAS were not provided, either in this paper or cited source (Boquin et al., 2014). In relation to pressure, the 17 items shared comprised seven classed as negative (measures of reward for eating, disapproval for not eating and insistence on eating) and four classed as positive (play to encourage eating, praise for intake, encouragement to try, and letting the child choose what to eat from the food provided).
(Seiverling et al., 2016)	Parent Mealtime Action Scale (PMAS; Hendy et al., 2009)	Three of the nine factors of the PMAS relate to pressure. The factor

		positive persuasion included items such as telling a child that a food tastes good or that a friend likes it. The *insistence on eating* factor is self-explanatory. The *use of rewards* factor was framed as adaptive (excepting rewarding behaviour with food). It included incentivising eating by making it fun or through food and nonfood rewards. Positive persuasion was equated with an authoritative feeding style (Hughes et al., 2005) and insistence on eating was equated with pressure to eat (Birch et al., 2001).
(Chan et al., 2011)	Study specific questionnaire	Includes insisting on eating and encouraging eating with food and nonfood rewards.
(Gilmore, 2006)	Study specific questionnaire	Includes eight questions about feeding practices. The factor *family involvement* included an item on eating as a family and an item on insisting the child eats everything.
(Wright et al., 2007)	Study specific questionnaire	Includes questions about how parents encourage children to eat and how they manage food refusal.

Table 3.2 shows the wide range of ways in which practices mapping onto the concept of pressure to eat are assessed. Furthermore, it is notable that some researchers draw no conclusions about the adaptive (or maladaptive) nature of the practices measured, whereas others do make qualitative judgements.

3.4.1.6 Observation

Table 3.3 shows how observation was used to assess parental use of pressure to eat.

Table 3.3 *Observational Measures of Pressure to Eat*

Study	Assessment	Data collection
(C. Brown et al., 2016)	Bribery (negotiation, bargaining or rewarding for eating) Pressure (encouragement to eat or drink)	Mealtime videos (home)
(Fries et al., 2017)	Encouragement to eat Prompts were coded as: neutral instruction, reasoning, food reward, nonfood reward, prompting to finish Praising and hurrying were also analysed but were not categorised as encouragement	Videos of each time the child was given food or drink
(Goulding et al., 2014)	Verbal and physical instances of encouragement to eat were counted	Videos of a standardised food presentation scenario in a laboratory
(Powell et al., 2018)	Parental control was assessed with the Family Mealtime Coding System (FMCS; Haycraft & Blissett,2008). The following behaviours were counted: pressure to eat more food, physical prompt to eat more food, contingencies (incentives or conditions) to induce eating.	A video of a typical mealtime at home

Table 3.3 shows that observational methods too, diverge in the practices they are used to assess. In some cases, any instance of encouragement was recorded, in another, pressure to eat was classified as a separate practice from the use of physical prompts and contingencies. In another, praising and hurrying, which could both be seen as examples of encouragement to eat, were not viewed as such.

3.5 Discussion

The only identified descriptions of pressure to eat in relation to the instruments reviewed, pertained to quantity. These descriptions were circular because they included

the term pressure. They were as follows: “mother’s tendency to pressure child to eat more food at meals” (Goulding et al., 2014, p. 3) and “parents pressure the child to consume more food at meals” (Musher-Eizenman & Holub, 2007, Appendix). Birch et al.’s (2001) original items tapping pressure to eat also relate solely to quantity, potentially explaining this ongoing emphasis. There was some consistency regarding whether practices were considered adaptive or maladaptive. For example, with the exception of the PMAS (Seiverling et al., 2016), the offering of food and nonfood rewards for eating, was viewed as maladaptive, as were types of pressure which were more clearly coercive, such as the use of threats. Other practices, particularly the use of praise and encouragement, were variously framed as adaptive and maladaptive.

3.5.1 Reliance on Parental Report and the Role of Observation

Although a small subset of the studies considered included observational methods, there was a heavy reliance on parental report to assess pressure to eat and related constructs. It is of note that the studies using observation were all carried out in the last decade, demonstrating that this approach to assessing parental feeding practices is a relatively recent introduction to the field of avoidant eating. Unlike maternal report of child eating behaviours, mothers’ reporting of their feeding practices has been shown to be unreliable in the context of avoidant eating (Powell et al., 2018). It has also been suggested that the use of the term *sometimes* as a response option in self-report questionnaires about feeding practices may give rise to unreliable data due to its lack of clarity (Fries et al., 2017). These possible vulnerabilities to bias and ambiguity inherent in self-report measures underscore the utility of observation in the context of the assessment of pressure to eat. Qualitative approaches too, may leave more scope for a nuanced assessment of parental feeding practices.

3.5.2 Inconsistencies in the conceptualisation and assessment of pressure to eat

There is a question regarding whether pressure to eat simply concerns an attempted increase in volume of intake or should also encompass pressure to try or pressure to eat certain foods because of their perceived health benefits. Presumably from the perspective of the child, all three are experientially similar. An example of pressureful practices extending beyond attempts to increase intake is illustrated by the CFPQ (Musher-Eizenman & Holub, 2007), which has a pressure subscale. However, alongside this, it includes items in other subscales that arguably map onto the construct

of pressure to eat. All the items in the subscale *Encourage balance and variety* could reflect pressureful practices entailing the over-riding of child eating autonomy:

- Do you encourage this child to eat healthy foods before unhealthy ones?
- I encourage my child to try new foods.
- I tell my child that healthy food tastes good.
- I encourage my child to eat a variety of foods.

(Musher-Eizenman & Holub, 2007, Appendix)

Conversely, parents could agree to some of these statements in relation to responsive practices, such as indirect encouragement via modelling or encouraging variety by serving a variety of foods. Again, the use of observation, mixed methods or perhaps qualitative study design is indicated, as a means of learning more about the context of practices being investigated.

3.5.3 An Authoritative Feeding Style

Perhaps the biggest problem highlighted by this review concerns Hughes et al.'s (2005) conceptualisation of what constitutes an authoritative feeding style, put forward by they and many others (Patrick et al., 2005; Vaughn et al., 2016; Zucker & Hughes, 2020) as the 'gold standard'. Hughes et al. consider the level of responsiveness, in relation to demands, to be the deciding factor in terms of whether or not a feeding approach is adaptive. This is problematic due to ambiguity around what constitutes a positive feeding practice; the importation of the demandingness construct into the feeding context is not necessarily straightforward. For example, reasoning is given as an example of an authoritative (highly responsive and highly demanding) feeding practice, whereas others (E. Jansen et al., 2014) consider it to be example of a nonautonomy supportive, maladapative technique.

Like Hughes et al. (2005), Goulding et al. (2014) summarised demandingness as the degree to which eating is encouraged or discouraged, but these authors viewed demandingness as maladaptive. Participants in their study who had depressive symptoms reported higher levels (than participants without depressive symptoms) of both demandingness and use of pressure to eat, suggesting a possible association or overlap between the two constructs. Goulding et al. stated that, in their study, certain practices used by participants with depressive symptoms were controlling, defining controlling as: "more pressure to eat and demandingness" (p. 9). They had asserted previously that a controlling approach to feeding is nonresponsive, thus implying that

they understood demandingness and pressure to be distinct constructs reflecting maladaptive practices.

E. Jansen et al. (2014) made the point that Satter's (1986, 1990) work, while not using the word explicitly, characterises demandingness in terms of structure and limits. Using this understanding of demandingness, they claimed that an authoritative feeding style offers an "inherently plausible and flexible framework" for a consideration of parental feeding practices (E. Jansen et al., 2014, p. 2). Furthermore, these authors asserted that such a framework provides a means to assess parental structuring practices and responsivity which, when exercised in tandem, facilitate self-regulation of energy intake. The contention put forward in this thesis that, by redefining authoritative feeding as high structuring and high responsivity (as opposed to equating demandingness with encouragement of eating), E. Jansen et al. (2014) have solved the problem highlighted above in relation to the PFSQ (Hughes et al., 2005).

3.5.4 Practices as Context Dependent

An important question in relation to practices relevant to pressure to eat is whether they are consistently adaptive or maladaptive, or whether their impact may be context- or child-specific. For example, the items in the *Modelling* subscale of the CPFQ (Musher-Eizenman & Holub, 2007) regarding the demonstration of enthusiasm about eating healthy foods could be seen as a type of pressure, depending on the context, as could the *Teaching about nutrition* subscale, which is described as the use of educational methods to encourage the eating of foods which the parent considers to be healthy. An example given was the discussion of the importance of consuming healthy foods with the child. In a feeding context with a child who was an avoidant eater, such discussions could arguably constitute pressure. Indeed, they come under the *Persuasive feeding* subscale in the FPSQ (E. Jansen et al., 2014). For a child with a positive relationship with food, a conversation about nutrition could presumably be a neutral or positive experience.

Similarly, *Positive pressure* and *Insistence in eating* as measured by the PMAS (Hendy et al., 2009) correlated positively with child consumption of a healthy diet in Hendy et al.'s sample of typical eaters. Perhaps this would not have been the case with a sample of avoidant eaters. This also raises the issue of whether dietary intake should be the sole metric of interest, or whether the child's longer term relationship with food is also a factor to be considered. It has been shown that episodes of forced consumption

during childhood are strongly associated with a rejection of that food in early adulthood (Batsell et al., 2002). This would indicate that a focus on boosting intake in childhood is not necessarily an adaptive goal when a lifespan approach is taken.

There is evidence for a more nuanced approach to parental feeding practices in the literature. In relation to context, Sleddens et al. (2014) argued for a view of child feeding that takes wider parenting into account, on the grounds that encouragement had differential impact on food consumption depending on the wider parenting dynamic. In the same vein, Blisset (2011) highlighted the influence of both the emotional environment and child characteristics (such as sensory processing) on the impact of feeding practices. In another study, the influence of maternal modelling was reduced by child sensory sensitivity (Coulthard & Blissett, 2009). Elsewhere (Blissett et al., 2016), maternal use of physical prompting (coupled with modelling) only increased levels of acceptance of a novel fruit in children who were food responsive, in contrast to children with low food responsivity, as measured by the CEBQ (Wardle et al., 2001). Blissett et al. (2016) recommended that the latter group of children would benefit most from modelling without prompting.

3.5.5 Implications for Research

The aim of this review was to ascertain how pressure is conceptualised and assessed in the avoidant eating literature. It has shown that there is a high degree of divergence in how pressure to eat is conceptualised and assessed. Furthermore, future research into the use of pressure to eat in the field of avoidant eating should make use of observational, qualitative, and mixed methods designs alongside (or instead of) a traditional reliance on parental report. Following E. Jansen et al. (2014) it is held that the notion of feeding styles is a positive one, but that a better transposition of Baumrind's (1967) typology to the feeding sphere would involve the equating of structuring and limits (rather than encouragement of eating) to demandingness. E. Jansen et al.'s (2014) FPSQ is not validated in children over the age of 3 years and this is a limitation. However, the sDOR2-6y (Lohse & Satter, 2020) covers a wider age range and also assesses structure as well as taking a broad approach to the measurement of pressure to eat. This instrument was not included in the review as studies using it were not located, which is unsurprising considering its recency.

In their content map to guide research into parental feeding practices, Vaughn et al. (2016) responded to the challenge of inconsistencies in the field with the proposal of

three core areas. The first of these is *coercive control*, including pressure to eat and threats and bribes, which they considered to be distinct. The second is *structure*, which includes modelling and exposure and the timing and content of meals. The third is *autonomy support*, which includes encouragement, praise, reasoning, and negotiation (p. 98). It is argued that Vaughn et al.'s framework is problematic because it rests on the assumption that encouragement is adaptive rather than being an example of pressure. This is perhaps unsurprising as there is an overlap in authorship of the content map and the CFPQ (Musher-Eizenman & Holub, 2007) in which encouragement is seen as positive. A return to Birch et al.'s (2001) original conceptualisation of pressure to eat is recommended, while broadening it to encompass more than just attempts to increase volume of intake. Birch describes any attempt to get a child to eat more as pressure. Encouragement, praise, negotiation and reasoning are all means of getting a child to eat more than they want or maybe need to. The proposition that these practices are inherently adaptive is highly problematic.

Instead, in this thesis, a pressure spectrum is proposed, ranging from gentle practices such as praise, through to coercive practices such as the use of threats to induce eating. It is also argued that pressure to try should be included alongside pressure to eat. The unifying feature of the practices on the proposed pressure spectrum is that they are all parental attempts to make children eat or try foods, as distinct from the facilitation of autonomous eating in the context of a parent-led structure (Daniels, 2019; Finnane et al., 2017; Satter, 1986). A pressure spectrum including pressure to eat and pressure to try could represent a constructive move away from Hughes et al.'s (2005) notion of demandingness, in which arguably, potentially pressureful practices are spread across factors. E. Jansen et al.'s (2014) work on the FPSQ could feed into its development.

Underpinning the notion of the pressure spectrum is an openness to the possibility that individual children may experience particular practices differently; this would depend on several factors, including their relationship with food and environmental factors. It is hoped that the idea of the pressure spectrum could form the basis of the development of tool to be validated in relation to the assessment of parental use of pressure. This would be a useful addition to existing instruments which include, but do not focus on, pressure in the context of child feeding (E. Jansen et al., 2014; Lohse & Satter, 2020).

Although further research is needed to illuminate how children respond to various types of pressure in the context of avoidant eating, it is a positive step that more recent tools and measures (E. Jansen et al., 2014; Lohse & Satter, 2020) take a broader view of pressure than some of the tools and measures developed in the aftermath of the CFQ (Birch et al. 2001). The pressure to eat subscale of the CFQ perhaps taps beliefs and attitudes more than practices and is arguably limited in scope, with no distinction between pressure to eat more, to eat specific foods, or to try foods. However, it rests on a broad question about whether children can be trusted to regulate their own energy intake or whether parents need to take responsibility for their child's consumption. A pressure spectrum represents a return to this fundamental question underlying parental feeding practices, recognising that when parents do not trust children to self-regulate, their responses to this may be many and various.

4 Methodology

Following the systematic review of conceptualisation of pressure to eat in the context of avoidant eating, this chapter represents a return to the empirical element of this programme of research, the rationale for which has been introduced previously (1.3 and 2.11.2). There now follows a presentation of the theoretical basis for the study. This is in terms of its ontological and epistemological underpinnings and thus the conceptual assumptions it relies upon. These assumptions are discussed in relation to the critical realist paradigm (Bhaskar, 1975). The decision to use Interpretative Phenomenological Analysis (IPA; Smith, 1996; Smith et al., 2009) is justified here in relation to its suitability for the research question: How do parents of children they identify as avoidant eaters make sense of their feeding practices and of their child's eating behaviours? Following Smith et al.'s (2009) assertions regarding the core philosophical ideas upon which IPA rests, this justification will include an exploration of *phenomenology*, *hermeneutics* and *idiography*. Finally, in the light of these discussions of what can be said to be real and what can be known about reality, issues of rigour, generalisability, and researcher positioning are explored.

4.1 The rationale for a qualitative approach

It is extremely difficult to reach a succinct definition of qualitative research and there is a proliferation of approaches including themselves under this banner. It is used in multiple disciplines, taking different forms in different fields, and paradigmatic tensions abound (Denzin & Lincoln, 2018, p. 13). Flick (2015) described qualitative research in terms of the functions it fulfils, arguing that qualitative projects will have one of three goals. These are as follows: first, to try to understand subjective experience; secondly, to explore aspects of a situation that may be nuanced, complex or hidden from participants' conscious awareness; and finally, to describe the societal and interpersonal structures in which participants exist. From the perspective of the current study, it could be said that all three of these functions are in operation, perhaps with a prioritisation of the first two.

Given the challenges associated with the demarcation of qualitative research, it may be more fruitful to describe it through an examination of what it is not. In qualitative research, the search for objective, quantified knowledge is largely eschewed. Instead, qualitative researchers are concerned with the study of phenomena in their natural environment rather than in an experimental setting (Flick, 2018). Throughout

the last century, the predominant paradigm seen in health psychology research has been a positivist one, engaged with the study of things that can be observed and measured (Broom & Willis, 2007). In contrast, recent decades have seen a movement towards the valuing of the kind of subjective and intersubjective experience which is the central focus of qualitative inquiry (Richardson, 1996; Wertz, 2014). The utility of qualitative research has now been so extensively established as to render its defence redundant (Giacomini, 2010). With this in mind, a goal of this chapter will be to justify its selection rather than its merit.

Despite this embracing of qualitative inquiry in the wider field of health psychology, research into parenting practices in the context of childhood avoidant eating continues to be dominated by cross-sectional studies. Indeed, using the same inclusion and exclusion criteria as regards topic, the search of qualitative literature documented in Chapter 2 (2.11) generated seven results, whereas the search of quantitative literature (see Appendix D) generated 53. In Chapter 2, it was argued that qualitative inquiry into parental feeding practices in the context of avoidant eating is scant but growing. A goal of the current study is to contribute to this emerging qualitative work but also to go beyond descriptive qualitative inquiry. This was through the employment of a methodology designed to produce detailed interpretative accounts of lived experience as opposed to descriptions of it.

Rigorously conducted qualitative research in healthcare can be seen as a robust addition to traditional positivist approaches such as randomised control trials (Biggerstaff & Thompson, 2008). Qualitative methods do not, therefore, need to be framed in opposition to quantitative methods, a more useful perspective being a consideration of which methodological approach best fits the research aims. The distinction between methodological paradigmatic decision making on the basis of philosophical position versus suitability for the research question has been described as *technical* versus *epistemological* (Bryman, 1988, p. 10). Although it could be argued that the latter label is problematic due to the implied omission of ontology, the differentiation between decision making on the basis of applicability as opposed to philosophy is a useful one. In the current study, the rationale falls more comfortably into the technical category of decision making: It was decided that a qualitative approach was the best fit for a research question concerned with parental meaning making. In conclusion then, the lack of qualitative research in the field, coupled with the appropriateness of qualitative inquiry for the research aims, provided the basis for

the decision to conduct a qualitative study. Beyond this, an interest in meaning making led to a decision to employ a phenomenological, interpretative (hermeneutic) approach. Phenomenology and hermeneutics will be explored in more detail below.

4.2 A Consideration of Paradigms

4.2.1 Positivism

In order to contextualise the ontological and epistemological basis for the current study, a brief examination of conventional approaches to knowledge production will be useful. Traditional scientific inquiry posits an objective, measurable reality in which facts exist, waiting to be uncovered. It follows that an appropriate methodology to deploy when searching for these facts, must be able to establish "how things *really* are and *really* work" (Lincoln & Guba, 2013, p. 38) by testing hypotheses and measuring variables. Crotty (2014) asserted that rather than take issue with science per se, a challenge to positivism should question the privileged status given to knowledge derived from scientific enquiry whereby it is deemed objective, correct, and the sole type of knowledge that has any validity.

As mentioned above, in the field of child feeding and avoidant eating, there are many examples of studies which seek to test hypotheses and measure variables, such as the longitudinal population-based studies (Cardona Cano, Tiemeier, et al., 2015; P. Jansen et al., 2014; Taylor et al., 2019) and sibling or twin studies (Farrow et al., 2009; H. Harris et al., 2016). In relation to cross-sectional studies, it has been specifically suggested that qualitative phenomenological research is needed in order to augment the existing understanding of the bidirectional relationship between avoidant eating and controlling feeding practices (Loth, 2016). Although work into adult avoidant eating has been conducted using IPA (Fox et al., 2018), the current study is thought to be the first in which parenting practices in the context of avoidant eating are examined using IPA.

4.2.2 Constructionism

In contrast to positivism, constructionism has now become the leading paradigm in some fields of scholarship (Crotty, 2014). It holds that there is no meaning independent of the meaning maker and there are no objective truths 'out there' awaiting discovery. Constructionism is not a single, coherent philosophy but comprises multiple approaches sharing the view that reality is constructed through its very interpretation (Flick, 2018). The extreme relativism espoused by constructionism is considered to be

flawed because it does not acknowledge the very real social structures in which individuals operate (Houston, 2001).

4.2.3 Critical realism

The assumptions brought to this study about what can be known and what can be said to exist are located in the critical realist paradigm (Bhaskar, 1975). Critical realism represents a solution to the problem of how to make space for a phenomenological approach while not being forced to commit to the absolute relativism of the social constructionists. Critical realism takes the position that epistemology and ontology are often conflated at the expense of the latter. This is known as the *epistemic fallacy* (Collier, 1994, p. 76). Instead, critical realists propose what can be seen as a combination of ontological realism and epistemological relativism. This enables researchers to recognise the cocreated and subjective nature of knowledge while making assertions about reality that have utility. Critical realism offers a complex understanding of reality which leaves room for both the multiple realities situated in individual experience, and an appreciation of the social structures in which individuals operate. As such, it represents a 'middle way' between the extremes of positivism and social constructivism. This dovetails with Smith's (1996) goal of finding a path between the seemingly irreconcilable poles of social cognition and discourse analysis, described below (4.3).

The critical realist stance entails the view that things in the world are real but our knowledge of them is fundamentally contextual and subjective. Sayer (1999) described critical realism as a "fallibilist philosophy" (p.2). This is predicated on the assertion of a reality that exists independently of human perception of it (contrary to the constructionist stance). If things can be said to exist regardless of how (or whether) they are being made sense of, knowledge of those things is open to error. Sayer (1999) goes even further, arguing that it is humankind's very fallibility - the mistakes inevitably made in people's flawed attempts to understand the world - that demonstrates the existence of an objective reality. If the world were entirely constructed by one's understanding of it, there would be no scope for being wrong.

Bhaskar (1975) posited a multi layered ontology whereby three levels of reality exist: the *empirical*, the *actual*, and the *real*. Hood (2016) summarised Bhaskar's complex philosophy as follows: The empirical is derived from what can be known via the sense data humans perceive; the actual refers to events that take place in the world;

and the real describes the mechanisms operating beneath the surface, giving rise to these things that take place (p. 162). With an acknowledgement of the actual, the critical realist stance helps the researcher arrive at an ontological and epistemological place where impact is prioritised. It allows for a sceptical attitude towards social and scientific hierarchies, while eschewing the extremes that a firmly constructivist or positivist position may give rise to. This happens through the belief that impact presupposes 'actual problems' requiring 'actual solutions' (Wiltshire, 2018, p. 532) .

Porter (2002), shed light on the critical realist ontology and epistemology with the analogy of magnetism: It is known that magnetism exists because it is possible to perceive its effects on objects in the world. Claims about its existential status rest upon what it does rather than upon people's ability to perceive magnetism itself. Similarly, invisible social forces and structures can be said to exist because their impact on people's lives can be perceived (p.59). A more pertinent example from the field of child feeding and avoidant eating could be cultural norms in relation to child feeding. A feeding behaviour, such as encouraging a child to eat another mouthful, could be identified by an observer. However, the parental assumption that it is their job to make the child eat, could be a social norm (or force) underpinning that practice. Against this ontological backdrop is the epistemological assumption that what can be known about events and structures (and the mechanisms through which they affect human behaviour) is both subjective and imprecise.

4.3 Interpretative Phenomenological Analysis

IPA is a qualitative methodology that facilitates the exploration of a particular aspect of the participants' *life-world*, to use Husserlian terminology (Husserl, 1970). The analytical approach associated with IPA is extremely detailed and is concerned with individual, contextual accounts. In IPA, there is no attempt to establish objective truths about research participants. Instead, the core concern is to engage with participant attribution of meaning, with the researcher seen as an active agent in the sense-making process (Smith et al., 2009). An understanding of phenomenology and hermeneutics is necessary to an appreciation of IPA. These two branches of philosophy are therefore considered prior to a consideration of the history and context of IPA and its applicability to the research question. This will be followed by an examination of idiography.

4.3.1 Phenomenology

To say that simply by dint of exploring human experience, a methodology is phenomenological, is mistaken (van Manen, 2017). For psychology research to be considered phenomenological, the examination of experience needs to take place from the perspective of the person doing the experiencing (Smith et al., 2009).

Phenomenology is based on Husserl's work (Husserl, 1913, 1970) and comprises a study of what it means to be a conscious being. This enterprise grew in parallel with the development of psychology as an area of scholarship (Giorgi & Giorgi, 2003).

To succinctly summarise Husserl's phenomenology is challenging, if not impossible. However, at the core of his philosophy is the exhortation to "go back to the things themselves"(Husserl, 1913, p. 88). Smith et al. (2009) described Husserl's 'things' as "the experiential content of consciousness" (p.12). In order to return to this, it is necessary to be free from the trappings of being an encultured being; to reach beyond our socially established ways of compartmentalising the world (Smith et al., 2009). Husserl (1913) called this plethora of assumptions influencing perception, the *natural attitude.* According to Husserl, scientific (positivist) inquiry relies on perceptions made in the natural attitude. It cannot, therefore, be objective. In order to perceive phenomena objectively, one must bracket one's assumptions. This facilitates the transcendence of the natural attitude, revealing things as they really are. Husserl's term for this bracketing was *epoché.* The critical realist epistemology aligns with phenomenology because of the emphasis on the subjectivity of knowledge and the contextualised nature of meaning making.

4.3.2 Hermeneutics

The participant's quest for meaning in relation to their experience of their life-world is the business of phenomenology. However, the researcher's interpretation of this meaning making is the preserve of hermeneutics (Smith, 2019). Hermeneutics is the theory of interpretation, specifically in relation to texts. With its roots in the study of religious writings, it was developed by Schleiermacher (Bowie, 2008) into the philosophy of how things come to be understood, resting on the question of whether the meaning contained in texts is a stand-alone product of their author or is of the reader's construction (Thiselton, 2009).

Further to this, there is the question of whether authorial intent and social context play a role in the reader's interpretive process. Smith (2007) argued that

Schleirmacher's thinking has a distinctively modern feel, in that he posited a multi-layered view of textual interpretation whereby an understanding of both the author and the text itself is sought. Smith (2007) exemplified this approach to interpretation, stating that when analysing an interview transcript: "I am trying to make sense of the words used but I am also trying to make sense of the person who has said those words" (p.5).

Larkin et al. (2006) made a distiction between phenomenology's concern with *giving voice* and the hermeneutic task of *making sense*. However, they cautioned against inferring that phenomenology is exclusively descriptive, as is held by some branches of phenomenological inquiry (Giorgi, 1992). Smith (2019) overtly opts for a version of phenomenology in which giving voice and making sense are inseparable. In justifying this, Smith (2019) highlighted the etymology of the word 'phenomenology', which derives from the Greek *phenomenon* (something appearing to view) and *logos* (reason). Both components are significant because they provide the foundations for Heidegger's (1962) view of phenomenology as an essentially interpretative pursuit (Smith, 2019).

An investigation of how a person experiences the world must necessarily include hermeneutics because experiences are constructed through the interpretative process. This is the *logos*: the sense making that uncovers the previously obscured phenomena. Heidegger (1962) described people themselves as *hermeneutic.* They are interpreters inhabiting an interpreted world. He meant this at a mundane, quotidian level: The very business of living involves being an agent of interpretation (Ashworth, 2003). This focus on the everyday, as opposed to the transcendental or abstract, is part of what distinguished Husserl's work from Heidegger's, of whom he was a student (Smith et al., 2009).

Through his chosen nomenclature for IPA, Smith (1996) necessarily highlighted the role of interpretation in knowledge creation. This is relevant at multiple levels. Central to IPA is the acknowledgement that the researcher themselves contributes to the construction of knowledge. Consequently, the research findings are not a direct representation of what it is like to be the participant as much as the researcher's interpretation of what it is like to be the participant (Smith et al., 1995). This has been dubbed the "double hermeneutic" (Smith et al., 2009, p. 3) - the researcher interpreting the participant's interpretation of their lived experience. It could be argued that the reader of any ensuing research report is in turn contributing to a triple hermeneutic as they make sense of the researcher's account.

4.3.3 The Hermeneutic Circle

The Hermeneutic circle embodies the notion that the act of interpretation is not linear: The part is interpreted in the light of the whole and vice versa . It is a powerful way of conceptualising the interpretative process (Smith, 2007). In the context of an IPA study, the hermeneutic circle is in evidence when the researcher makes sense of a particular word or metaphor in the context of the sentence in which it is located, makes sense of a sentence in relation to an earlier sentence, interprets this further in the light of the entire transcript, and makes interpretations across cases. The researcher may return many times, in different ways, to the words, sentences, excerpts, cases, and other units of data. Thus the process of interpretation is inherently circular. Smith (2007) pointed to the intuitive element involved in working with the hermeneutic circle: There is a practical decision to be made about when an interpretation is complete and simultaneously, it can never be said to be complete.

IPA's valuing of intuition - and consequent invitation to see the procedural guidance as a suggestion rather than a prescription (Smith et al., 2009) - has been subject to criticism. It has been argued that, rather than celebrating nuanced differences in how individual researchers conduct IPA, such variation should be corrected in the name of scientific rigour (Giorgi, 2010). However, given the epistemological status of conclusions drawn from IPA studies, specifically their tentative and idiographic nature (see below), both flexibility and the prizing of intuition are arguably philosophically coherent. Furthermore, when writing up IPA projects, it is suggested that researchers use verbatim excerpts from the data to illustrate their themes and that they clearly differentiate between researcher interpretation and what the participants themselves said (Smith & Osborn, 2003). Thus, an amount of transparency is brought to bear and the reader is able to both follow and challenge the researcher's interpretative process.

4.3.4 IPA: History and Context

IPA has been used extensively in health psychology research. Brocki and Wearden (2006) identified 52 studies published in or before 2004, in their systematic review. Since that date, it has continued to be used in multiple areas of health psychology, such as the experience of chronic and life-limiting illnesses (Archer et al., 2015; Sternheim et al., 2011) and mental health (O'Mullan et al., 2014; Palmer et al., 2010). As previously stated, no studies using IPA in the area of child feeding and avoidant eating have been identified, further strengthening the case for conducting a

detailed interpretative analysis of parental meaning making, as offered by the current study.

IPA was introduced more than two decades ago by Smith (1996). While initially employed predominantly in health psychology, it later gained traction in clinical, counselling, educational and social psychology (Smith et al., 2009). IPA has also been used in fields beyond psychology, such as sports science and humanities (Smith & Eatough, 2019), although Smith et al.(2009) hold that it is fundamentally psychological. IPA was originally proposed as a response to the seemingly irreconcilable clash in social psychology of social cognition and discourse analysis (Smith, 1996). Social cognition reflects the move away from the exclusive study of phenomena accessible via external observation towards the study of internal states of mind. It is predicated upon the theory of mentalism - the belief that people have a conscious mind - and upon a methodological emphasis on quantification. Thus cognitive processes are seen as accessible and measurable, via tools such as questionnaires (Smith, 1996).

Smith (1996) characterised discourse analysis (Potter & Wetherell, 1987) as "a radical and explicit attack on social cognition" (Smith, 1996, p. 262). Following Smith's thinking, this rejection of social cognition is embodied by the choice made by discourse analysts to instead study how individual and social worlds are linguistically constructed. According to McLeod (2001), discourse analysis is not so much a discrete, coherent methodological stance as a convergence of approaches brought together by their shared opposition to experimental social psychology specifically and positivism more generally. Smith's (1996) project, then, was to attempt to straddle the divide between social cognition and approaches coalescing through their opposition to it.

With this end in sight, Smith (1996) highlighted the potential inherent in an approach that acknowledges the value of a dialogue between qualitative and quantitative inquiry. Furthermore, his stated hope for IPA was that it could contribute to the corpus of psychology research by taking an *interrogative* stance, that is, through challenging or shedding light on existing theory (Smith, 2004, p. 43). Thus findings from studies conducted in the positivist paradigm can inform the interpretation of data, while also making space for the prioritisation of linguistic analysis and phenomenology (Smith, 1996). Indeed, Smith gave more than a nod to discourse analysis through the valuing of close textual analysis that is integral to IPA. According to Smith et al. (1995), if the researcher's goal is an understanding of participants'

realities - both psychological and interpersonal - then detailed analysis of text is considered a necessity

Returning to the current study, the recognition of the value of quantitative research by proponents of IPA also contributed to the belief that it was an excellent fit for an investigation of parenting in the context of avoidant eating. This is because (as evidenced by the previous chapter) there exists a wealth of quantitative research which can shape the data analysis while leaving ample scope for a detailed exploration of how participants make sense of their child's eating behaviours and their own feeding practices. In a recent description of the applicability of IPA, Smith (2019) used the concept of *hot cognition* (Abelson, 1963, as cited in Smith, 2019), meaning cognitive processes which are suffused with affect as opposed to those uncoloured by emotion. Smith (2019) argued that IPA is especially well suited to research into how participants make sense of significant life events involving hot cognition.

Hot cognition, according to Smith (2019) applies to enduring situations as well as individual incidents. Where something has affective significance, a person may be grappling with what it means for them at both an affective and a cognitive level, and this process may be ongoing (p.167). Avoidant eating impacts parental emotions both directly and via parental feeding practices, which may contribute to negative emotions during meals (Wolstenholme et al., 2020). It is, therefore, likely to involve precisely the type of hot cognition and long term attempts at sense making that Smith (2019) asserts are so well suited to exploration using IPA.

Since its initial presentation (Smith, 1996) the remit and significance of IPA have grown considerably, cementing its current status as an established methodology in the field of psychology and beyond (Smith & Eatough, 2019). Similarly, the IPA project has been developed beyond Smith's first summary (Smith, 1996). Arguably now set in a broader context, Smith (2019) aligned IPA with Bruner's (1990) vision for cognitive psychology as "the science of meaning and meaning making" (p.170).

4.3.5 Idiography

Having considered two of the three philosophical strands central to IPA (phenomenology and hermeneutics), there is now a discussion of the final strand: ideography. Working on personality from the 1930s onwards, Allport (1937, as cited in Marceil, 1977) developed the concept of idiography, using the term to refer to the study of unique experience. Although at first glance this emphasis on individual cases appears

to have a phenomenological flavour, Allport was not a phenomenologist (Ashworth, 2003). However, their focus on the unique nature of the individual was instrumental in the development of an idiographic approach to psychology research. This was in stark contrast to the dominant *nomothetic* perspective (meaning an emphasis on common features or the seeking of general laws) at their time of writing (Ashworth, 2003).

It is interesting to note that it may be an erroneous reading of Allport's work to conclude that they were framing nomothetic and idiographic approaches to psychology research as opposites to be pitted against one another (Marceil, 1977). Marceil drew attention to Allport's claim that nomothetic and idiographic approaches are, in fact, "overlapping and contributing to one another" (Allport, 1937, p.22, as cited in Marceil, 1977). This is especially salient in the context of a consideration of a critical realist stance. As described above, critical realism allows for subjective accounts of reality set against a backdrop of social frameworks which can objectively be said to exist.

Smith (2004) asserted that IPA is "strongly idiographic" (p. 41). This is evident in the emphasis on both divergence between cases as well as the suggestion that each case is analysed in turn prior to any across-case analysis (Smith et al., 2009). Furthermore, in IPA, there is a focus on how common themes may mean different things to specific participants (Smith, 2011). IPA's idiographic character is also reflected in the suggestions made in relation to sampling. Samples are small and purposive, even comprising just a single case study (Smith et al., 2009). Consequently, rather than seeking a broad sense of how multiple people experience a particular phenomenon, the IPA researcher seeks an in depth understanding of what a particular condition, event, or situation is like for the individuals experiencing it, at a fine-grained and nuanced level.

The advice to approach each case anew (Smith et al., 2009) contradicts Smith's earlier suggestion (Smith & Osborn, 2003) that initial analyses can inform the themes used in subsequent analyses. It could be argued that, just as pure epoché is an impossibility, so is an approach to analysis where earlier cases must be forgotten before the researcher proceeds to the next. However, by taking the idiographic commitment seriously, the contention in relation to this study is that it is possible to, at the very least, hold an awareness of participant uniqueness. For example, themes can be shaped by the participants' own use of language and the researcher can remain wary of assuming that closely related ideas appearing in different transcripts pertain to the same thing. In the current study, the objectives of exploring parental meaning making, both in relation to

feeding practices used and child eating, lend themselves to idiographic exploration: The analysis stops short of a comparison but there is an emphasis on divergent cases. Divergence can illuminate different ways in which parents interpret their feeding role and their child's responses to food.

4.4 Validity, quality and rigour

Given the epistemological and ontological basis for this study, it is clear that the traditional quality evaluation criteria associated with the positivist paradigm are not applicable. These are: external validity, internal validity, neutrality, and replicability (Lincoln & Guba, 1986). External validity is not directly relevant to idiographic research because this type of research does not strive to generalise. Internal validity is not a fair test because there are neither statistical operations taking place nor an argument for the existence of measurable facts awaiting discovery. Neutrality does not come into play because it is argued that the researcher is essentially unable to be objective.

There is perhaps a partial argument to be made for replicability. This is because an accurate and careful description of the method is aspired to. Thus, it should be at least theoretically possible to reproduce the steps taken in the data collection and analytic process. However, given the prizing of intuition in relation to analysis and the acknowledgment of the unique worldview of the researcher, it would be erroneous to claim that a second researcher would find the same things in the same way simply by following the same steps.

The uniqueness of the participants is important too. If a second researcher recruited the same number of participants in the same way, there may be some commonalities in their experiences but there could be no assumption that they would share the same interpretations of those experiences. An acknowledgement that replicability is impossible does not mean that there is no call for the researcher to ensure the interpretations are reasonable and do not stray too far from the participants' accounts. In IPA, it is often the case that a second researcher will also analyse a section of a transcript, facilitating comparison with this goal in mind. Further to the question of quality assurance, Smith's (2011) guide for the evaluation of IPA research offers ten quality evaluation criteria. These are discussed in the next chapter (5.8.1).

4.5 Generalisability

Williams (2002) raised the fundamental question of whether an idiographic commitment renders any form of generalisation logically impossible. They acknowledged the appeal of viewing the product of idiographic inquiry as a snapshot of a unique moment in time from a specific perspective. However, they argued that such a snapshot does not serve the more practical purpose of making meaningful changes to a person's (or group of people's) life. Williams asserted that this is especially true when research has the capacity to inform policy. To mitigate this, they proposed an approach to claiming generalisability that comes with caveats. They termed this *moderatum* generalisation (Williams, 2002, p.125). This entails the acknowledgement of its limitations in order to render it useable.

To fully appreciate Williams's (2002) argumentation, a brief consideration of their treatment of Guba and Lincoln's (1982) approach to generalisation is merited. Williams (2002) claimed that, in their denial of the possibility of making generalisations on the basis of interpretative inquiry, they reveal three possible understandings of the term 'generalise'. The first, Williams termed *total* generalisations, whereby a situation represents the operation of a general law. They gave the example of a statement about how quickly an electric element cools, which is calculable via the law of thermodynamics. Secondly, there are *statistical* generalisations whereby the researcher is able to use statistics to demonstrate the likelihood of the occurrence of a particular phenomenon in a specific context. Thirdly, there are *moderation* generalisations (later termed moderatum), where certain features of a situation can be viewed as examples of a wider identifiable set of characteristics. They called these the *generalisations of everyday life*, arguing that this is the only category of generalisation that interpretative researchers can hope to make (pp.130-131).

According to Williams (2002), to endow moderatum generalisations with ontological credibility, they need to be tempered with an acknowledgement of their fallibility and fragmentary nature: They are neither certain nor complete. This does not mean they cannot constitute evidence, however. If the goal is to arrive at findings which can underpin actions leading to social change, the production of evidence becomes a moral imperative (p.138). Furthermore, *cultural consistency* (a level of shared experience without which people could not function at an everyday level) can be assumed (Williams, 2002, p.134). On this basis, it becomes possible to extrapolate from idiographic research findings to a wider context, as long as the sacrifice of certainty in

the name of utility is overtly recognised. Moderatum generalisations can be said to be moderate in two ways. First, through the scale of what is claimed, which is modest rather than far reaching; and secondly, through the status of what is claimed, which is open to revision rather than absolute (Payne & Williams, 2005).

It is not without irony that the functional aspect of William's (2002) moderatum generalisability in fact fulfils an element of Guba and Lincoln's (1986) prescription regarding *trustworthiness* (an alternative to positivist tests of rigour) in qualitative inquiry. Guba and Lincoln proposed five criteria for authenticity against which trustworthiness can be assessed. Of these, *catalytic authentication* refers to the facilitation of real-world change and *ontological authentication* is concerned with arriving at changes that are consciously appreciable at an individual or group level (p.p. 81-82).

The concept of moderatum generalisability is utilised in relation to the current study. It is felt that the ability to generalise - albeit in a way that acknowledges the ultimate impossibility of certainty and the scope for mistakes and gaps - in fact allows researchers to produce evidence that has the potential to drive meaningful change. This is reminiscent of more contemporary arguments for research impact (Penfield et al., 2014). This not only corresponds with the critical realist fallibilist philosophy, it is also in keeping with the exhortation to make claims - but make them tentatively - in IPA (Smith et al., 2009). Smith et al. also made the case for 'theoretical generalisability'(Smith et al., 2009, p.4) whereby the reader can apply their own subject knowledge and personal experience to the research findings in order to draw conclusions.

4.6 Researcher positioning

In keeping with the qualitative research tradition and the epistemological foundations of the current study, the researcher takes an *emic* rather than an *etic* position. This is what Evered and Louis (1981) termed "inquiry from the inside" as opposed to "inquiry from the outside" (p385). Harraway, (1988; as cited in Willig, 2013) used the phrase "God's eye view" to describe the etic position (p.7). This characterises the researcher as an objective, detached entity, able to channel their omniscience to understand an aspect of an objective reality which they do not affect.

If the researcher is not claiming the God's eye view, this allows for them to think about the assumptions they bring to the research and how their current perspective

and prior experience colours the research design, the analysis, and thus the findings (Willig, 2013). This can be partially framed in terms of researcher bias. Not only do the assumptions the researcher brings have an impact on the findings, but so do the researcher's aims. Eisner (2003) sums this up succinctly: "what we are interested in learning affects what we look for" (p.21).

In IPA, the emic is valued but not at the expense of the etic. As described previously, the version of phenomenology that IPA entails goes far beyond simple description. Excessive focus on the insider perspective can potentially lead to 'bad IPA' (Larkin et al., 2006). This is IPA that is afraid to lean on the etic and interpret in the light of existing theory. Ricoeur's (1970; as cited in Smith et al., 2009, p.36) distinction between the *hermeneutics of suspicion* and the *hermeneutics of empathy* is useful here. IPA is therefore multi-layered. The researcher is both seeking to give voice to the participants while also applying familiar theoretical frameworks to the participants' statements. Empathy is concerned with that ineffable sense of 'what it is like' to be the participant; an amplification of a small corner of human experience. Suspicion, though, sits at a remove as the researcher wonders about contradictions, notices patterns, or applies psychological theory to the participant's account.

A final point to be made in relation to researcher positioning pertains to the notion of *epistemological humility* (Williams et al., 2014). This requires the researcher to recognise the inherent privilege in their role. Researchers usually have access to material resources, support from other academics and institutional backing via their position as academic or student. In most cases, these are things the participant has no access to. Such awareness of privilege helps the researcher to embrace the hermeneutics of suspicion in a way that mitigates against an assumption of superiority through knowing things about the participant that they themselves may not know. Conclusions are drawn tentatively, interpretations are tied closely to text, and the reader is the ultimate judge of whether the findings are valid.

5 Method

Moving on from the preceding presentation of the epistemological and ontological foundations of the study, the goal of the current chapter is to give an account of the research procedure itself. There is a brief restatement of the importance and purpose of the study, followed by a summary of the study design. The bulk of the chapter comprises a description of the steps taken to develop the study design, recruit participants and then gather and analyse the data. Ethical considerations are discussed, including the important question of rigour. The chapter concludes with a reflexive section exploring the positioning of the researcher in relation to data collection and analysis. In keeping with a precedent set regarding reflexive accounts in Interpretative Phenomenological Analysis (IPA; Goldspink & Engward, 2019), this final section - unlike the rest of the chapter - is written in the first person.

5.1 The importance of the study

The aim of the study was to gain a rich and detailed sense of parental meaning making in the context of avoidant eating in early childhood. This includes both how parents make sense of their feeding practices and how they interpret their child's eating behaviours. As described elsewhere, much is known about which feeding practices are adaptive and maladaptive in relation to avoidant eating and this is captured within the construct of responsive feeding (see 2.9). Despite this body of research, there is a lack of qualitative inquiry exploring the perspective of parents of avoidant eaters in relation to their feeding practices (see 2.11). As described in the previous chapter (section 4.3), IPA was the chosen approach for the study due to its heavily interpretative and phenomenological nature. As argued previously (1.1 and 2.9.1.3), nonclinical feeding advice for parents in the UK lacks robust and consistent information on responsive feeding, a problem which potentially has its roots at policy level. To attempt to address this gap, it is argued that a better understanding of parental meaning making in relation to child feeding is essential.

5.2 Study design: summary

As evidenced below, this IPA study is typical in its use of a small, purposive sample. Participants were mothers of children aged between 2 and 5 years, who had approached their health visitor requesting help with avoidant eating. The study used a nonclinical sample; parents of children about whose health the health visitor had

concerns, were excluded. The recruitment materials and interview schedule were piloted and then amended according to feedback from the pilot. Following recruitment, data were gathered using semi-structured interviews. The interviews were transcribed and analysed following the conventions of IPA (Smith et al., 2009). The analysis was carried out case by case and then across cases.

5.3 Pilot

A minigroup (Greenbaum, 1998) was used to pilot the recruitment materials and interview schedule. This resulted in changes intended to enhance accessibility in relation to the former, and minimal linguistic changes to the latter. Accessibility was improved via the construction of a research website where a simplified leaflet and video version of the information sheet were hosted, alongside the traditional information sheet (See Appendix K). This pilot has been written up both in relation to the use of the minigroup to refine qualitative study design and in relation to the use of Braun and Clarke's (2006) version of thematic analysis to analyse minigroup data. Both of these publications (Cormack et al., 2018a, 2018b) were part of the SAGE Research Methods Cases series. The former is appended (Appendix E) as it documents the pilot. A detailed description of the pilot is not, therefore, included in this chapter. The project website can be visited at https://pickyeatingresearchbgu.com. As well as functioning as a platform for the alternative versions of the information sheet, it was hoped that the project website would demystify the research and bridge a perceived distance between academia and potential participants that had been highlighted in the pilot.

5.4 Participants

In this section, information concerning the participants is shared. This includes details relating to sampling, such as the sampling strategy used and the rationale for the chosen sample size. The inclusion and exclusion criteria are summarised and demographic details about participants are tabulated.

5.4.1 Sampling Strategy

Purposive sampling was used for this study. This nonprobability approach to sampling is appropriate where research does not seek to make population wide generalisations (Etikan, 2016). When using IPA, a homogenous sample is sought (Smith et al., 2009). This is because the focus of IPA is on psychological commonalities and particularities in the context of a group that shares significant characteristics or

experiences of a certain phenomenon (Pietkiewicz & Smith, 2014). In the current study, the phenomenon of interest was that of feeding a young child who was perceived to be an avoidant eater by the parent (although the term 'picky' was used in the participant-facing documents). It was decided that identifying participants on the basis of their help-seeking behaviours within the National Health Service (NHS) would support the goal of recruiting a homogenous, nonclinical sample.

5.4.2 Inclusion and Exclusion Criteria

Health visitors and allied professionals offer advice to parents of children under 5 years of age. If they feel that there may be a medical problem, such as problematic weight loss, they will refer the parent to the child's general practitioner (GP) who may in turn make an onward referral to a specialist (a dietitian or paediatrician, for example). Often this works in reverse, and the GP will refer parents to the health visitor if there are no clinical concerns. By limiting recruitment to parents who were not sign-posted back to their GP, it was possible to exclude children with clinically significant eating challenges, as identified by the health visitor. A health professional's assessment of level of need in an NHS context has been used previously to aid sampling in an IPA study (Lewis et al., 2015), thus lending further support to the appropriateness of this approach in the current context. The full list of inclusion and exclusion criteria are shown in Table 5.1.

Table 5.1 *Inclusion and Exclusion Criteria for the Study*

Inclusion criteria To take part in this study, potential participants had to:	**Exclusion criteria** Parents were excluded from the study if:
have primary (or shared) responsibility for feeding the child	they felt there were issues other than the child's relationship with food preventing the child from eating a varied diet, e.g., parental lack of food preparation skills or food insecurity
have parental responsibility for the child	the health visitor had recommended that the parent saw the GP for further investigation, treatment or onward referral (in relation to the child's eating)
have a child aged from 2 to 5 years	they did not approach or were not referred to the health visiting team or had not raised their child's eating with their health visitor
have approached or been referred to the health visiting team for help with avoidant eating in relation to this child	they did not have primary or shared responsibility for feeding the child
	the child was attending school full time
	the child was adopted or in a foster placement
	the child had a clinical diagnosis or health problem that explained their avoidant eating (e.g., gastro-intestinal problems)
	they spoke insufficient English to take part in an interview without an interpreter

5.4.3 Age of Children

The age of the children of participants in the sample was determined by several factors. First, the top end of the age range was based on the fact that in the UK, once they attend school full time, children fall under the remit of the school nurse rather than the health visitor. Furthermore, as 5 years is the age when most children start full time education, it is also likely to be a point in their lives when the number of meals and snacks consumed in the home reduces. The lower end of the age range (24 months) followed previous work by researchers based at Great Ormond Street Feeding and Eating Disorders Service (Harvey et al., 2015), which is a centre of excellence for the treatment of avoidant eating in the UK. Harvey et al.'s (2015) study of parental perceptions of child eating used a sample of children aged 2 years and above. This was on the grounds that 2 years is the age when children can normally be expected to self-

feed. This is supported by empirical findings on self-feeding skill development (Carruth & Skinner, 2002). It should be noted that two participants had children who were five years old at the time of the interview but not at the time of recruitment. Given the recruitment challenges described below, it was felt that flexibility in relation to this was appropriate and pragmatic.

5.4.4 Geographical area

Participants were recruited across Lincolnshire and Nottinghamshire. The rationale for this involved a balance between convenience for participants and the maximisation of recruitment success by covering as wide an area as possible. Given the decision to recruit via the NHS, determining the geographical scope of the study in line with NHS Trust areas seemed sensible. Therefore, only participants living in areas covered by Lincolnshire Community Health Services NHS Trust and Nottinghamshire Healthcare NHS Trust were included[9]. Given that access was challenging and had to be arranged via extensive correspondence and separate meetings with gatekeepers at both NHS Trusts, incorporating further NHS Trusts would have been impracticable. There is a discussion of the steps taken to gain access later in this chapter (5.5.2).

5.4.5 Sample size

While not being absolute in their recommendations, Smith et al. (2009) suggested between three and six participants for an undergraduate study and four to 10 for a professional doctorate, acknowledging that it is harder to be specific for PhDs. In IPA, samples are usually small, allowing for a sufficient depth of focus to fully appreciate each participant's account (Pietkiewicz & Smith, 2014). Reid et al.(2005), in their review of 65 IPA studies conducted between 1996 and 2004, stated that 10 participants constitutes the upper end of the acceptable range. At a similar time, Brocki and Wearden (2006) carried out a review of IPA studies in the field of health psychology. They reviewed 52 articles and included a comparison of sample sizes. Of the studies solely using interviews to gather data, sample sizes ranged from one to 30. The mean average was 12 and the modal average was 20. They argued that a trend towards smaller sample sizes was emerging.

This observation seems credible: A search on the database *PsychInfo* using the search term *interpretative phenomenological analysis* for the period 2016 - 2017

[9] These will be referred to henceforth as Nottinghamshire NHS Trust and Lincolnshire NHS Trust for brevity

yielded eleven results, of which only two used samples larger than 10. A further literature search using *Scopus* was carried out in 2019. According to this, during the first 6 months of 2019, 95 papers in the field of psychology using IPA were published. Many were ruled out due to a noncomparable data collection method, poor quality IPA or sample sizes at the extremes of the range. See the flowchart (Appendix F) for details. Of the remaining 32 studies, nearly three quarters (n=23) had samples of eight to 12 participants. On the basis of the guidance described here and conventions in recent scholarship using IPA, a sample size of 10 to 12 was chosen. Ten was considered ideal, with the additional two people providing insurance against participants choosing to withdraw or failing to attend interviews. It was felt that this was a sufficiently small sample to facilitate a detailed and in depth analysis, while being sufficiently large to achieve the desired analytical breadth and complexity.

5.5 Recruitment

In this section, the recruitment process is described. This includes a summary of recruitment materials as well as an overview of the approach taken to gain access to the population of interest, and attendant challenges.

5.5.1 Recruitment materials

An A4 flyer (Appendix G) was designed of which 4,800 copies were printed, ready to give to health visitors to disseminate when they met with a parent who appeared to meet the inclusion criteria for the study. See Appendix H for the covering letter given to health visitors setting out the study and the recruitment procedure. As well as describing the project and basic inclusion criteria, the flyer directed potential participants to the project website. On the website, they were able to access the information leaflet, the information video and the traditional information sheet. They were invited to contact the researcher either by telephone, email or via the contact form on the project website.

5.5.2 Access

Access to the service managers responsible for the health visiting team managers proved challenging. They are busy senior professionals who were hard to reach. Ultimately, invitations to attend regional management meetings at both NHS Trusts were secured. The meetings were attended by the managers of the health visiting teams for each region (Nottinghamshire and Lincolnshire, respectively). Attendance at these two meetings involved a 10-minute opportunity to give a presentation about the

project and answer questions. The meeting attendees were universally supportive and agreed to share the flyer with the health visitors they line managed. They represented all health visitors across both NHS Trusts (nine teams in Lincolnshire and 23 teams in Nottinghamshire).

The meeting attendees explained that other professionals working alongside health visitors might also take on the role of advising parents concerned about avoidant eating. These would usually be family support workers or members of the *Healthy Family Teams*. Healthy Family Teams deliver an integrated service combining care provided by multiple services, including health visitors, school nurses and the National Childhood Measurement Programme (Nottingham Healthcare NHS Foundation Trust, n.d.). A decision was made to involve these allied professionals in recruitment alongside health visitors as this did not constitute a substantial amendment to the study design: Participants would still be parents who had approached frontline healthcare professionals in an NHS context, seeking help with avoidant eating.

5.5.3 Recruitment challenges

The initial phase of recruitment proved extremely slow, with only one person contacting the researcher as a result of the flyers given to the health visiting team managers. After a period of trying to get back in touch with the service managers for both NHS Trusts, it was finally ascertained that the Nottinghamshire teams had moved location and both services (at Nottinghamshire and Lincolnshire NHS Trusts) had experienced internal restructuring. It seemed this had resulted in a lack of communication about the research project, which had "fallen off the radar" in the words of one of the service managers. This was understandable, given the state of flux of the services themselves, combined with the pressures on health visiting teams more generally. Anecdotal evidence suggests that health visitors are often engaged with urgent risk assessments and child protection work. It appeared, therefore, that the initial approach to recruitment was not going to be successful and required revision.

In response to these unforeseen difficulties, a second phase of recruitment was developed. It followed a procedure suggested by one of the service managers who was still keen to support the project despite the barriers to recruitment thus far. She suggested that Sure Start Facebook pages could be used to share details of the study. As information about the project was already located online (on the project website) this was a practical solution. The Health Research Authority (HRA) ethical clearance had

been sought and granted because the research was conducted in an NHS context (see 5.8.9) The HRA were contacted regarding the proposed amendments to the recruitment procedure. They were satisfied that this new recruitment tactic did not constitute a substantial amendment and were supportive of the new approach.

Sure Start centres across Nottinghamshire and Lincolnshire were then contacted by telephone and were generally very helpful and willing to share the link to the project website on their Facebook pages. This recruitment phase was successful and 31 potential participants made contact. Of these, 11 did not meet the inclusion criteria. A further 11 agreed to take part and nine others did not respond to communications. After two attempts to reach them by email and one by telephone, these nine parents were discounted on the basis that further contact could have been intrusive. The process for recruiting (following initial contact) was as follows, in chronological order:

- A brief conversation was scheduled, in order to discuss the project and ascertain suitability in relation to the inclusion and exclusion criteria.
- Arrangements were made to email or post the information sheet to participants who had not downloaded it from the project website.
- Participants were asked to read the information sheet, take time to reflect and get back in touch to either ask questions if anything on the information sheet was unclear or to schedule an interview if they were happy to proceed.

Including the single participant who responded to the flyer during the first phase of recruitment, twelve mothers agreed to take part in the study. Two of these did not attend their scheduled interviews and did not respond to attempts to reschedule. All participants were White women living in Lincolnshire or Nottinghamshire (by chance, the sample was divided equally across the two counties). Further demographic characteristics are recorded in Table 5.2.

Table 5.2 *Participant Characteristics*

Participant	Age	Child age (yrs)	Ethnicity	Highest level of qualification	Self-defined social class	Single parent
1	Did not complete	2	Did not complete	Did not complete	Did not complete	Did not complete
2	36	4	White British	Postgraduate	Middle class	No
4	37	5	White British	Postgraduate	Middle class	No
5	31	4	White British	Graduate	Working class	Yes
6	28	2	White British	Graduate	Working class	No
8	37	2	White British	Graduate	Middle class	Did not complete
9	36	2	White British	A-level	Working class	Did not complete
10	28	2	White British	A-level	Working class	No
11	31	5	White British	NVQ 2 & 3	Did not complete	Yes
12	41	2	White Spanish	Postgraduate	Working class	No

Demographic categories were based on guidance for researchers on demographic questions (J. Hughes et al., 2016). The completion of a demographic survey was optional.

5.6 Data collection

In this section, the data collection process is described, from the matter of determining practicalities such as interview location, to details of the interview itself. Care taken to ensure that informed consent was given is also documented.

5.6.1 Logistics

The HRA had specified different locations for interviews depending on which NHS Trust area the participant was resident in. For Lincolnshire NHS Trust, it was deemed acceptable for participants to come to Bishop Grosseteste University campus for their interviews. For Nottinghamshire NHS Trust, the HRA considered that the distance to travel was too great for participants (although travel expenses were covered) and interviews had to take place in Sure Start centres across the county. Arranging interviews that were both convenient for participants and fitted with centre opening times (which were limited in several cases) was difficult but achievable. These

interviews also involved a lot of travelling on the part of the researcher, as Nottinghamshire covers a wide geographical area.

5.6.2 Informed Consent

Prior to the gathering of data, participants were given a further opportunity to read the information sheet. They were again asked if they had any questions and if they understood the content of the information sheet. The items on the consent form (see Appendix I) were discussed and understanding was confirmed. Participants were then asked if they were happy to proceed with the interview and if so, were asked to sign the consent form. A final confirmation that participants had understood the information sheet and consented to taking part in the study, was made verbally at the beginning of each recording, providing a further record that informed consent had been granted.

5.6.3 The Semi-structured Interview

In line with IPA conventions (Smith et al., 2009), a semi-structured interview was used to collect data. See Appendix J for the interview schedule and probes. Pietkiewicz & J. Smith (2014) described the IPA interview schedule as a *guide*. They recommend active listening and open questioning enhanced by prompts, facilitating deeper exploration of participants' experience. The interview schedule began with a question about what the phrase 'picky eating' meant to the participant. This question was general rather than personal, in line with a *funnelling* approach to interviews (Smith & Osborn, 2003). This supported the development of rapport before more sensitive issues were addressed.

The second question was about the child's eating to date. Again, with funnelling in mind, this took the participant slightly closer to their own experience. However, it was felt that asking for historical information was still less intrusive, at this early stage in the interview, than asking about current feeding practices. As the interview progressed, participants were asked about a range of topics including their responses to and interpretation of their child's eating behaviours. For some participants, prompts were frequently used. Conversely, others responded to the questions with extensive and detailed answers and so prompts were used less. In all cases, participants seemed willing to share their thoughts and feelings about feeding their child. Many reported that the interview had been a positive experience for them.

5.6.4 The Recording Process

In order to guard against inadvertent data losses or technical problems, two methods were used to audio record the data. This was explained to participants at the outset. The first method involved a microphone plugged into a laptop, giving rise to high quality audio with a view to making transcription easier. The second method entailed the use of a mobile phone placed on the table.

5.7 Data Analysis

Three aspects of the analytical process are considered in this section. The first concerns the transcription process, the second relates to the conduction of the analysis itself, and the third pertains to how researcher positioning and assumptions may interact with the analysis of the data.

5.7.1 Transcription

According to Smith and Osborn (2003), in IPA, transcription must be sufficiently detailed to capture how speech takes place, including nonverbal communication such as laughter, pauses and hesitation. It is not, however, as detailed as would be expected in approaches with an even stronger linguistic focus such as conversation analysis (Sacks et al., 1974). Transcription of the interviews - which all lasted approximately 1 hour - was laborious and took an average of 50 minutes of transcription per 5 minutes of speech. However, it could be argued that the analysis began with transcription because this is the point at which *immersion* (Moustakas, 1990) can truly begin to take place, when the researcher begins to live and breathe the research question. It is, of course, possible to outsource the data transcription task. However, this would arguably rob the researcher of an important opportunity to get closer to the data. The interview transcripts were copied and pasted digitally onto an A4 layout with a wide margin on the left and an even wider margin on the right. This left physical space to note the themes on the left and carry out the manual coding of the data on the right. Lines were numbered.

5.7.2 Analytic process

Exponents of IPA prize its flexibility (McCormack & Joseph, 2018; Pietkiewicz & Smith, 2014; Tuffour, 2017) and in setting out the steps involved in conducting an IPA analysis, Smith et al. (2009) were careful to highlight that they did not intend to be strongly prescriptive. The analytic process they described (Smith et al., 2009, pp. 82-106) is set out below. See Figure 5.2 for a summary of adaptions made to this process.

In relation to each case:

- Read and re-read the transcript
- Make initial notes
- Develop emergent themes
- Search for connections across emergent themes

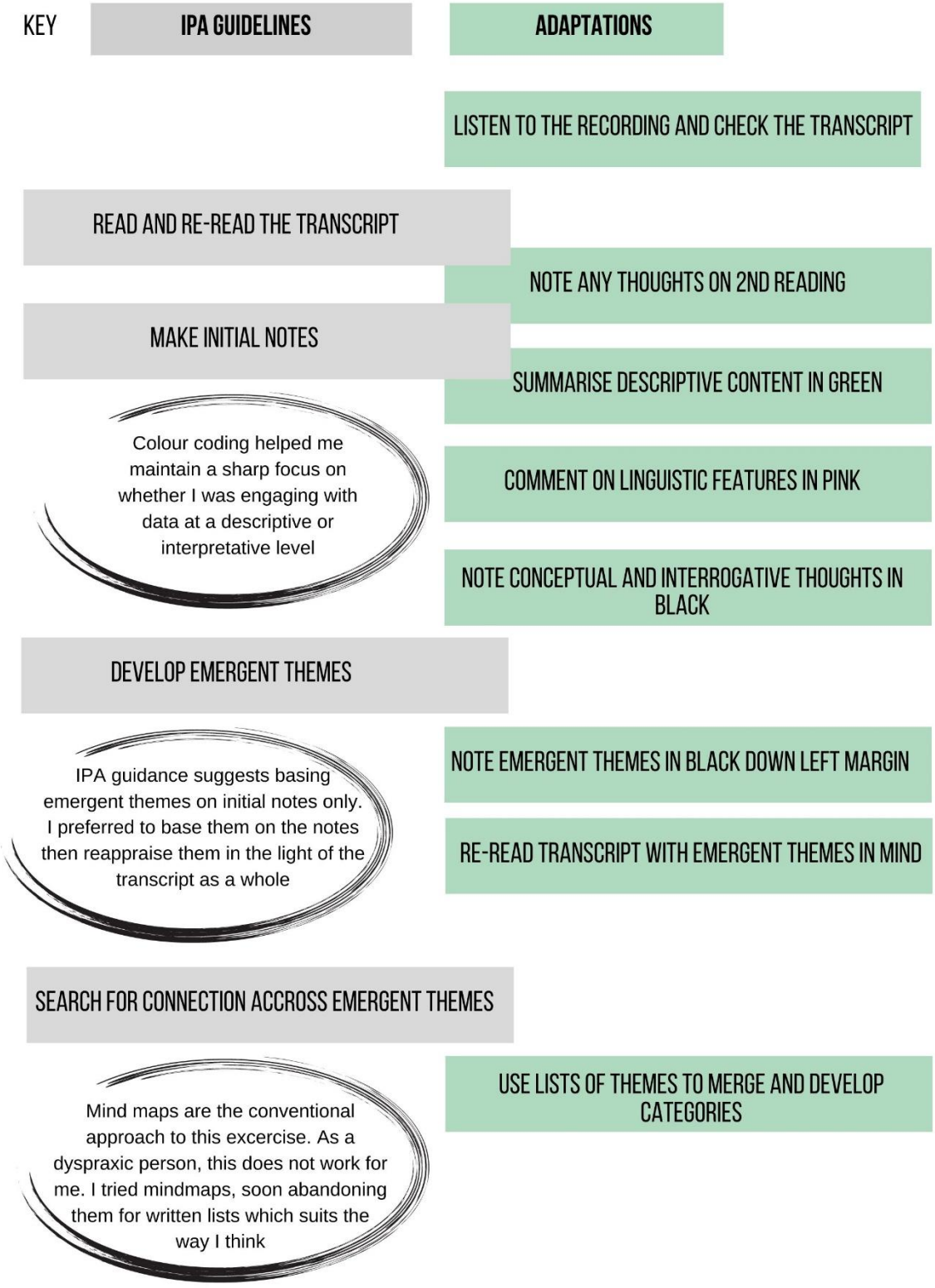
Then, in relation to the dataset at a whole:

- Look for patterns across cases, including divergence

During the initial noting stage, multiple layers of analysis take place. Smith et al. (2009) termed these *descriptive, linguistic* and *conceptual* (pp. 84-88). Descriptive coding stays close to Ricoeur's (1970, as cited in Smith et al., 2009) hermeneutics of empathy, described in the last chapter (4.6). This embodies the phenomenological commitment to conveying the participants' experiences from their perspective. The linguistic aspect of the analysis supports the conceptual, as the IPA researcher attempts to generate a rich and detailed analysis with close attention paid to lexis and grammar. Nonverbal aspects of speech (e.g., pauses) are also supportive of these more interpretative elements of IPA which map onto Ricoeur's (1970, as cited in Smith et al., 2009) hermeneutics of suspicion (see 4.6). The concept of an *interrogative* analysis to support the conceptual was found to be extremely useful in the current study. This term was shared at a workshop at Glasgow Caledonian University, led by key IPA scholars, Adele Dickson and Paul Flowers. The notion that the IPA researcher is constantly asking questions of the data is a powerful one.

Figure 5.1 shows the stages followed at the level of individual case analysis. It also shows the adaptations introduced in order to fit the analytic process to the researcher's preferred ways of working and thinking. As discussed previously (4.3.3), in their development of IPA, Smith (Smith, 2007) drew on Heidegger's (1962) notion of the hermeneutic circle, thus the process of moving between the parts and the whole - both within and across cases - is an intuitive one.

Figure 5.1 *The Analytical Process with Adaptations*



Following the analysis of a single case as described in Figure 5.1, a table was produced for that case, with every theme and subtheme listed and every associated

excerpt from the transcript (with page and line numbers) entered into the table. Then the next case was approached in the same way. When all the cases had been analysed individually, the across-case analysis was undertaken. This involved a written summary of all the themes from all the cases. Subsequently, these nascent themes were sometimes merged or discarded and at other times, subdivided. Ultimately, a list of superordinate themes for the dataset was arrived at. Each superordinate theme (and associated themes and subthemes) was then entered into a table into which all relevant excerpts from all the individual case tables were entered. This was done by participant (across the top axis) so prevalence could be visually ascertained.

5.7.3 Epoché

Throughout the analytic process, reflection on researcher positioning and assumptions was ongoing. According to Smith et al. (2009), in IPA - as with phenomenology in general - the researcher attempts to bracket their own assumptions and prior knowledge as far as possible. These authors also stated that the same goal applies when moving from case to case. It is only at the level of conceptual analysis that theory is applied to data. In so doing, the dialogue discussed in the previous chapter (see 4.3.4) between extant empirical work in the field, and the data being analysed, is precipitated. The experience of attempting epoché in relation to the current study is discussed in the reflexive statement that concludes this chapter (5.9).

5.8 Research Ethics and Integrity

Having discussed the practical tasks associated with the study (recruitment, data collection and data analysis) ethical issues are now considered, with particular attention to rigour. The goal was to embed ethics - to view the commitment to ethical research as a continuous process or attitude, rather than a task that requires completion. It has been argued that research ethics can be seen from two angles: via a consideration of researcher characteristics and via responsibility to the participants (Walliman, 2017). There is debatably also a missing third perspective - the safety of the researcher. Each of these elements is explored in turn, along with ethical challenges specific to this project and the process of gaining ethical clearance. The personal traits of the researcher can be tied to the overarching concept of *research integrity*. According to the Concordat to Support Research Integrity (Universities UK, 2019), research integrity has five core values: *honesty*, *rigour*, *transparency and open communication*, *care and respect*, and *accountability* (p.6). Each of these values is considered in the light of the study:

5.8.1 Honesty

Both the study aims and the obligations associated with taking part were conveyed to potential participants as clearly and truthfully as possible. Interviews were carefully transcribed in their entirety. The quality of transcripts is itself an important element of rigour (Davidson, 2009; Poland, 1995). Transcripts were checked by listening to the audio while reading them back - an extra step that also facilitated immersion in the data. Ensuring that the analysis was closely tied to the data was supported through the checking of the quality of the analysis. To this end, the researcher's second supervisor analysed a section of an interview for comparison. It was found to be in agreement with the researcher's analysis.

5.8.2 Rigour

There is a lack of consensus in relation to how to evaluate rigour in qualitative research (Koch et al., 2014). In relation to the current study, two approaches were considered. These were not felt to be mutually exclusive. The first is the notion of *impact* and the second is the use of evaluative criteria specific to IPA (Smith, 2011). Building on Lincoln and Guba's (1986) concept of *authenticity*, the 'real-world' consequences of research for the stakeholders has been highlighted as a means of establishing rigour (Finlay, 2006). It could be argued that this view extends the traditional understanding of rigour (relating to careful and thorough work) to the overlapping concept of *quality*. Nonetheless, it is felt to be a valuable lens through which to assess qualitative work. The current study was very much grounded in an aspiration to bring about meaningful change for parents of avoidant eaters. This may happen indirectly through the development of future studies evaluating statutory support or piloting interventions. It may also take place through recommendations for changes to how support is offered to parents. To underscore this focus on impact, Chapter 10 is centred around the practical implications of the findings for frontline professionals, policy, and future research.

Turning now to IPA-specific evaluative criteria, Smith (2011) reviewed 293 that used IPA, published between 1996 and 2008. Drawing on their assessment of these papers, their review culminated with a summary of the central indicators of quality in IPA. These are set out below, accompanied by an explanation of how the current study met each indicator.

5.8.2.1 Clarity of Focus

The study explored a very specific parenting challenge (nonclinical food avoidance) in relation to mothers of children in a precise age range (2 to 5 years of age). The sample was still more specific by virtue of the recruitment strategy; only the experiences of parents who sought help from their health visitor were examined.

5.8.2.2 High Calibre Data

Smith (2011) pointed out that strong data is dependent on competent interviewing. As described later in this chapter, it was felt that the researcher's professional background contributed to effective interviewing which elicited powerful data. Participants seemed comfortable sharing personal and frank reflections on the topic of interest.

5.8.2.3 Rigorous Research Accounts

Smith (2011) made several recommendations regarding the writing up of IPA studies which were followed in the current study: They advocated making statements of theme prevalence; excluding themes that were not applicable to at least half the sample; and (where the sample size exceeds eight) including excerpts from a minimum of three or four participants in the account of each theme. Despite the decision to follow these recommendations in relation to rigour, it was felt that they were perhaps excessively prescriptive given the avowed idiographic commitment of IPA.

5.8.2.4 Adequate Theme Coverage

Smith (2011) recommended the prioritisation of quality over quantity in relation to thematic accounts. This may entail judicious decision making regarding the writing up of themes, as was the case in the current study. Smith's guidance aided decision making in the current context because there was a temptation to include all the themes that seemed interesting and important. Instead, only themes considered to be either a novel contribution or of particular clinical utility, are presented. The provision of detailed and rich accounts of the themes chosen for inclusion was an aspiration.

5.8.2.5 An Analysis That is Both Descriptive and Interpretive

Both in the process of analysis and the presentation of the themes, there was an ongoing attempt to do justice to both the descriptive and interpretive obligations of IPA. The colour-coding system used (see Figure 5.1) helped to identify any imbalance in terms of these analytic strata; it was apparent at a glance if the analysis was erring towards excessive description.

5.8.2.6 Highlighting Convergence and Divergence

There was an attempt to weave together a narrative for each theme that explored what it meant for the participants to whom it pertained. These meanings were sometimes common to these participants and sometimes not. As indicated by Smith (2011), the way in which themes manifest themselves for different participants itself contributes to the interpretation of the data. For example, a participant with an older child who had grown out of avoidant eating felt notably more confident about her food parenting than other participants. This spoke to the theme of agency: Her experience had perhaps endowed her with a greater sense of control.

5.8.2.7 High Quality Writing

Reminiscent of Finlay's (2006) views on artistry in relation to rigorous qualitative research, Smith (2011) suggested that a vivid and engaging evocation of themes is desirable. Good writing is hard to quantify but care has been taken to write as skilfully as possible with a view to bringing participants' accounts alive.

5.8.3 Transparency and Open Communication

As part of the process of epoché, assumptions about what may be found were considered in advance, in an attempt to set them aside. These included the belief that using pressure would make eating worse. There was a clear sense that if parents reported positive outcomes or experiences of apparently pressureful practices, this data needed to be included in the analysis, despite confounding expectations. In fact, participants universally reported that pressure did not work, although the majority of them used it. It could be argued that IPA reports are inherently honest because of the emphasis given to sharing excerpts with the reader. Thus interpretations are set out alongside the evidence for them. Additionally, findings will be submitted for publication with a view to sharing the research outcomes in a manner that does justice to the time and effort the participants gave to taking part in the study. Such dissemination can be seen as exemplifying the principle of transparency and open communication.

5.8.4 Care and Respect

Care was taken to carry out each stage of the research process to the highest possible standard. To do otherwise would have been disrespectful to the participants. Similarly, respect was conveyed in relation to managing potential distress (see 5.8.7) and to ensuring participant comfort in simple, practical ways. These included offering

refreshments and providing clear information about the interview locations in advance in order to minimise the risk of participation being a stressful experience. Finally, as documented below (5.9), participants (and other interested parents) were invited to attend free workshops on avoidant eating. This was in the name of reciprocity (Trainor & Bouchard, 2013): the goal of giving something back to research participants, as well as a wider drive to provide an educational resource to the local community.

5.8.5 Accountability

Participants were given the contact details of the researchers' supervisory team in case they were unhappy with any aspect of their experience of taking part. Supervision also provided an extra layer of accountability through the provision of a space where the researcher was able to discuss the process and ensure her work was of a sufficient standard.

5.8.6 Integrity as a Personal Characteristic

The drive to approach the study with honesty and to work to the highest possible standard fitted with the researcher's personality and general work style. Furthermore, having worked with the population of interest for many years, the starting point was one of empathy. This naturally facilitated an attitude of care and respect. Integrity as a personal characteristic was reinforced by adherence to both the Bishop Grosseteste Research Ethics Policy (Bishop Grosseteste University, 2019) and the British Association for Counselling and Psychotherapy Ethical Framework (BACP, 2018)

5.8.7 The obligation to participants

Ethical obligations to participants fell into two categories: those associated with any human research project and those specific to this study. In the first category, there was a consideration of confidentiality (achieved through anonymising participants and changing or removing identifying details). Appropriate storage of records was important too: Paper records were kept locked in a cabinet on the university campus and digital files were kept on the university's encrypted server. As described above, care was taken to ensure that participants understood what the project involved and gave their consent freely. This included an understanding that, until the commencement of analysis, they could withdraw at any time. Ethical challenges specific to this study were threefold: There was a risk to participants due to the emotive nature of the content being explored; there was a degree of vulnerability conferred by the use of a statutory healthcare setting for identification and recruitment of participants; and as participants

were necessarily parents, there was an obligation to consider possible inconvenience and expenses incurred in relation to childcare.

In order to reduce these study-specific risks, there was a clearly outlined opportunity for participants to debrief after the interviews. Furthermore, the opportunity to speak to another person who understood the project was offered, in case any participant felt that they were upset after their interview and wanted to speak to someone other than the researcher. Finally, details of local counselling services were provided in case it became apparent that a participant had feelings about the topics covered in the interview that merited professional support. Being mindful of the identification and recruitment context, it was made explicit that potential participants' access to support from their health visitor was in no way affected by their decision about whether or not to participate in the study. Finally, a budget was sought and granted to cover participants' travel and childcare expenses.

5.8.8 Personal safety

The original intent at the outset of this PhD had been to interview participants in their own homes. As the researcher was used to carrying out home visits in a clinical context, this did not seem unusual. However, supervisory input led to the reviewing of this strategy on the grounds that it would contravene the institutional lone working policy and so would be a barrier to ethical clearance.

5.8.9 Ethical clearance

The process of gaining ethical clearance in relation to this study was extremely challenging. This was because Health Research Authority (HRA) clearance was required, alongside institutional clearance. As the HRA's procedure was unfamiliar to the researcher, learning to navigate the electronic application system and draft the many supporting documents required, took several months. While difficult, this was ultimately advantageous; engaging with the process of seeking ethical clearance from the HRA necessitated consideration of the study design at a fine-grained level. This meant that by the time clearance was granted, the practical details of the study had been very carefully thought out. Similarly, institutional ethical clearance was straightforward because it simply entailed the summarising of the content of the HRA application.

5.9 Reflexive statement

Having described the research procedure and ethical considerations, it remains to provide a reflexive statement to further elucidate the role of the self in the

interpretative process. IPA is very much centred around understanding another person's or group of people's experience from their point of view. However, at the heart of this task, both the researcher's worldview and the quality of the interchange between researcher and participant is implicit (Willig, 2008). This means that a high degree of reflexivity and a keen awareness of the double hermeneutic (described in the previous chapter) is imperative. In writing this reflexive statement, I am trying to draw together disparate strands from my research journal to convey my experience of carrying out the study. This incorporates my positioning in relation to the topic, the participants, and the research process.

When conducting IPA, there is a tension between the need to maintain a degree of organisational control over the data and the need to be sufficiently immersed in it to carry out detailed interpretative work (Eatough & Smith, 2017). In other words, the researcher must lose themselves in the data without getting lost. This challenge is perhaps part of what makes IPA "both imaginatively and emotionally demanding" (Smith et al., 2009, p42). It has also been said that, while rewarding, IPA is very laborious and time consuming (Reid et al., 2005). For me, all of these things were present in my experience of carrying out a study using IPA: the organisational challenges, the emotionally draining nature of the process, and the myriad hours involved. Furthermore, the sheer volume of data felt overwhelming at times. Perhaps the biggest challenge was being able to 'kill my darlings' and make robust decisions about what to leave out.

Although the analytical process felt difficult and intense, one of the hardest aspects of conducting the study had presented itself before the analysis had even begun. This had to do with untangling my multiple roles in relation to the phenomenon of interest. In order to come closer to the unattainable ideal of epoché, Creswell & Kasmad (2020) suggested that researchers should begin by giving an account of their own experience of the topic being researched. For me, this centred on my professional role as a feeding specialist, and such an account was presented previously (1.2). This history meant that I came to the study with knowledge and expectations that I tried to set aside as far as possible as I engaged with the data collection and the phenomenological aspects of the data analysis.

When working clinically, although information-seeking is an important element of the process, fundamentally, clients come to me because they want my guidance. If I were to enter into research interviews coming from a perspective of 'knowing best' I

would largely miss participants' frame of reference. For me, epoché involved trying to suspend *knowing*. The most difficult example of this task came in my very first interview when I was least ready for it. The participant (P1) was extremely anxious about her child not eating enough. She described how multiple health professionals had disregarded her concerns, saying his weight and growth were fine. She talked about how his weight was plotted on his growth charts. It was clear to me that his weight, as far as she described it, was probably not concerning at all and that she perhaps did not understand how to interpret the charts. She was so worried about her son and it felt awful not to explain the growth chart percentiles to her and reassure her that her child most likely needed far less to eat than she imagined. My task, however, was not to correct her perception but to get closer to it; to try to understand the meaning she attached to her child's eating behaviours and his body. In the latter stages of the analysis, I was able to take a more interpretative stance and apply the literature on parental misperceptions to this case. However, it was essential - in the first instance - to stay close to this participants' worldview, unencumbered by my own assumptions.

I took this experience to supervision, reflected on it, and documented it in my research journal. I tried to focus on the wider goal of conducting good quality research. Although I was not in a position to offer advice to this mother, by contributing to scholarship in the field and aiming to better understand parental meaning making in relation to child feeding, I was hopefully offering a different - albeit less direct - benefit. In response to what I can most accurately describe as my guilt in relation to not giving advice, I decided to provide free workshops for participants and other interested parents to attend. Participants could only attend after data had been gathered (so as not to impact the data) but attendance was not made conditional upon taking part in the study. In these workshops I provided generic, evidence-based information about child feeding. I was not able to carry out the last workshop due to Covid-19, but offering the workshops helped me feel that the research process was reciprocal. I was able to give something back to participants and to provide educational resources in a boundaried and appropriate way.

My instinct to be directive or to offer information was compounded by some participants' explicitly asking for advice. I had stated in my participant-facing information that the research interview was not an opportunity to ask for advice, signposting concerned parents back to their GP or health visitor. However, I had to reiterate this multiple times. Again, this felt difficult. Especially in one case, where the

parent felt sure she had created her child's eating challenges and I very much doubted that this was true. Had she been a client, or even a parent in my Facebook group, I could have given her the very important but simple message that her child's avoidant eating was not her fault.

Other parents described what appeared to be sensory processing challenges on the part of their child. My professional response would have been to recommend screening by an occupational therapist. This would not have been appropriate at a research interview, yet not sharing this valuable information left me feeling conflicted. Again, offering the workshops mitigated feelings like this. In terms of refraining from advising during the interviews themselves, although it felt odd emotionally, it was not too difficult at a practical level. This is perhaps because when I was working as a therapist before specialising in feeding work (feeding work being inherently more directive than psychotherapy) I became used to being very boundaried and monitoring my responses in the moment.

Perhaps a more challenging manner in which my background as a therapist manifested itself was the way in which it interacted with the process of data collection. At times, I felt drawn towards an inappropriate use of therapeutic skills during the research interviews. My role was not to help participants come into contact with some of the difficult feelings they may have had in relation to feeding their child, and I needed to remember that. There was one instance in particular which stood out. A participant made a connection between her own experience of being sent to bed without any food as a punishment and her powerful need to protect her child from feeling hunger. I knew this was a profound moment - it had the flavour of a pivotal insight in therapy where a client realises something very important for the first time. The way the participant framed it though, was almost casual and incidental. This is often the case in the therapeutic context, where challenging thoughts or feelings are minimised as clients struggle to cope with them.

P10 said: "I'm just worried about, if he's hungry, he's going to be feeling... upset, unloved, um, tired, grumpy... anything negative" I responded: "being hungry equals being not loved….?" . In so doing, I had homed in on the significant emotional content linked to childhood experiences which the participant had glanced over. By metaphorically holding it up to the light like this, I helped her make a new connection between her past and her feeding practices. She replied: "yeah, yeah. It's... I'd... an' actually, I hadn't realised until I just said it then, that that's probably what it boils down

to, is me worrying that he's going to feel unloved because he's hungry. [pause]". The weight of this realisation hung heavy in the room. Later, this participant commented that the interview had felt therapeutic. While this was expressed positively by the participant, it had not been my intention for the interaction to be therapeutic.

I felt that I had not judged the interview very well. I was so caught up in my engagement with these profound connections the participant was making, I had erred too far towards the creation of a therapeutic space. I applied this learning in a later interview where the participant discussed the death of her child's father, in relation to his eating behaviours. She did not choose to go into this in any detail and I moved the conversation along, conscious that the interview was nearly at an end and that the potentially emotional nature of this content could not be contained.

While at times, my familiarity with the therapeutic space and my experience of giving feeding advice were a hindrance, in other ways they were helpful. I was able to listen actively and carefully judge when to probe and when to leave silence. My familiarity with the field helped me pose the questions in such a way that I was able to elicit rich data. In the main, I was not surprised by what my participants shared: They described thoughts and feelings that were typical of the parents I have been working with clinically for many years. Perhaps this helped me convey a nonjudgemental attitude. I was not shocked by the practices parents reported using even though I imagine that to a lay person, some of them (like pushing a child to eat until they vomited) would have been shocking. It is always hard to hear about a child in distress, but I was able to see that these practices were borne of desperation and a lack of alternatives.

5.10 Method Summary

The aim of the study was to explore parental meaning making in relation to both child-feeding practices and child eating behaviours, in the context of avoidant eating. The use of IPA against the backdrop of a critical realist ontological and epistemological position, facilitated the realisation of these aims. The study design enabled the researcher to explore how parents made sense of avoidant eating (and their responses to it) at a detailed and nuanced level. The experience of conducting the research was a valuable learning experience in multiple ways. Navigating the HRA ethical clearance process, in particular, was a steep but productive learning curve. Lessons learned about recruitment were also beneficial; were a similar study to be undertaken in the future,

recruitment would be approached very differently. Interviewing skills were refined during the data gathering process, with important opportunities presenting themselves for reflection about boundaries and the role of the researcher.

6 Findings 1: Getting the Food Down the Child

Having set out the methodology and method employed in the empirical element of this programme of research, the findings are now presented. This takes place over four chapters. Along with an introduction to the findings section as a whole, the current chapter includes a summary of the feeding practices used by participants, followed by an analysis of selected maternal rationales for the use of those practices. This summary and analysis are encapsulated by the superordinate theme: *Getting the food down the child*. The remaining superordinate themes are considered in the subsequent three findings chapters (Chapters 7, 8, and 9). See table 6.1 for a summary.

Table 6.1 *Overview of the Findings Section*

Chapter	**Superordinate theme**
Chapter 6	Getting the food down the child
Chapter 7	Feeding and sense of self: being a crap parent
Chapter 8	Parental sense of agency: it's completely uncontrollable
Chapter 9	Trying to understand: absolutely no clue

The study's dual objectives were as follows:

- to explore how parents of avoidant eaters make sense of their feeding practices
- to explore how parents of avoidant eaters make sense of their child's eating behaviours

On this basis, the current chapter contains an overview of the feeding practices in question. The chapter ends with a more interpretative analysis of aspects of the maternal rationale for the use of these practices. Throughout the remaining findings chapters (7,8, and 9) there is a particular focus on how mothers position themselves in relation to their child's avoidant eating, with two unanswered questions echoing throughout the findings: have they caused it and can they control it?

6.1 Introduction to the Findings Section

In each findings chapter, there is a detailed consideration of one superordinate theme, with supporting excerpts. Relevant themes and subthemes are tabulated in each chapter. The findings chapters each end with a discussion section, in which the

implications of the findings presented are considered in the light of relevant literature. Unless there is specific justification for doing otherwise, in line with guidance on quality in *Interpretative Phenomenological Analysis* (IPA; Smith, 2011) themes are only included in the findings chapters if they are relevant to at least half the sample (see 5.8.2.3).

6.1.1 Terminology, Thematic Labels and Transcription Conventions

With a view to accurately reflecting the sample, the terms *mother* and *maternal* (as opposed to *parent* and *parental*) are used when referring to the data and the participants. However, although the sample included mothers only, some recommendations can be applied to other family members with direct responsibility for child feeding. In these instances, the terms *parent* and *parental* are used.

Participant numbers (e.g., P3) are used to identify the mothers in the sample. These numbers are not sequential due to participants' 3 and 7 not attending their scheduled interviews. Initials (changed for anonymity) are used in relation to people referred to by participants by name (e.g., their partner). Thematic labels, while not all direct quotes, draw heavily on the data, in an attempt to stay close to participants' characterisations of their experience. Participant quotations are indented in single-spaced type to aid readability and to distinguish them from the commentary. Table 6.2 shows transcription conventions employed in the reporting of the findings.

Table 6.2 *Transcription Conventions*

Punctuation / annotation	**Meaning**
. at the end of the quotation	The excerpt ends with speech transcribed as a full sentence
… at the end of a quotation	The speaker 'trailed off'
… at the beginning of a quotation	The excerpt opened with a hesitation
… in the body of the quotation	The participant hesitated or verbally stumbled
[pause] in the body of the quotation	The participant paused (longer than a hesitation denoted by …)
….. anywhere in the quotation	Researcher speech that was considered immaterial (e.g., "yeah" or "right") was removed for ease of readability
[*italicised comment*]	Denotes contextual information felt necessary to an understanding of the quotation
[nonitalicised comment]	Denotes nonverbal communication (e.g., laughter)
Sentence begins with "And" or "But"	A decision was made to sacrifice grammar at the expense of more accurately conveying the rhythm of the participant's speech
R	Researcher (used to indicate the researcher's speech)

6.1.2 Diagrammatic Overview of the Findings

Figures 6.1 and 6.2 provide a diagrammatic overview of the findings. To enhance the legibility of the text, what was originally a single diagram has been split into two separate ones. In the original, all four superordinate themes were presented along the same horizontal axis. The separation of the four superordinate themes into two groups of two for the purposes of these figures is therefore not related to how they should be interpreted.

Figure 6.1 *Overview of Superordinate Themes 1*

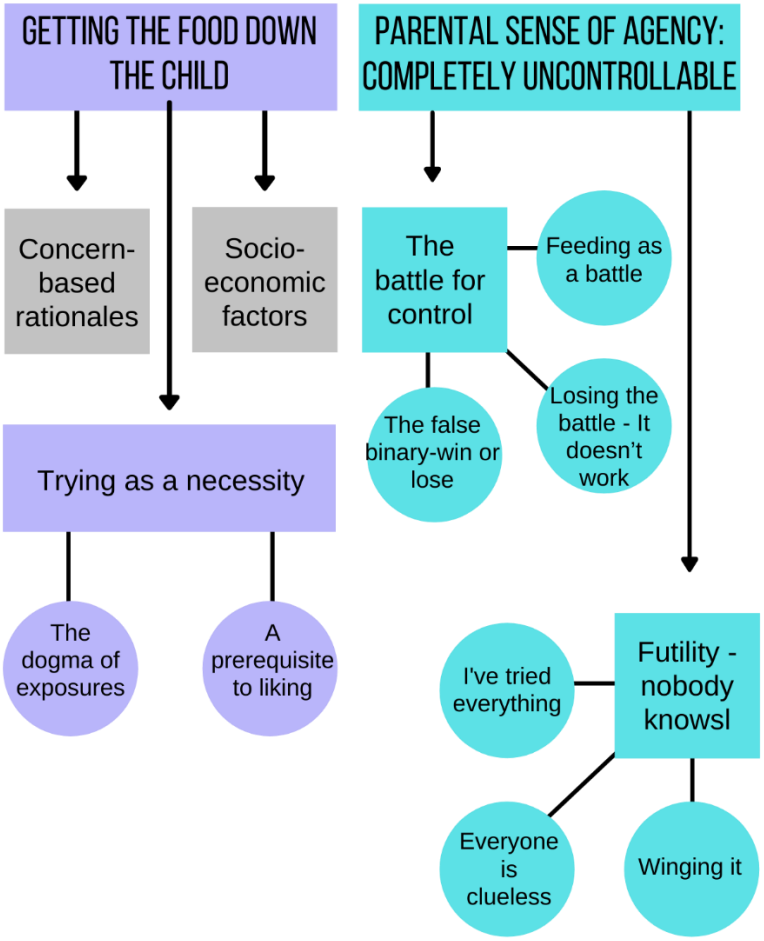
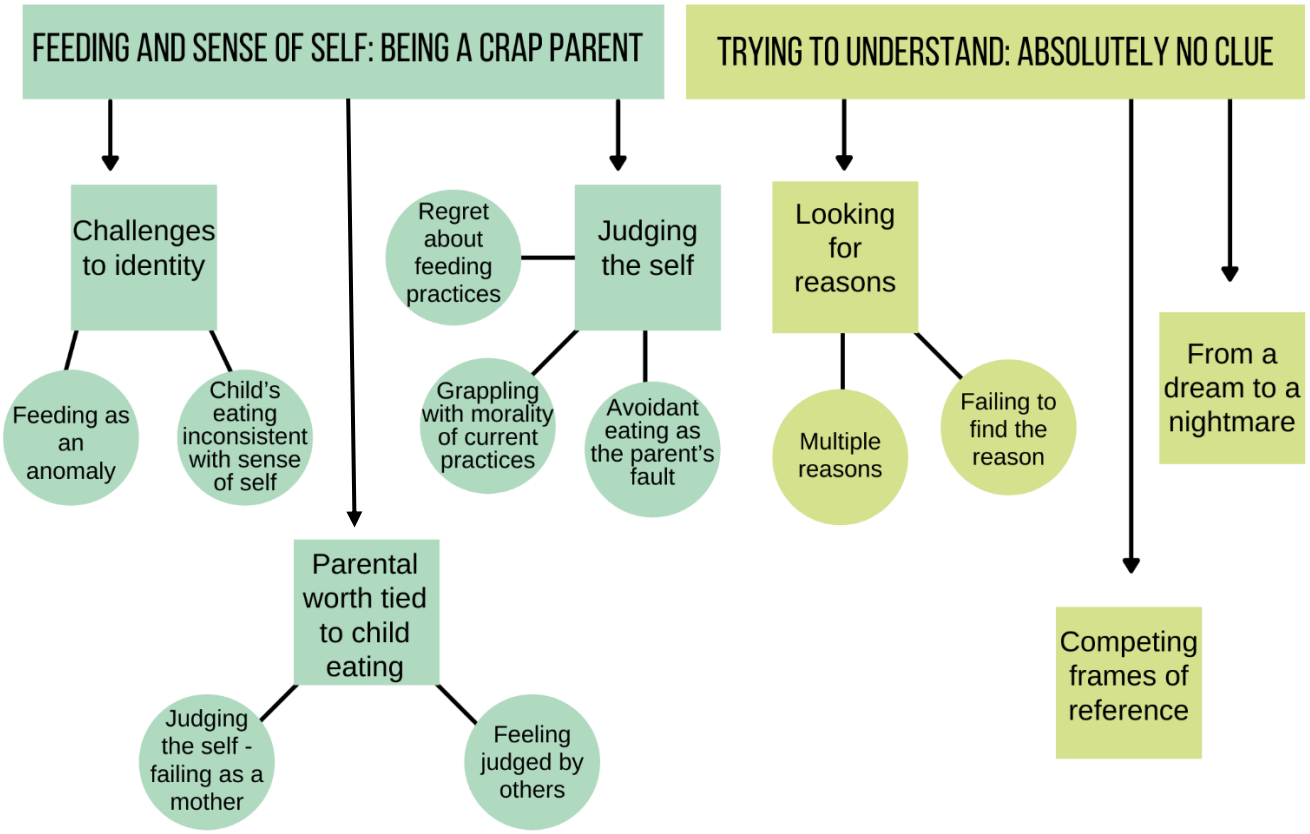


Figure 6.2 *Overview of Superordinate Themes 2*



6.1.3 Findings Not Reported

Some findings from this study are not reported in detail in this thesis. Due to the sheer overall volume of findings, a decision was made to prioritise the reporting of findings felt to be especially novel or useful (see 5.8.2.4). Figure 6.1 indicates two aspects of maternal rationales for feeding practices used which are not reported. These are differentiated in grey. They relate to concern-based rationales for feeding practices (such as anxiety about a child's health) and socio-economic factors (such as dislike of waste on financial grounds) relating to feeding practices. These topics have previously been explored through a qualitative lens (Goodell et al., 2017; H. Harris, Ria-Searle, et al., 2018; Hayter et al., 2015; Rubio & Rigal, 2017). Appendix L features a diagram in which further detail on these unreported findings is provided.

In addition, practices relating to maternal structuring decisions have not been reported in detail and are not shown in the diagrammatic summary (Figures 6.1 and 6.2). These findings concern how mothers made decisions about which foods to offer and when to offer them. This has also been examined qualitatively, in relation to adherence to Satter's *Division of Responsibility* model (sDOR; Satter,1986,1990) by

Loth et al. (2018). Appendix M comprises a summary of maternal structural decision making in this sample, including supporting excerpts from the data. Other potentially interesting themes in the data were not analysed, again, due to volume. These concerned maternal support-seeking behaviours and how mothers categorised foods.

6.2 Findings Reported in this Chapter

The findings shared in this chapter are somewhat different from those in the remaining three findings chapters because they include a descriptive analysis of maternal feeding practices. The rationale for this is as follows: As described in detail in Chapter 4, IPA is strongly interpretative. This does not mean that it is never descriptive - in fact, good IPA both interprets and describes (Larkin et al., 2006). On this basis, a descriptive overview of participants' accounts of their feeding practices is offered, in an attempt to convey a sense of participants' worlds. Further to this, how particular themes support the illumination of other elements of a report is a factor to be considered, when deciding what to include in the writing up of an IPA study (Smith & Osborn, 2003). In the current context, the aim was to convey which feeding practices were being used in order to aid understanding of the themes pertaining to how the participants made sense of those practices.

It is hoped that the descriptive aspects of this chapter will serve to preface the more heavily interpretative analysis which follows, both later in this chapter and in the following three chapters. After an examination of the nature of feeding practices used in this sample, there is a discussion of selected rationales for these feeding practices (coming under the theme *Trying as a necessity*, see Figure 6.2). The analysis in relation to *Trying as a necessity* is more interpretative than that associated with the analysis of the practices themselves.

Table 6.3 provides a summary of the superordinate theme: *Getting the food down the child.* Themes and subthemes are indicated. These are expanded upon and discussed in this chapter.

Table 6.3 *Superordinate Theme: Getting the Food Down the Child - Summary*

Superordinate Theme **Getting the Food Down the Child**	
Theme	**Subtheme**
Trying as a necessity	The dogma of exposures
	A prerequisite to liking
Concern-based rationales	Not reported
Socio-economic factors	Not reported

This superordinate theme relates to practices with the implicit goal of getting the child to eat or try a food. Using the spectrum model of pressure proposed previously (3.5.5), these practices (ranging from persuasive to coercive) fit the construct of pressure to eat. Participants described doing many things to try to get their child to eat. Indeed, pressureful strategies were universal in this sample, albeit framed as former rather than current practices in some cases. Some mothers used strategies representing attempts to persuade or reason, such as telling their child that a food would be good for them. Others used strategies that were more overtly autonomy-thwarting, such as compelling a child to eat a disliked food until they vomited. Some participants reported the use of a combination of strategies from both the persuasive and coercive ends of the spectrum.

Table 6.1 summarises which participants described using which practice. It should be noted that, as described above, some indication of incidence is expected with IPA (Smith, 2011). However, it is not as pertinent to the analysis as it would be in a content analysis (Krippendorff, 1980) and firm numerical conclusions are not being drawn. Incidence has been included primarily to highlight just how ubiquitous pressureful strategies were in this sample. The practices were grouped into categories (highlighted in bold in Table 6.4). Brief descriptions of the practices can be found in Appendix N, followed by tabulated illustrative quotations from participants (Appendix O).

Table 6.4 *Incidence Table: Getting the Food Down the Child (Descriptive Analysis)*

	P1	P2	P4	P5	P6	P8	P9	P10	P11	P12
Persuasive practices										
Encouragement			X		X		X	X		X
Verbal Prompting	X				X	X			X	
Food PR					X		X	X		X
Praise		X		X	X		X		X	
Play / fun	X				X	X	X		X	X
Authoritarian practices										
Insistence	X	X	X	X	X				X	
Punishment	X				X					
Forcing child to stay at table	X			X	X					
Making child go hungry *			X	X	X					
Re-presenting rejected food **		X	X				X		X	
Enforcing food-trying		X		X	X	X			X	X
Contingent practices										
Food bribe / reward		X	X	X	X			X	X	X
Nonfood bribe / reward			X	X	X				X	X
Conditional dessert / preferred food		X	X	X		X	X		X	
Reasoning										
Health/nutrition-based arguments		X	X					X	X	X
Appealing to rational arguments			X		X				X	
Negotiation		X	X			X			X	
Begging the child to eat								X		
Physically feeding the child ***							X	X	X	X

* In the absence of the provision of some accepted foods

** As the only option

*** Despite child being developmentally capable of self-feeding

6.3 Theme: Trying as a Necessity

It was argued in the systematic review of the conceptualisation of pressure to eat (3.5.5) that the notion of pressure to eat in relation to avoidant eating ought to be sufficiently broad to encompass practices whereby mothers attempt to induce children to try foods as well as consume them. In line with this understanding of pressure to eat, both of the subthemes discussed in the current section are underpinned by the maternal belief that, unless the child is made to eat and try foods, their relationship with food will never improve.

It can be seen from the preceding summary of feeding practices that, despite some divergence in the strategies employed by mothers, inducing children to accept foods that they did not want to eat or try was a common goal. For some participants, it

is an end in itself; they simply want the child to eat, and so do what they can to bring this about. For example, P10 describes pleading with her child to eat:

> P10:…um, and I've tried sitting there and begging him with the spoon and "please, please, please, please, please" and that doesn't work, so I try not to do that so much, but sometimes you do just feel like I, I, I don't know what to do. He's got to eat, and that is what I sort of resort to.

Here, P10 is not so much employing a strategy to improve her child's eating as desperately trying to get him to eat something because she believes it is essential to his wellbeing. The repetition of "please" underscores her distress and her transition between first and third person pronouns suggests an attempt to separate herself from these painful experiences.

In contrast, other participants appear to have a conceptual framework forming the basis for their goal of compelling the child to try nonaccepted foods; enforced food-trying seems to be underpinned by a belief that children need to be exposed to a food many times before accepting it. This is captured by the subtheme: *The dogma of exposures.* The related subtheme, *Trying as a prerequisite to liking*, concerns scenarios where the trying of foods is framed as a necessity, but not one which is necessarily part of a long term strategy.

6.3.1 Subtheme: The Dogma of Exposures

In the following excerpt, P9 alludes to a need for children to try a food twelve times before they will accept it.

> R: right, so just 'cos he's tried something one day, it doesn't mean he'll try it another?
>
> P9: it doesn't mean we've got him on it, yeah, it is a... I think we then hit the, 'they've got to try it twelve times before they accept it', thing. [laughs]

P9's calling the concept of multiple exposures a "thing" indicates that she sees it as a recognised theory of how children expand their diet: a theory she has encountered and subscribes to. The verb "hit" implies that this is a barrier that she has come up against forcefully. There is a conflict between her belief that her child has to eat something twelve times and her inability to bring this about. In a later excerpt, P9 describes worrying about her child's refusal (or inability) to try foods:

> P9: I do worry sometimes, yes, I don't think I'd have as much worry if I could get him to put it in his mouth because then I knew, it'd be more of a... trial and

> error, and the whole, "oh, you've got to try him again and again and then he'll accept it" sort of thing, but him refusing to try it in the first place does worry me

P9 quotes an imagined unnamed expert stating the need for repeated exposure. The imperative "you've got to" indicates her sense of exposure as an obligation, but this is an obligation she cannot meet. For P9, her inability to persuade her child to try disliked foods - taken in conjunction with her beliefs about exposure - potentially contributes to a sense of helplessness and worry. If trying is a required step towards acceptance and she cannot bring this about, this is extremely anxiety-provoking. This sense of impotence is connected to the theme of *agency* discussed in the next chapter.

P8 also has a strong belief that enforced exposure is the right approach. She speaks with passion about the importance of exposure in early childhood:

> P8: ...yeah, yeah, just give him the best chance really, because it d... it's, it's lifelong and these early years are so, so important, and if you don't give people the, children the tools and the variety and exposure to everything around food, you know…

The implication here, is that to not provide exposures to nonaccepted foods equates to not giving her child the best chance in life. Earlier, P8 talked about her approach in this regard as something that requires effort, but an effort she is prepared to make. This strong belief in the value of exposure goes some way to explain why the effort feels justified:

> P8:… I think we've tried really, really hard….. um, and exposed him to lots of different things

And later…

> P8:… y'know, on Sunday just gone, we had a Sunday dinner and F [*partner*] cut up some green beans from the garden into tiny little pieces, and he [*child*] had four or five of those and a small, side bit of broccoli. And he ate them and wretched all the way through it, like, b… a... h... drinking water and F said "no, if you want pudding, you've got to, you've got to... and he s... took them off the plate, said "look, that's all you've got to eat, never mind that lot, just these bits here" and he had some chicken and he had a Yorkshire pudding... um, in gravy, 'cos he quite likes gravy. And he ate them, but he was, it was... it was vi... I mean, it was like you and me trying to eat faeces, you know, it was awful to watch him... absolutely hated it.

P8 appears to have an empathic reaction to her child's distress at eating a disliked food: She describes it as "awful", using the extreme simile of "eating faeces"

and the superlative “absolutely” to convey just how much she “hated” witnessing his distress. Despite this compassion, she seems to be able to override her discomfort. Perhaps this is because she believes that eating these nonaccepted foods is supportive of her child’s relationship with food. This sublimation of empathy in a child’s perceived best interest could be compared to the experience of a parent having their child vaccinated: They hate to see the child in pain but support it as an ultimately protective act. It could be that some of the ‘trying hard’ discussed above reflects the effort of coping with witnessing the child’s distress resulting from the feeding practices employed.

Like P9, P5 explicitly refers to exposure theory. In her case, this is in relation to her training as a professional working with children:

> P5: for her... I, I would only ever ask her to try something once, for the simple reason that for her to try something once is huge….. um, I know from my training that you have to try something quite a few times to actually know if you like it or not and I would maybe to continue to offer, and uh, the same with my son. He's told me he doesn't like things and I've re-offered after a few months, just to see. Um, but with her I won't, because for her to try something once is a huge thing. And I've always said to her "if you try it and you don't like it, that's fine" so then for me to say, "well, you've got to try it again next week"... that would just, she would just lose the plot, and actually, when she loses the plot it's nobody's happy ending, so... [laughs loudly]

P5 clearly acknowledges the distress that trying a disliked food gives rise to in her daughter. Like P8, she empathises with her child and can see the experience of food-trying from her perspective, using the adjective “huge” twice in relation to it. Her rationale for her policy of enforced tasting is based on compromise, as she navigates the tension between empathy for her daughter, wanting to avoid challenging behaviour, and believing that exposure is adaptive. Her solution is to insist that a new food is tasted just once.

Not all participants were as confident as P5 and P8 in their policies regarding interaction with disliked foods. P11 describes a scenario where a teacher at her son’s school persuaded him to try a Spring roll. He complied but vomited:

> P11:… and then the same again with the, um, Spring roll. He actually tried it, whereas he won't even try anything for me, so it's good that he's tried it, you know, and I did, I did make a fuss about it and so did they**,** but if he's throwing it back up then I don't want to push him to try it, so, and then, and then all I kept thinking about, but if I make him swallow something, is he going to throw it back up? So I thought, no, best to let him spit it out because then it's not gonna...

'cos otherwise, it's gonna to put him off altogether and I don't want to put him off altogether, if he knows it's gonna make him sick, so... um, yeah

As P11 reflects on this incident, she is grappling with the presumption that food-trying is inherently positive and the opposing instinct that the aversive experience may in fact make things worse. This contradiction appears to preoccupy her significantly ("all I kept thinking about"). The frequent contrasting conjunctions reveal a vacillation between two perspectives, which P11 finally resolves with the pivotal "no" as she concludes that it is best to let her child spit out foods he does not want to eat.

This subtheme has shown how some participants specifically draw on ideas about exposure which presumably have their origin in the feeding literature. Some feel compelled to facilitate exposures to nonaccepted foods while also having an empathic reaction to the evident distress of the child. Such contradictory perspectives are discussed further in Chapter 9 (9.2) in relation to the theme: *Competing frames of reference*. Other participants do their best to facilitate multiple exposures but are keenly aware that it is not an achievable goal. This seems to be an anxiety-provoking dissonance. Participants react differently to child distress: In some cases, it leads them to question the appropriateness of enforced exposure, in others it does not.

6.3.2 Subtheme: A Prerequisite to Liking

The second subtheme has to do with meaning making regarding food-trying as an end in itself. Even where the maternal goal is not necessarily multiple exposures as a means to acceptance, trying food was framed by many participants as an unavoidable prerequisite to liking. This has a certain logical coherence to it: If acceptance means willingly taking multiple bites of a food item and swallowing them, then trying (i.e., taking one small, tentative bite) appears to be an incremental move towards that end goal. Put differently, a child who does not consume a tiny amount of a food cannot eat a more sizeable quantity of that food, just as the top rung of a ladder cannot be reached without standing on the bottom rung. The apparent logical relationship between trying and accepting seems to contribute to the rationale of several participants for making children try foods.

P4, like P11 described above, wrestles with how to think about her feeding practices:

P4:… you think, well, there's no point in that *[enforced trying leading to gagging]* because obviously she's quite upset by it 'cos she thinks she's been sick

> and then I'm like, have we forced her to eat it? But then, I think, unless you try these things, you'll always think, I'm not eating that, I don't like that

Her child's reaction to being pressured to try a food leaves P4 with a question: Is it damaging to facilitate an exposure that leads to gagging, or is it an essential step towards a broader diet? Perhaps for P4, it is both. Similarly, P6 focuses on the goal of getting her child to try just a small amount of a food:

> P6: um, we've tried the... "just have a spoonful"... 'cos I thought, even if I get him to only have a spoon of something new, he might start thinking, actually, that doesn't taste as bad as I thought….. even if it was just a mouthful of something….. but we've tried that, we've tried sitting him at the table and saying "just have a spoonful" um, and I've always... he's always had to ask if he can leave the table. He's always had to say "can I get down now Mummy?" or " can I get down now Daddy?" and we've tried saying "no - you're not getting down until you've had a spoonful"
>
> R: and how did that go?
>
> P6: doesn't work.

For P6, there is a sense that the child is refusing the food because of a lack of awareness of how it tastes, the implication being that the child just does not know that they do in fact like the food. If this were the case, this would presumably be a successful strategy, which P6 later said it was not. Quantity is not an issue here; this practice does not seem to relate to a long term nutrition goal. P6 believes that if her son could just try a very small amount of a disliked food, this would facilitate acceptance. The verb 'get' ("get him to only have a spoon") is frequently used in relation to eating across the sample. It is indicative of the maternal sense of their role: They need to *make* their child interact with foods in certain ways. This is clearly in opposition to a responsive approach to feeding where child autonomy is prioritised. Notably, the author of a book for parents on the management of avoidant eating (Rowell & McGlothlin, 2015) talks about helping parents move "from get to let" in her educational work concerning the promotion of responsive feeding (J. McGlothlin, personal communication, November 13, 2020).

Like P6, P9 also sees trying as a prerequisite to acceptance. She too talks about how the food, in fact, tastes good:

> P9:…but i... it's, if he won't try it, he won't put it in his mouth, he's never going to learn to accept it, that it's not a bad thing. I mean even when it's something

> like, really, really nice, I was like "try it, try it, it's lovely, I promise you, it's lovely!" "No, no, I'm not gonna try it, stop telling me"

Reminiscent of P6, P9 seems to struggle to separate her assessment of the food as desirable from her child's responses to the food. Again, frame of reference, explored in Chapter 9, is relevant here: P9 is seeing the food from her perspective, not her child's. The repetition in her report of her own speech indicates an intensity of affect: Is she frustrated at the perceived irrationality of her child's eating behaviours?

This feeding practice is used in the context of a child who regularly rejects foods and yet it seems very hard for P9 to think that her child would not classify the food in the same way she does (as "really, really nice") if he only knew how it tasted. The imagined response from her (nonverbal) child is unequivocal: Not only does he refuse to comply repeatedly, but he also demands that she stops pressuring him to try it. This puts P9 in an impossible position, given that she believes that the route to acceptance is for her child to try the food. P5 communicates a similar view:

> P5: [sighs] oh, I don't even know [sighs] yeah,….. but I think it's more frustration that actually, she probably would quite like it. If she would just try it, d'you know what I mean?

She too, appears to express frustration; she has a belief that her child would in fact like the food if she only knew what it tasted like. Her sighs provide a clue to the depth of her feeling. Like many of the other participants, if trying is the route to liking and a child will not try, she is left in stasis.

Slightly different but related, P2 and P5 see trying as a precondition of a legitimate food rejection. For P5 especially, there is an implication that to reject a food without trying it is rude, thus her explanatory model is grounded in cultural norms about manners.

> P2: er... if he says "I don't like it", I'd say "I'd like you to try it and then you can tell me whether you like it"

Again, there is a surface logic here. Can a person reasonably state a sensory preference about something they have not experienced? This perhaps reflects how food rejection is conceptualised by the participants. The phrase "I don't like it" is commonly used about food and denotes a rejection. But maybe what children are expressing is not that they have a prediscerned preference, but that they are anxious about trying the food or are put off by an aspect of its appearance or its smell. Perhaps it provokes an unpleasant

memory or reminds them of another disliked food and they are categorising it accordingly. Such cognitive processes in relation to food rejections have been suggested in the literature (Lafraire et al., 2016). However, the participants seem to interpret “I don’t like it” extremely literally, consequently concluding that, because liking comes from oral sensory experiencing of food, a child who has not tried a food is not in a position to make a judgement about liking.

For P5, this concerns manners. She has clear family rules about what is and is not acceptable behaviour in relation to food rejection:

> P5: …nd, and I, I make it very clear to my children that actually, there is foods that we don't like and grown-ups don't like certain foods and that's absolutely ok. But, it's not ok to just say "I don't like it" before you've even tasted it.
>
> R: so is that almost a family rule for you?
>
> P5: it is, yeah, very much so.

She conceptualises food preferences as legitimate: Even grown-ups - fully functioning members of the social group, thus epitomising the social norms of that group - dislike some foods, and that is acceptable. However, P5 seems to associate a statement of dislike without trying, with rudeness. For her, it is perhaps an indication of disrespect towards the person who has provided or prepared the food.

This theme has shown how food-trying is viewed as extremely important. It may be seen by participants as part of a long term exposure-based strategy. It may be perceived to be a short term requisite behaviour upon which food acceptance is conditional. Alternatively, it may be the only basis upon which a rejection is viewed as legitimate. Finally, it may be rooted in a social norm and beliefs about what constitutes polite behaviour. Not all participants discussed a rationale for trying to persuade children to try food, however, and divergent cases are now considered.

6.3.3 Divergent Cases

Of all the participants, only P1 and P12 did not discuss a rationale for encouraging food-trying. As described above, in relation to structure and content, P1 takes a permissive approach to feeding. She is very concerned that her son is not eating enough to meet his needs, although medical professionals have suggested otherwise. She is less worried about variety. Perhaps this goes some way to explaining why she does not focus on persuading her child to try new foods. Instead, she offers him multiple opportunities throughout the day to eat preferred foods. Given the broad

(according to maternal report) variety in her child's diet, he would not be classified as an avoidant eater using the definition set out in Chapter 2 (2.2.2).

In contrast, P12 is worried about her child's limited diet but has encountered information supporting a responsive approach to feeding (see 2.9). Although she used pressure previously (and describes her husband's current use of pressure) this is not something she herself still endorses; she no longer frames her feeding role as being to persuade her child to eat or try food. Through her own research, she has rejected the notion that she needs to make her child try foods.

6.4 Discussion

In this chapter it has been shown that mothers of avoidant eaters in this sample used many different types of pressure to induce their child to eat or try foods. The theme *Trying as a Necessity* represents an attempt to illuminate maternal rationales for their use of pressure in the context of food-trying. Several different maternal interpretations of this practice were considered, ranging from mothers who were unsure about whether or not pushing their child to try food is a constructive practice, to the endorsement of this practice despite it putting the child through an ordeal which the mother likened to eating faeces.

6.4.1 Exposure as grounds for enforced food interactions

If theory about exposure from the field of child feeding is a central aspect of maternal rationales for the feeding practices they use, this could have significant implications. In order to explore this, grey literature is examined with a view to conveying a flavour of the types of messages about exposure that parents may be getting. Next, the academic literature on exposure is considered. There is also a reflection on the applicability of the principle of exposure in the context of avoidant eating.

Table 6.5 is a summary of messages about exposure and avoidant eating found via an online search. Only messages from nonprofit organisations or the NHS were examined, in order to maintain a focus on official or quasi-official messaging.

Table 6.5 *What Messages are Parents Getting?*

Organisation and citation	**Organisation description**	**Message**
Zero to Three (Zero to Three, 2010)	A global nonprofit organisation providing information to the public and to political leaders about issues pertaining to babies and young children.	They state on their website under the heading: What to Do About Picky Eating, that "Children need to be offered a new food as many as 10-15 times before they will eat it."
Greater Glasgow and Clyde NHS (NHS, 2017)	NHS	In their *Fussy Eaters Information Sheet, they state:* : "Remember some new foods need to be tried around 20 times before a liking for it can be developed."
West Suffolk NHS (NHS, n.d.)	NHS	In their patient information leaflet entitled *Toddler Food Refusal*, write: "Some children need to see a food 6-7 times before trying it and taste it 10-15 times before liking it."
The UK National Childbirth Trust (NCT) (NCT, n.d.)	A national charity supporting parents	Under the topic of *Mealtime Tantrums and Food Refusal Tips,* states: "Repeated taste exposure is one of the most simple, although of course often frustrating, techniques you can try. Trying a certain food at least eight to ten times can be the key to earning a regular spot on your toddlers yes list."

The provision of a comprehensive picture of such advice is beyond the remit of this thesis and the entries in Table 6.5 are only a few examples. However, it is interesting to note three salient features of this guidance. First, there is variability in the quoted exposure statistics. Secondly, there is no detail provided about what constitutes *trying*, *offering* or *exposure*, or the conditions surrounding its occurrence. Thirdly, this advice regarding exposures is all specifically aimed at parents of avoidant eaters. The significance of this third point is considered below.

As described in Chapter 2 (2.2.1) *neophobia* (a wariness of unfamiliar foods) is so widespread in early childhood as to be considered a normal phase of development, and one which evolutionary psychologists have speculated was originally adaptive. In their review of the exposure literature, Aldridge et al. (2009) referred to theory from the field of memory scholarship to explain why young children often feel cautious or anxious about trying unfamiliar foods: On receipt of sense data, perceived characteristics are checked against long term memory for matches with previously acquired schema. When a food is unfamiliar, it does not fit with any category the child already has and thus elicits no sense of recognition, recognition being a prerequisite of a positive attitude about an object. Similarly, Cooke (2007) referred to the concept of *learned safety* (Kalat & Rozin, 1973, as cited in Cooke, 2007), positing learned safety as a mechanism through which familiarity relates to acceptance, in the context of children's eating.

Regardless of the mechanism, the importance of familiarity in food preference formation is firmly established in the literature, as evidenced by the body of empirical work described below. Taken in conjunction with the universally acknowledged phenomenon of neophobia in early childhood, it is easy to see how the championing of food exposures - in the name of increased familiarity to combat neophobia - could have become part of the contemporary parenting canon. It is also reasonable to speculate that messages about the merit of trying foods many times may contribute to the strength of a popular belief in the goal of getting children to try foods per se.

In a systematic review of the literature on preference formation in children up to 36 months of age (Mura Paroche et al., 2017), 48 studies were identified. Of these, 24 studies dealt with familiarisation. All samples were from the general population. The authors of the review broke down exposure into four categories in these 24 studies: taste exposure, exposure to a varied diet, exposure to varied textures and visual exposure. Although exposure across all domains was found to enhance food acceptance, this relationship weakened as children got closer to the top of the age range considered in the review. This phenomenon fits with the observations that the impact of exposure is seen to lessen with age (Dovey et al., 2008) and that - presumably accordingly - more exposures are necessary to acceptance as children get older (Cooke, 2007).

Looking beyond the age range considered by Mura Paroche et al. (2017), in an earlier narrative review (Cooke, 2007), one study of three- and four-year-olds (Sullivan and Birch, 1990, as cited in Cooke, 2007) constituted evidence for exposure aiding

acceptance in this age group. It should be noted that there is some inconsistency in the exposure literature, as researchers who carried out a longitudinal study of children up to 24 months (Howard et al., 2012) found that exposure was not related to food acceptance in their sample. This latter study was not included in Mura Paroche et al.'s (2017) review.

6.4.2 The Socio-emotional Context of the Exposure: The Missing Piece?

It is the contention of this chapter that concepts from the exposure literature may be forming part of parenatl rationales for the feeding practices used. It seems clear that most of the participants in the current study believe that making their child try foods is very important. Thus, exposure as an end provides justification for the means, despite distress on both the part of mother and child. The choice of the name of the first subtheme: *The dogma of exposures,* was an attempt to convey the potency of the belief that enforced exposures were the right thing to strive for - a belief seemingly able to supersede maternal intuition and empathy to the point of children vomiting. Such practices may be a reflection of the depth of maternal anxiety about child eating, and these two interpretations (faith in exposure as a driver and anxiety as a driver) are not mutually exclusive.

If popular beliefs about exposure are being used to justify pressure to eat, what is missed is the potential negative impact on the child (and on the interaction more generally) of thwarted autonomy. It seems highly likely, given the evidence for the negative impact of pressure to eat (see Chapter 3) that thwarted autonomy may be over-riding any benefit conferred by the newly won familiarity with the disliked food. This is not necessarily an omission made in the academic sources in which exposure is originally discussed, although some secondary sources, such as a recent literature review (Patel et al., 2020), do omit it. Indeed, Dovey et al. (2008) highlighted the importance of a positive feeding style when tackling developmentally normal neophobia, warning that: "a stressful feeding encounter is not likely to stimulate a positive response from the child to novel and/or aversive tasting foods" (p.182). Similarly, Aldridge et al., (2009) tempered their conclusion that research repeatedly demonstrates how increasing familiarity considerably improves novel food acceptance, with the following caveat:

> "Physical and emotional reactions and associations to the consumption of a novel food are crucial, if the experience is positive, whether this is the social and

> emotional atmosphere during feeding or the physiological effect of the food itself, preferences are liable to form. Conversely, if the experience is negative or coercive in any way, this will be associated with the food item and rejection will inevitably follow. The related research bestows a significant message that children like and benefit from a degree of autonomy." (Aldridge et al., 2009, p.40).

The importance of the context of food exposures has long been known about. For example, a study from the nineteen seventies involved children undergoing chemotherapy, which gave rise to nausea and vomiting. In the experimental group, the children were given ice cream during their treatment period. Those in the control groups were not. When offered a choice of ice cream or a game several weeks later, 21% of children in the experimental condition chose ice cream, versus 67% and 61% of the children in the two control groups (Bernstein, 1978; as cited in Birch, 1987). This study demonstrates how children may form associations between unpleasant experiences and specific food items, which then influence subsequent preferences.

6.4.3 Individual difference

As well as the socio-emotional context of the exposure, another important consideration is individual difference. For example, research has shown that sensory sensitivity reduces the positive impact on food acceptance of parental modelling and exposure (Coulthard & Blissett, 2009). Indeed, child factors have a significant influence on food acceptance more generally (see Blissett and Fogel, 2013, for a review). Studies investigating the impact of exposure on food acceptance are typically conducted with samples from the general population as opposed to children identified as avoidant eaters (Anzman-Frasca et al., 2012; Fildes et al., 2014). Extrapolating from their findings to children who are not typical eaters is problematic. As Dovey et al. (2008) pointed out, a child who is anxious about novelty in a food context will necessarily have a negative experience when exposed to a new food (where the exposure compromises autonomy). This fear reaction will then contribute to how that food item is encoded by the child (Dovey et al., 2008).

The child's negative response to a forced exposure may also negatively impact parental affect and the wider atmosphere (Wolstenholme et al., 2020). Thus, both the socio-emotional environment of the exposure and child characteristics - including the child's existing relationship with food and feelings about nonaccepted or new foods -

must be taken into account when suggesting that exposure will improve dietary repertoire. A recommendation drawing on the findings of the current study is as follows: Frontline health professionals need to be educated in the importance of helping parents understand the potentially negative impact of impinging upon child autonomy in the name of exposure. Parents are presumably doing their best and believe themselves to be using best practice but may inadvertently be exacerbating the very problem they are trying to address. In the next chapter, there is an exploration of what the use of practices that are perceived not to work may mean for participants' sense of self. They are using pressure to eat while saying it is not working and this may have ramifications for their sense of agency.

7 Findings 2: Parental Sense of Agency: Completely Uncontrollable

Table 7.1 provides a summary of the superordinate theme: *Parental sense of agency* Themes and subthemes are indicated. These are expanded upon and discussed in this chapter.

Table 7.1 *Parental Sense of Agency: Completely Uncontrollable - Summary*

Superordinate Theme **Parental Sense of Agency: Completely Uncontrollable**	
Theme	**Subtheme**
The battle for control	Feeding as a battle
	Win or lose - the false binary
	Losing the battle - it doesn't work
Futility - nobody knows	I've tried everything
	Everyone is clueless
	Winging it

The previous chapter explored what mothers said they did in order to induce their children to eat, as well certain aspects of their rationales for these practices. Structure- and content-related practices were also described. In this chapter, the focus shifts to an examination of the more abstract question of maternal agency. Agency describes "feelings of control over actions and their consequences" (J. Moore, 2016, p. 1). This chapter, then, considers mothers' experience of being out of control of their child's eating behaviours. They can choose their actions (albeit within certain limits, which are discussed later) but their actions do not bring about the desired consequences. The superordinate theme covered in this chapter is broken down into two themes. The first pertains to a sense of being engaged in a battle for control. The second concerns a lack of knowledge about how to respond to avoidant eating and an associated belief that

knowledge about how to respond is not even ‘out there’. No one knows what to do and the battle is, therefore, futile. Thus agency and hope appear to be interconnected.

7.1 Theme: The Battle for Control

This theme comprises three subthemes, at least one of which was evident in all participants’ interviews. Although not all participants specifically used the military analogy covered in the subtheme *Feeding as a battle* (six did), every single participant talked about feeding practices that they either currently or formerly used and stated that they do not (or did not) work. This is captured by the subtheme: *Losing the battle - it doesn’t work.* The volume of data in this regard is so compelling that the table showing incidences of this subtheme has been appended (Appendix P). This is with a view to conveying the overwhelming sense from the majority of participants that the (pressureful) strategies they employ or employed are ineffectual. Finally, in the subtheme *Win or lose - the false binary*, there is an exploration of how some participants seemed to experience the options available to them in relation to their feeding practices: as a choice between being uncompromisingly controlling or giving up completely and embracing extreme permissiveness.

7.1.1 Subtheme: Feeding as a Battle

In this excerpt, P8 conveys her wish that she had parented differently when her child was an infant:

> P8: um, just disappointing that... that... how, how is he doing this when he's... why didn't we do this when he was eight months old? Let, and just let him get through it then? And then we wouldn't be having these battles.

Her premise here seems to be that the fight to get her child to eat is a battle that needs fighting, and it would have been easier if she had got it out the way when he was smaller. Perhaps she feels that he would have been a less formidable adversary when he was younger. Her conceptualisation of her feeding role is further elucidated here:

> P8: one time he sat down and he had four Weetabix, four! 'cos he was so hungry at night. Then, I gave in 'cos it's nearly bedtime and he hadn't had any dinner, we'd had a meltdown about it.

P8’s giving her child Weetabix before bed is perhaps, to her, akin to holding up a white flag. In the incident she describes, her son’s tantrum and her negative feelings about him going to bed hungry proved too much and she lost her resolve. The phrase “gave in” is very telling. This incident is framed as his victory and her loss.

As discussed in the preceding chapter, P8 is very committed to her pressureful practices. For P4, however, battles are largely in the past. Although she reports current pressureful practices at other points in the interview, overall, she describes her approach to feeding as less controlling than it used to be. She has learned through experience that pressure does not work:

> P4: yeah, I'm kind of trying to be a bit more... relaxed about it [*getting the child to eat*]….. because I just think, well, it hasn't really got us anywhere, the last three years.

And later…

> P4: yeah. I've kind of come like, round to her... because after three years you just think, if I give her this, to say "oh look, you've got variety", we're all having like, fish tonight, then she won't eat it. So it's just pointless. And then it becomes a battle that she won't eat it.
>
> R: has it been like that then, historically? Has it been a battle?
>
> P4: yeah, trying to like, bribe her to eat things
>
> R: tell, tell me about that, that sort of 'battle' dynamic. What does that look like, you know, what, what might she say, what might you say?
>
> P4: she'd say: "I don't want that, I don't like that". I'd say: "well, you do, because you... but you used to eat this." "No. I don't like it" "w... you know, you'd, you have ate it, can you just try it?" "No." And then you'll sort of try and reason with her, like "just eat two pieces of it, like two little bits of fish finger". "No".

Here, it is the experience of being in battle (an experience that lasted three years), and P4's feelings about it, that seems to have informed the change in her attitude to feeding her daughter.

P6, like P8, describes an incident where she 'gave in'. For her, it was connected to her energy levels and her experience of her working day:

> P6: last night, I was so tired, I got home from work, I'd had a really hard day and I said "do you want some tea?" and he said "no, wanna watch telly" and I just said "ok" and I just left him to watch telly because I just wasn't... I didn't have it in me to have a battle.

This excerpt points to the impact of the repeated engagement in battle so many of these participants seem to be experiencing. The image of P6, exhausted after a hard day, is a poignant one. She did not even have the strength to insist that her son had a meal in the first place, let alone that he ate it.

P6 describes her thought process in relation to the metaphorical battle with her son to eat the foods she wants him to eat:

> P6: …it was, it was about two weeks and I just thought, I'm not having this anymore, you're gonna, you are going to eat what I give you, so I purposely didn't give him any of the foods that he would normally eat and I gave him meals that I wanted him to eat, normal... food. And I sat him at the table, gave him it, he would have a complete meltdown, start crying, have a tantrum and he would tell me he's hungry and I just ignored him, and I just said, "well there's your dinner. If you want it, you will eat it". I mean, I used to leave it there all day. And he still, wouldn't, like, his dad would come home from work and say "has he eaten anything?" and I'm like, "no, it's still there, his breakfast would be there cold, his dinner was there cold.

Little doubt is left as to P6's resolve, in her repeated use of the future imperative tense; she moves from the elided "you're gonna" to the emphatic "you are going to". The emotions behind these words seem powerful - borne perhaps of desperation, anxiety, or sheer frustration that her child is rejecting "normal" food. Her statement: "well there's your dinner. If you want it, you will eat it", provides a glimpse of her interpretative model of the child's eating: His food rejection must be a choice and therefore constitutes wilful noncompliance. Unlike the defeated tone of the previous excerpt, here, P6 has garnered her energy and does not give in as subsequent meals are rejected throughout the day.

7.1.2 Subtheme: Win or Lose - The False Binary

Some of the excerpts shared above foreshadow this subtheme. In P8's decision to give Weetabix, either she has control (the child is only given his dinner) or the child does (he gets Weetabix). For P6, either she has control (he eats the foods she wants him to eat) or he does (she cedes control and he chooses whether a meal even takes place). This view implies two options perceived by mothers: total capitulation, where the child wins the battle for control, or total victory, where the adult wins the battle for control. The binary is termed 'false' because it is argued (see 7.3.1) that it is negated by a responsive approach to feeding.

The first illustration of *The false binary* comes from P8, who explicitly states that this is how she sees her options:

> P8: but I..."but you've got to try it" you know "do you want me to help you?" "no". 'Cos he wants to be in control of.. you know... doesn't ever want to be fed… so he wants the control, for sure. But yeah, I think we do like, we do

> expect it [*that he complies with instructions to eat*], but I don't, for me, I don't see another way, like, if we g' if we give in to this kind of stuff, I don't…
>
> R: what is the alternative then? The alternative's giving in?
>
> P8: I think so. Yeah, I think so. That's quite binary for me. You're either trying to improve things or you're not. And if you're not then you're saying "what would you like for dinner?" they say "pizza" and you... that's what you cook for them.

This is black and white for P8. She is either trying to improve things or she is not, and this equates to either trying to control her child's eating or handing over control to him, preparing pizza on demand. She says categorically that she sees no alternative.

P4 is less confident about which aspect of the binary to opt for, pausing as she reflects:

> P4: yeah, I don't want her to not eat anything and be hungry [pause] but and then I don't want her to just have bread at every meal…

Like P8, she has an urge to protect her daughter from hunger but if she gave her daughter control, she would opt to only eat bread. Again, these two bald opposites are put forward as the only available options. Likewise, P11 describes the false binary in action:

> P11:… and the lady [*from the Healthy Families Team]* said to me, "try not to get cross with him. Try," you know, "try not to make a fuss, because we don't want it to get worse". So then, you know, I went through a period of trying to ignore it, and then letting him eat what he wanted to eat.

Here, 'getting cross' and 'making a fuss' presumably alludes to P11's attempts to control her child's eating. Following a caution from the health professional that this approach may make things worse, she tried what she arguably construed as her only alternative: 'Ignoring' his responses to food and giving him whatever he wanted. Thus, the child was given total control.

P11 goes on to explain…

> P11:… and then if he didn't eat anything it didn't matter. But... then... there's only so long you can go without him not eating and not wanting to eat, and then I think, well am I a... if I'm just ignoring it, um, he's gonna think that he don't have to eat. You know what I mean?

P11 describes reflecting on the implications for her child, of her choice between these two polarised options (to fight for control or to give her child complete control). Her stance implies the view that, without her direction, her child would not know that he needs to eat at all. This seems to reflect a lack of trust both in his ability to eat volitionally and to regulate his own energy intake. It is not necessarily possible to take from the evidence available in P11's case, that the false binary was perpetuated by the health professional. However, P6 reported the family support worker very much presenting her options along these lines:

> P6: …um, and she [family support worker] was saying "well, just give him what he wants for tea, 'cos that's better than nothing"

These options are extreme: "whatever he wants" or "nothing".

P1 reflects on her practice of letting her child eat whatever he wants whenever he wants:

> P1: so he... we're just kind of giving him a little bit at a time and he'll... as he wants it, we'll give it to him now.

This approach to feeding facilitates what would be referred to by clinicians as a *grazing* pattern of eating; it is recognised as counterproductive (Kerzner, 2009). For P1, the false binary is set against the backdrop of her anxiety about her child's weight, growth and nutritional status (deemed unconcerning by health professionals). Her concerns serve to justify her feeding practices:

> P1: I think the way we're doing it at the minute is probably helping him, because it means that he gets what he wants... he gets the nutrients he needs as he needs it, whereas…
>
> R: so you feel like it's got the right end result?
>
> P1: yeah, um the way we're doing it is probably gonna help him grow, have... under and like have more food, rather than him just going hungry….. and that's probably gonna help him

The binary P1 perhaps perceives is the choice between the child either being nourished and growing or going hungry. Reminiscent of P8's account, nonresponsive feeding practices seem driven by a powerful drive to care for the child and optimise his health.

7.1.3 Subtheme: Losing the Battle - It Doesn't Work

If the false binary speaks to the perceived diametrically opposed options of fighting for control of the child's eating versus admitting defeat in the battle to feed

them, then this subtheme focuses on the experience of choosing the first option and being defeated. As stated previously, the sense that pressureful feeding practices were ineffectual was ubiquitously expressed in this sample (see Appendix P). A few examples are presented here, selected to illustrate different manifestations of this particular subtheme.

> P1: He never really, he didn't really... if he didn't want it, he just wouldn't eat it. So, and he's... and he's…, the plate of food in front of him, he'll only pick at what he wants and leave the rest….. and even if you try and force him to eat, he'll just not do it.

In referring to trying to "force" her child to eat, P1 exemplifies the use of what would be termed an example of *coercive control* (Vaughn et al., 2016). The finality of "he'll just not do it" indicates the impossibility, for P1, of making her son comply. In fact, eating only some of the food provided would be considered typical eating behaviour in early childhood; the quantity young children eat each day fluctuates (Benelam et al., 2015), and leaving food is self-evidently an integral part of an effective self-regulatory capacity.

The excerpt from P6 below does not concern coercive practices. Instead, it illustrates the use of encouragement through what was labelled in *Food PR* in the previous chapter (see Appendix N for a description).

> P6: yeah, I've tried the "mmmm, this is so yummy! Ah, Daddy's so good, he's eating his tea! Oh look at your sister!" and I've tried all that and it's just... n… n... there's nothing there, there's no point.

P6 offered an evocative account of her attempts to persuade her child to eat. She described her bids to engender excitement via hyperbolic allusions to others' eating enjoyment. It is reasonable to infer that she had experimented with this type of approach extensively ("I've tried all that"). Ultimately, she hesitated, culminating with the nihilistic statement that "there's nothing there, there's no point". She has no control.

The next two excerpts refer to participants' meaning making regarding past feeding practices. The notion that feeding practices are in flux and change with experience is in keeping with previous qualitative findings (Wolstenholme et al., 2019).

> P2:… I think there must have been a turning point where we realised for R, my eldest, that us standing over him sort of dictating what he was gonna eat and being quite "you haven't eaten your dinner, you can't get down" wasn't working….. We became more laid back with him and he started to eat more. Um… and he has start... slowly... slowly he is starting to eat a wider variety of food and I think that's because our attitude has changed.

P2 not only saw the detrimental impact of using pressure, she has also seen the commensurate positive impact of the change in her food parenting in relation to both the quantity and variety of food consumed by her child. Thus P2's interpretation of her feeding practices links them directly to her child's eating behaviours. P4, conversely, had not seen an improvement in her child's relationship with food. However, as described earlier in this chapter, she had made a decision to adopt a more relaxed attitude to feeding due to her perception that pressure was ineffective:

> P4: but then, in the past, we've sort of 'made' her eat it, and that doesn't really work, 'cos that's when…
>
> R: and how have you made her eat it?
>
> P4: oh, promise her things, like, "you eat this and you'll get a marble", or "you can have some Haribos" or... and that doesn't really work.

P9 is confident that the strategies she is using (on the advice of her health visitor) are the right ones:

> P9: I'm not sure how well they're working... because I think, if you go for a week and there's been no progress whatsoever, you start to get a little bit despondent, but I know that I'm using the right strategies, I'm using everything that I was taught to do, so it gives me a little bit more confidence there...

Notably, the origin of her confidence is not any discernible improvement in her child's eating but seems to be in the source of the strategies she has been given. She, unlike the majority of participants (see below), expressed a high level of trust in her health visitor. She spoke with conviction about the approaches she (P9) uses. As mentioned elsewhere, P9 has more optimism about her child's eating generally, perhaps because (unlike all other participants in the sample) she has an older child who grew out of avoidant eating.

It is striking that, not only did all participants talk about strategies they used or use being ineffectual, but some also shared their belief that some of their strategies had

actually made things worse. This is connected to the construct of *self-blame* discussed in the next chapter. For example, P5 describes her use of a sticker chart:

> P5: …..I have tried um doing stickers for trying something new but it's so rare that she will taste something she's not had before that it just wasn't working because she was never getting anything and then I sort of feel that you're actually making things worse because she's never being rewarded

The way P5 reflects on her experience with the reward chart suggests an amount of discomfort. She uses the qualifying "sort of" and distancing third person. Perhaps it is not easy for her to look back on this strategy. She seems to feel her perceived unfair treatment of her daughter keenly. This comes back to the notion of choice, which is critical to a discussion about control. If a child's avoidant eating is a choice then the parent could seek to influence that choice - to exert control - as they might exert control over a behaviour like tidying toys away. If it is not a choice, strategies like a reward chart are, as P5 implies, simply setting a child up to fail.

This theme has shown that control, and who has it, is a central issue in relation to feeding children who are avoidant eaters. The widely used battle metaphor gives a sense of just how stressful feeding a child who is an avoidant eater may be. It is also ongoing: a battle not a fight. As seen in the last chapter, mothers in this sample ubiquitously reported the use of pressureful feeding strategies and yet (while some mothers made experientially based changes to their food parenting) in the main, they continued to employ them. Is this because of a lack of alternatives, as explored by the subtheme *The false binary*? The pessimistic sense that there is no answer 'out there' will be further explored in relation to the next theme.

7.2 Theme: Futility - Nobody Knows

This theme was applicable to nine out of ten participants. Notably, the only participant to whom it did not apply was P12. While P2, P4, and P5 had all developed their feeding practices and moved towards a more responsive approach based on their own experience of what worked and what did not work, only P12 had done research which had led her to information about responsive feeding practices. She was a medical professional educated to doctoral level. It is, therefore, perhaps unsurprising that she was more able to access good quality information than other participants. However, despite her ability to source reliable information about child feeding, she spoke of her husband's continued use of highly pressureful feeding practices. This implies that one

parent sourcing evidence-based information may not be enough to change the feeding dynamics within a two-parent family. The theme *Futility: nobody knows* is explored via three subthemes. They relate to: a lack of further strategies to try (*I've tried everything*), the notion that no one knows how to tackle avoidant eating (*Everyone is clueless*), and a lack of control over eating outcomes (*Winging it*).

7.2.1 Subtheme: I've Tried Everything

Even P9, who was confident in the strategies shared with her by her health visitor, feels that she has tried everything within her capabilities to get her child to eat:

> P9: I'm always open to new ideas, definitely. I think I'm trying everything that I can do at the moment with the information that I've got, but if I can find something that is the key, you know, that, ooh, hang on a minute, this might work, I'd jump at it, yeah.

There is an optimism here that is absent from other accounts. Her desperation to improve her child's relationship with food is discernible nonetheless, in her use of the colloquialism "jump at it" in relation to any possible new solutions. P10 is not so optimistic. She describes her preconceived intention to ask the health visitor for advice:

> P10:… I had it preplanned, I was going to ask the health visitor: "He's not eating, he's lost a lot of weight, what do I do? Because I've, I've tried everything." It felt like I'd tried everything.

In this case, P10's sense of having exhausted all strategies available to her formed part of her help-seeking decision making. P11 expresses a similar sentiment:

> P11: …um, but, I've tried everything, literally. And, and, it's, it's not got any better.

And later…

> P11: there's nothing else I can do….. there's nothing else I can... nothing else I can... figure out to do with him, um, to get him to do it [*eat*] yeah.

This impotence - coupled with high anxiety about the child's eating - must be hard to bear.

7.2.2 Subtheme: Everyone is Clueless

This subtheme can be seen as a development of the preceding one, as participants extend their sense of having tried everything - and hence having no further options to try - to the idea that actually, no one has any information or advice that could

help them. Of course, these concepts are logically connected; the belief that others could suggest strategies that would work would belie the belief that they had tried everything. Not all participants held that “everyone is clueless” but eight out of ten participants did. Multiple excerpts have been selected to illustrate this subtheme because the notion that there is no solution ‘out there’ is felt to be important, especially in terms of its implications for health professionals and for a greater understanding of parental help-seeking behaviour in relation to avoidant eating.

P2 described her attempts to seek information online via the parenting forum Mumsnet:

> P2: [I have done] incessant reading online um…
>
> R: what kind of resources have you found?
>
> P2: probably what everyone turns to, sort of, mumsnet. I've never posted anything on Mumsnet or any other of those ones….. but I've certainly looked at other people's similar issues….. and they always just say the same thing as..." I don't know what to do either!" [laughs] so, you know, I think everyone is clueless.

Perhaps a product of her positive attitude about her current feeding approaches and her child’s improved eating, P2 seems to reflect on what she perceives to be a universal deficit in insight, with humour. Maybe there is even comfort in feeling she is not alone in her lack of confidently held knowledge about how to approach avoidant eating.

P4 also has no faith in the existence of a solution to avoidant eating that she has not come across:

> P4:… I thought, there's probably not this... like, magic solution that I've just not read about….. i... i... it won't be there

P4’s use of the word “magic” suggests that a solution is both so elusive and so divorced from reality, that it would have to be supernatural in nature. There is a dismissive note in her tone; the idea that there is an answer seems preposterous. This makes sense in the light of the struggles she has experienced over such a long period of time. P6 is similarly dismissive. Her response to the information she comes across online is to ignore it:

> R: what kind of stuff have you found on google?
>
> P6: oh just... I just ignore it actually

R: really?

P6: yeah, I've not... most of it is just like forums of parents talking 'n' I just don't, nothing's helpful

Likewise, while a minority of participants found them helpful, several participants had no faith in the possibility that front line health professionals could help them. P2 describes her interaction with her health visitor:

P2:… it was only an informal kind of um, yeah, "he really isn't eating very much, do you think there's…?" she said "don't worry about it, it's perfectly normal for a child to go through a fussy phase. He doesn't look ill to me." [laughs] You know, pretty much….. I got the feeling she didn't really have much advice to give

As did P8:

P8:… I mean you know, I ha... always happy to hear more, but I said to the health visitor, like, "is there anything else you can think of that we haven't tried?"….. She said "no, it sounds like you're doing everything." It wasn't a long conversation. What can they really say?

P8's rhetorical question highlights the sense, at the heart of this theme, that there are no solutions 'out there'. She does not seem to lack faith in the health visitor's professional competence as much as viewing avoidant eating as fundamentally unsolvable.

P10 is unwilling to be critical of the health visitor, yet also describes the meeting with her as unhelpful:

P10: …um, the health visitor was... I w... I wouldn't describe it as a very helpful meeting. I hate saying it but it really wasn't that helpful. Um, she, the advice literally was: "just keep going. Just keep trying." Just, just keep swimming, almost. Um, don't chop up his food, um, make him chew, rather than giving him purees and things like that. Make him do this, make him do that... And I thought, I can't even make him get food in there in the first place, so 'making' him chew is just like an extra battle I just don't need right now. Um, and she just said, you know, "if he drops more weight then just ring us again, but there's not an awful lot we can do, just keep offering him lots of different choices."

In P10's account, even the health visitor herself stated that she had nothing to offer. There was enormous variation in the content of advice given by health visitors and allied professionals in the data. As described, there was also variation in how participants experienced it. Covering the specifics of health visitor advice was not included on the interview schedule and was not part of the study design, beyond an interest in parental help-seeking behaviour. It is, therefore, difficult to reach firm

conclusions about it because it was not discussed in detail with the entire sample. However, there is a need for further research into this area.

7.2.3 Subtheme: Winging it

The final subtheme has to do with the notion that many mothers in this study appeared to have an extremely low sense of agency in relation to their feeding practices. Given the strong urge to control child eating evident in the very high incidence of pressureful strategies used (see Table 6.4), this disconnect seems important. What does it mean for mothers to simultaneously want to control their child's eating, be trying hard to control their child's eating, and yet to feel incapable of doing so?

P4 sums up her food parenting in the following excerpt, which gave this subtheme its name:

> "P4:… I think we're just... kind of... winging it."

In the same vein, P11 described her general approach to feeding as "trial and error":

> P11:… um... it's just basically trial and error. You just have to keep asking him to see if he's hungry. "W… are you hungry? Do you want something to eat? Are you hungry? Do you want something to eat?" And he'll just keep saying "no."

All she can do is question him repeatedly, reminiscent of P10's hourly questioning described later in the final findings chapter (9.1.1). Indeed, P10 also attributes eating outcomes to factors beyond her control - luck perhaps. All she can do is "hope for the best":

> P10:… I d... I hate saying it, but I am quite a controlling person anyway. I like to know what's going on around me, I like my routine, I like to know this is what's happening at, at... same thing, with um, ending up having a C-section, wanting to breastfeed and being unable to, I wanted to do... this, this and this, I want him to eat well, um and this is just the... I can't control this. That's very difficult to let go of, I cannot control his eating, I can only give it to him and, and hope for the best or hope that he will accept it this mealtime.

It seems significant that P10 herself made the connection between a high need for control, attributed to her personality, and her difficulties with feeding her son. She also contextualises this through insight into a pattern of experience: Neither her son's birth nor early feeding went to plan. In other words, landmark experiences connected to being the mother of a young child all proved to be outside her control. There is a tension in this excerpt, between her statement - ostensibly self-talk - (" I cannot control his eating") and the difficulty she expresses regarding the giving up of control. She

seems to have an instinct that seeking control is not a strategy that is serving either her or her child.

Finally, P1, when asked about her ongoing strategies for feeding her child, does not feel she had options:

> R: so what are you thinking now - are you going to... what's your next step, do you think?
>
> P1: carry on doing what I'm doing and hope it works! [laughs] That's the only thing you can do really!

It makes sense that, in the absence of solutions from other parents, online resources or health professionals, continuing in the same vein may seem like the only approach to take. Especially given disbelief in the very existence of an answer. What is there but the current course of action?

This theme has shown that not only do many participants explicitly state that they have "tried everything", but they also believe that other people are no more informed than they are, including health professionals. From the majority of the participants' perspective, there is quite simply no solution to avoidant eating. Thus in the main, they are left relying on luck and carrying on as they are, with some exceptions when feeding practices shift through experiential or theoretical learning.

7.3 Discussion

The findings presented in this chapter have several implications in relation to how mothers of avoidant eaters may think about child feeding. First, if mothers are conceptualising feeding their child as a battle, this implies that they see their task as making the child eat - a goal which logically underpins the use of pressure to eat and is inconsistent with responsive feeding (Black & Aboud, 2011). This fits with the concept of the false binary: Parents are left with either getting their child to eat or not. This limited and polarised sense of options, coupled with the experience of being 'in battle' over long periods of time, perhaps culminates in a view that there is no other way of approaching child feeding. They have exhausted all their options ('tried everything') and nothing has worked. Thus agency and hope are connected. This perhaps has repercussions for maternal help-seeking behaviours.

7.3.1 The False Binary and Feeding Style

The concept of feeding styles (S. Hughes et al., 2005) was considered in chapter 3 (3.5.3). Although the conceptualisation of an *authoritative* feeding style was criticised for including what were argued to be pressureful practices, it was highlighted that the feeding styles construct can nonetheless have utility. In relation to the false binary, mothers seem to only consider what S. Hughes et al.(2005) would term a *permissive* or an *authoritarian* style: no control or complete control. Conversely, responsive feeding (Black & Aboud, 2011) represents a far more nuanced middle way in relation to the concept of control, in line with E. Jansen et al.'s (2014) notion of an authoritative feeding style discussed previously. Parents have control through the establishment of a structured approach to meals and snacks and they have control over what is served. Children have control over how much of the foods provided they choose to eat. This is in line with the *Satter division of responsibility* (sDOR; Satter, 1986,1990) which mechanises an autonomy supportive, responsive approach to child feeding (see section 2.9.1.2). It should be noted that accepted foods are served alongside nonaccepted foods when employing the sDoR because having acceptable foods available is viewed as essential to effective self-regulation (Satter, 2007). No battle is, therefore, taking place.

As detailed in Chapter 2 (2.9.1), responsive feeding is seen as best practice by multiple international health organisations and has been for some years (Engle & Pelto, 2011). It is endorsed by health practitioners around the world as a means of increasing children's fruit and vegetable consumption (O'Connor et al., 2010) and is known to reduce avoidant eating and increase eating enjoyment (Finnane et al., 2017). However, although a small minority of participants referred to practices which could be considered responsive, responsive feeding itself was not a notion familiar to any of the participants. Put simply, there is another way to approach feeding children, but this UK sample was unaware of it. This lack of awareness seemed to leave participants feeling trapped in an ongoing battle unless they chose the option of accepting defeat.

7.3.2 Agency and Help-seeking

In terms of the future, many mothers expressed the belief that there is no way forward; they feel that their feeding practices are futile but are their only option, short of giving up. In these findings, maternal lack of hope is mirrored in the low levels of faith expressed that health professionals have any useful recommendations. It would be interesting to learn more about help-seeking behaviours in relation to avoidant eating

and whether a belief in the potential for getting useful advice has any impact on how that advice is received and actioned. It also raises a question about whether there are many other parents dealing with feeding challenges who do not approach their health visitor for advice and are thus potentially hard to reach. As expanded upon in the final discussion (10.5.2) the study sample included an unusually high proportion of people working in healthcare, perhaps increasing the likelihood of these particular individuals approaching the NHS for support with avoidant eating. In fact, in one case, the family support worker whom the participant approached for help with feeding was her colleague. It should be noted that seeking help for avoidant eating via the health visitor was a prerequisite to inclusion in this study. This is also a limitation because it necessarily excluded parents who did not seek such help, removing the opportunity to learn more about barriers to help-seeking. It is likely that such barriers are significant, given that even those mothers who did seek help seemed to have such low confidence in that help.

7.3.3 Agency and Self-efficacy

The notion of agency has been explored in the parenting literature in relation to the allied concept of parental *self-efficacy*. Self-efficacy originated in Bandura's (1977) work in the field of education. Parental self-efficacy refers to a parent's sense of whether they are able to succeed in their execution of the parenting role (Wittkowski et al., 2017). This can be seen as a domain specific manifestation of agency. Parental self-efficacy has been positively associated with child consumption of vegetables and negatively associated with maternal distress in the feeding context (Koh et al., 2014). There may, therefore, be an interplay between child eating behaviours, parental affective state, and how parents feel about their food parenting. Indeed, such a connection is supported by the current findings, although findings about parental self-efficacy in the context of avoidant eating in other qualitative work are mixed (Wolstenholme et al., 2019). A conclusion that can be drawn from the findings presented in this chapter is that, when considering avoidant eating, low maternal self-efficacy and a lack of hope may have implications for maternal mental health and wellbeing. In the next chapter, there is further exploration of how mothers' feelings about their child's eating and their feeding practices may interact with their sense of self.

8 Findings 3: Feeding and Sense of Self: Being a Crap Parent

Table 8.1 provides a summary of the superordinate theme: *Feeding and sense of self: being a crap parent*. Themes and subthemes are indicated. These are expanded upon and discussed in this chapter.

Table 8.1 *Feeding and Sense of Self: Being a Crap Parent - Summary*

Superordinate Theme **Feeding and Sense of Self: Being a Crap Parent**	
Theme	**Subtheme**
Challenges to identity	Feeding as an anomaly
	Child's eating as inconsistent with sense of self
Parental worth tied to child eating	Judging the self - failing as a mother
	Feeling judged by others
Judging the self	Regret about feeding practices
	Grappling with whether current practices are right or wrong
	Avoidant eating as the parent's fault

This chapter builds upon the previous chapter, which considered maternal agency. In the previous chapter, the emphasis was on how ideas related to agency are made sense of, as the participants grappled with whether or not they have any control over their child's eating and what that means. The emphasis in the current chapter is still maternal positioning in relation to child eating, but specifically considering how it connects to maternal sense of self. A thread running throughout the findings is the tension between how the child eats, how the mother wants them to eat and the meanings the mother attaches to the dissonance between the two.

In this chapter, three connected themes are presented. Each of these relates to a different way in which maternal meaning making in relation to child feeding may impact maternal sense of self. First, the analysis demonstrates that many participants

struggled to reconcile their wider self-image - including perceived competence in other areas of parenting - with their difficulties with child feeding. Secondly, there is an examination of maternal self-worth as it concerns judgements about the child's eating. This is explored in relation to both internal and external judgements. Thirdly, self-judgement in relation to feeding practices (as opposed to child eating behaviours) is explored. This theme includes mothers' tussling with the notion of *fault*: Is the child's eating something their practices have caused or is it inherent in the child? This is connected to the superordinate theme presented in the subsequent chapter (*Trying to understand: absolutely no clue*). As previously, each theme and subtheme is examined with supporting excerpts from the data.

8.1 Theme: Challenges to Identity

The theme *Challenges to identity* is concerned with a perceived mismatch between the child's eating behaviours and the mother's sense of self. This theme was relevant to six of the ten participants in the study. It is broken down into two subthemes. The first is *Feeding as an anomaly,* which speaks to the disparity between maternal confidence in areas of parenting unrelated to food (such as sleep and behaviour) and their experience of child feeding. The second subtheme is *Child's eating as inconsistent with sense of self.* This is also concerned with maternal self-perception but in terms of a contrast between expectations and reality, and maternal professional self versus domestic self.

8.1.1 Subtheme: Feeding as an Anomaly

P8 talks about her inability to induce her child to eat the foods she considers healthy:

> P8:… we eat very healthily at home I would say... but for some reason, we're not capable of, of enforcing that on him, when we enforce other things really well, like good sleep health is a...absolutely paramount, they, they don't come into our... you know, we have n... we haven't had to go down those routes where they sleep in our bed or we've got difficulties with sleeping beyond the first hellish year of course, like everybody has!

The phrase 'enforce on' is telling. P8 potentially views her role as a parent in the light of her expectation that shaping, or even controlling, her child's behaviour should be achievable. Even 'enforcing' sleep - another physiological area - is within her capability. This conceptualisation of sleep and eating as equivalent to other behaviours provides a clue to P8's confusion at her impotence: Unlike responsive feeding, where

eating is internally driven (see 2.9), P8 is trying to drive eating externally and is left mystified that she apparently has no power to do so. She implicitly contrasts feeding difficulties with the common parental experience of early sleep challenges. P8's observation that "everyone" struggles with their child's sleep in the first year, perhaps highlights how her own feeding struggles do not feel like an experience shared with other parents.

Later, P8, through comparison, categorises eating as equivalent to other behaviours:

> P8: but other things, but I think other things we're doing really well at, his behaviour and his b... so when you look at all of his behaviours, his eating is just diabolical compared to everything else because he's so picky

If she is not "doing really well" with eating, does this leave her 'doing really badly'? This would imply that avoidant eating is being seen as a parental failure, something other participants express explicitly. P8's use of "diabolical" suggests that the child's eating is so bad and anomalous that it cannot be understood. This term perhaps distances the eating behaviours, as though their sheer inexplicability renders them demonic.

Later still, P8 looks back on her experience of breastfeeding, contrasting it with feeding her child now he is older:

> P8:… I could e... I enforced breastfeeding exclusively for six months, I breastfed him for a year, it was really hard but I did it because I wanted to do it and that's my choice and it's really well supported, whereas this, this realm…

P8 was able to "enforce" breastfeeding - here, effort was sufficient. Elsewhere, she talked about the effort she invests into feeding her child currently. It is possible that these early experiences reinforced her belief that she should be able to modify her child's eating behaviours if only she tries hard enough, again framing child eating as something a competent parent would be able to change. There is also a suggestion that her inability to enforce desired eating behaviours may be due, in part, to a lack of the kind of professional support provided in relation to breastfeeding. In fact, there is evidence for her perception that breastfeeding is supported in ways that later feeding (beyond nutritional advice) is not (Schwartz et al., 2011).

P10, like P8, talks of the contrast between her competence in other areas and her perceived inability to influence her child's eating. P10's child is nonverbal. She feels

very positive about how she has tackled this, through successfully teaching herself and her child to sign.

> P10:… being able to go out, recognise some things and then to sign... I mean, I have taught him sign language, when I didn't know it myself, so, that's a massive achievement... for me to be able to say "yes, my child can sign..."

And later…

> P10:… but it's, they're complete opposites [*feeding and communication*].
>
> With everything else, I feel like, the sky's the limit. We can teach ourselves to do anything.
>
> R: you can solve anything?
>
> P10: yeah. But I feel in control of everything but his food. So I've, I feel like I'm almost in control of how he can communicate because, okay, he, he didn't start speaking when he should have, um, but I took control, as it were, learned sign language and gave him his communication. I cannot give him an appetite! [laughs] I can't.

The lexis here is revealing: P10 seems to equate successful parenting with control, a word she uses repeatedly. By learning about communication, she could control it. It was, therefore, in her gift. Her impassioned statement that she cannot give her child an appetite like she gave him communication points to a conceptual framework whereby her child's difficulties are reduced to deficits in what she is able to provide. The burden of self-blame here is substantial. The metaphor: "the sky is the limit" in relation to all other areas of parenting - where knowledge is power - highlights the stark contrast with her perceived inability to influence his eating.

Similarly, P12 describes how she feels about feeding in relation to other areas of parenting:

> P12:… er, it is a constant worry, stress and frustration and a lot of things, yeah, yeah.
>
> R: Eating specifically, or parenting generally?
>
> P12: the eating. But parenting in general! [laughs]. The eating is very, is worrying and frustrating, 'cos everything else, I think we try to tackle as well as we can, you know? Every time she's sleeping a little bit better, er, every time she gets a little bit... we managing tantrums very well, I think, anyway. Er, everybody that knows her think she's a joy and she, she is a happy girl, so everything else we try to manage.

Although she jokes about the trials and tribulations of parenthood, P12 seems comfortable with her parenting in other domains. She is seeing gradual progress in relation to sleep and behaviour management; her daughter's wellbeing and happiness are testimony to this. For P12, this anomaly is both worrying and frustrating. Like P8 and P10, there is an implication that if she does her best as a parent, she should be able to influence how her child eats (like other areas) yet she cannot. Does this mean she is not trying hard enough? At the very least, it means that her daughter's eating is portrayed as her failing.

Likewise, feeding does not fit with the high degree of attunement she reported in other areas:

> P12:… I know if she get upset, I know what to do for her to get happy again, er, if she is kind of poorly, I think I know straight away how to... before she gets really poorly, I know she's gonna get really poorly, because of little signs and things like that. Er, if we are in a setting like with birthday or things like that, I, I look at her and I know how she feels, and I know when she's having a nice time or when she's a little bit... so all of those things, I think... we understand her well and, but, every, every time, p... or nearly every meal, um, it's like, even the weekend, breakfast is coming, if you present her place... in nursery, every day, she will have toast and cereals. If I give her cereal: "no mummy". 'Cos it has milk on it. And you come with the cereal and then make milk on the side, she says: "no milk". No, ok. And then, 30 seconds later: "milk!" and you put the milk there and she will eat it. But if you give the cereals with that, with milk, she will not have them. And then toast... one day, one day it's too dark, one day, it's not dark enough, one day it's too cold, one day it's too hot. So it starts with the breakfast, and then it's the rest of the day. So by five or six, it's like raaaa [makes frustrated sound]

Perhaps this constant second guessing is so exhausting and exasperating that P12 can only attempt to convey it with a noise. Her perceived level of insight into her daughter's mental and emotional state away from food bestows a confidence in her parenting. She understands what her daughter needs and is able to provide that, even pre-emptively, in some situations. This gives rise to the question of whether there may be a connection between understanding her child, confidence and control for P12.

8.1.2 Subtheme: Child's Eating as Inconsistent with Sense of Self

P6 loves preparing and eating food, as does her partner. This is part of her identity. It seems that her child's food avoidance clashes with her self-perception in this regard:

> P6:… I think of all the problems I could have had, this is the worst for me….. 'cos I just never thought, and I say it all the time to his dad, I'm like "how have we got a child that's a fussy eater? Because we both love food. And we always have done, and we're really...you know, I cook all the time, we're always experimenting….. I don't know how it's happened! [laughs] I don't.

Not only is the dissonance between her child's avoidant eating and her prior expectations hard for her to understand, it also influences what the feeding challenges mean for her: This is the worst problem she could have had. It is totally at odds with how she sees herself and what she had, therefore, anticipated. As with other participants, there is a strong sense of mystification here. P6 states that she repeatedly asks her partner how they have ended up with this particular parenting issue. This points to an unresolvable question - an ongoing attempt to make sense of the gulf between the child she expected to have and the child in front of her. There is a connection here, between this feeling of mystification and the superordinate theme discussed in the next chapter, dealing with parental attempts to make sense of their child's food avoidance. Like P6, P9 has had her expectations confounded.

> P9: I never thought I'd be obsessting [sic] over somebody else's food as much, before I had children... [laughs] it's not something you really contemplate….. that food could be a source of stress! [laughs]

Here, the way P9 thinks about food itself has been altered. The level of focus she finds herself devoting to her child's eating has affected how she sees the world.

For other participants, their professional sense of self has been challenged by their child's food avoidance. For example, P11 works with children for a living:

> P11:… and even though I've, y'know, I, I mean, all, all the things that you do like all the updates that you do and all the um, all the training that we... I mean, I suppose we don't do a lot on picky eating but we do do a lot to look at for other things and you'd think that I'd like to know what I'm talking about! [laughs] but I don't...

Although she acknowledges that the training she regularly undertakes in relation to her childcare role does not comprehensively cover food avoidance, P11 still feels she should be knowledgeable about it; child feeding should fall within the remit of her vocational expertise. However, she says that she does not 'know what she's talking about' in relation to food avoidance. It seems that this felt lack of knowledge clashes with her notion of herself as a trained professional. The phrase "I'd like to" is local dialect used to convey obligation and is synonymous with 'ought to'.

The contrast between what P11 knows and what she feels she should know is magnified by her ability to persuade other children in her care to eat:

> P11:… um... y'know, you always try different strategies, even when I were working there, and there's some children that don't want to eat their dinner and there's always something you can do to make 'em eat it. And, so I've tried everything, y'know, that I, I tried with all these other children, y'know, like, well if, you know, if - everything, literally - "if you, if..." you know, "if you can just try and eat this bit" or, playing games, for instance...

And later…

> P11:… but, and I think, well why don't that work wi' you, 'cos it's worked wi' all these other children and I think, and I've tried all these different things and y'know...

Maybe it is not so much that P11 does not think she knows what to do as that the strategies she employs to good effect (as she sees it) at her workplace, do not 'work' with her child. It is possible to see how P11's frustration at her inability to persuade her own child to eat could be intensified by her ability to persuade other people's children to eat. Similarly, her sense of herself as a knowledgeable professional is set in opposition to her sense of herself as a struggling mother. She rhetorically addresses her child in her imagination, asking: "Why don't that work wi' you?" Again, there is an impression of profound bewilderment as she poses a question that neither she nor her child can answer.

This theme has outlined how there may be discord between child-feeding experiences and mothers' notions of who they are. Although this challenge to identity takes different forms for different participants, it seems to universally compound a sense of impotence and confusion in the face of the child's eating behaviours. The next theme is concerned with self-worth; it also seeks to connect child feeding to self-perception, but here, the focus is on internal and external judgements about the mother.

8.1.3 Theme: Parental Worth Tied to Child Eating

This theme was applicable to six out of the ten participants. It is broken down into two subthemes: *Judging the self - failing as a mother* and *Feeling judged by others*.

8.1.4 Subtheme: Judging the Self - Failing as a Mother

For P8, who is very interested in nutrition and has a strong health agenda, feeding her child what she considers to be a nutritious diet feels like an obligation.

> P8: 'n' um, [pause] I just think it's my duty, as much as it is to keep him safe and to keep him... warm and all those other things, is to fuel him properly.

If he is not, as she sees it, properly fuelled, then this must necessarily be a dereliction of duty on her part. The comparison with other aspects of parenting (keeping the child warm and safe) is noteworthy. At least while children are in the age range considered in the current study (assuming sufficient resources and an absence of extreme or unusual conditions) keeping a child warm and safe could be said to be within a competent parent's control. Young children have minimal agency in relation to their warmth or safety because it comes down to parental decision making and boundary setting.

With eating however, only the food provision aspect of child feeding is within a parent's control. Like sleep and toileting, parents can strive to create an optimum environment but cannot enforce a physiological process in the way that they can insist a child wears a coat or does not play on the road. This lends further evidence to the notion discussed above in relation to P8, that she sees food consumption as something that ought to be enforceable. Furthermore, the enforcing of it is a moral obligation - a matter of "duty".

P6's judgement seems to be internal rather than external too, although it is precipitated by questions from friends and family.

> P6:… it's always a topic of conversation [*child's eating*]….. everywhere I go, so my mother in law is now looking after the children and she said to me this morning "is he eating any better?"….. "no, he's not". I think people think like, next week it's gonna be different, and it's not, it's a really long standing….. thing now. Um, and like…
>
> R: what is it like for you that people are asking? How does that make you feel?
>
> P6: um, [sighs]… a bit of a failure.

Here, it is not direct judgement from others that makes her feel like a "failure", it is perhaps more other people's expectation that her child's food avoidance will be a short-lived phase. For P6, this belies an understanding of her experience on others' parts. This contrast with her reality - that it is in fact a long-standing and entrenched issue - leaves her feeling like a failure. Others' anticipation that things will be getting better may be leaving P6 feeling ashamed that they are not improving, as though she should have found a solution by now. The superlative adverbs "always" and "everywhere" suggest that this shame in the face of being asked about her child's eating feels overwhelming. Like P8, the logical implication is that her child's food

consumption is her responsibility. If he does not eat well, does this mean that, by this logic, she is a bad parent who is not meeting her responsibilities?

P10 very explicitly and potently fuses her child's eating behaviours and her sense of self:

> R: did you try anything else apart from offering alternatives to get him to eat?
>
> P10: begging, crying [laughs]
>
> R: oh, really? Tell me about that…
>
> P10: um, I used to... sometimes I'd sit there and I'd just burst into tears and beg him to eat. Because he hadn't had breakfast that day, he, he hadn't had lunch that day, he hadn't snacked. And it got to dinner time and I was... I was feeling like a terrible person because I hadn't been able to convince him to eat. He was rejecting food again.

Her child's eating made her feel like "a terrible person" and the reason for this was that she had not been able to persuade him to eat. Again, this implies that persuading him to eat was something she felt she ought to have been able do. Later, P10 eloquently summed up this conflation of her affective state, how she views herself, and her child's eating:

> P10: so er, yeah, it's... the whole process [*feeding*], from start to finish has been tied up with emotions, and feelings of self-worth, loathing, all of the above. Um, it's almost like, how he eats, to me, is a measure of how well I'm doing as a parent. 'Cos it boils down completely to that.

P10's son's eating is, therefore, a measure of her parenting: A barometer furnishing her with multiple reminders of her failings every day. Her blunt appraisal of the relationship between his eating and her sense of herself as a parent implies a harsh degree of self-judgement; she leaves no room either for an alternative interpretation of his eating or any self-compassion. If he is not eating well, she is failing.

P10's meaning making in this regard is further clarified by an experience of feeling that she was succeeding. She described a short-lived period when things got better, an improvement she attributed to a new approach she had tried, where she reverted to pureed foods:

> P10: He'd drink water instead of just juice again, and, and er, things like that. And it felt... incredible. Um, I felt like I wasn't failing as a parent, I'd finally worked it out.

And later, (in relation to the same period)…

> P10: I'm succeeding! I'm a good parent! I'm a good Mum! An' um, y'know... I'd worked out what it was, well done me! And all this sort of thing.

The repeated emphasis on 'working it out' in these two excerpts suggests that it may have been the problem solving element that contributed so powerfully to P10's sense of identity. This echoes her reflections on tackling her son's communication challenges explored earlier in this chapter. Knowledge becomes power and in turn, this sense of agency becomes synonymous with being "a good mum". The next subtheme to be considered is also concerned with judgements about parenting, but this time it is in relation to perceived judgements from others. The role of knowledge is considered in the next chapter.

8.1.5 Subtheme: Feeling Judged by Others

Some participants were concerned about what they believe their child's eating communicates to others about their parenting. For example, in this excerpt, P4 describes how she is worried about her daughter rejecting foods at other people's houses:

> P4: yeah, but I think, yeah if you've got a child who will only eat bread or pasta, like certain pasta, it's really hard like, if you started to sort of get invited to a friend's house, and like, for tea, if she she goes, she won't eat anything 'cos it's not the same or…
>
> R: so another social situation that's difficult for her?
>
> P4: yeah. And then I think oh, I'm probably being judged as a parent.

It is not P4's daughter's discomfort which seems to be her primary concern here, as much as P4's shame about her child's potential rejection of the foods provided by the host. P4 assumes that her daughter's food rejection will give rise to a judgement about her parenting. Good eating has become a proxy for good parenting and consequently 'bad' eating must be a proxy for bad parenting.

For P11, her embarrassment concerns a perceived judgement of her financial status on the basis of her child's diet. She talks about worrying that her child's teachers may attribute the small amount of plain foods in his lunch box to an inability to afford anything more varied on her part:

> P11:… I thought obviously, they're all gonna to be sat wi't teachers and everyone else is gonna get their sandwiches out and X's gonna have this tiny little thing, and then, and then I kept thinking, God, I hope they don't think that I can't afford to put things on his wraps! You know what I mean?

P11 pictures a scene where all the other children are eating sandwiches and her child is not. Her use of the word "kept" and her exclamation ("God") highlights the force of this concern for her. She is not alone in finding comparison with other children's eating to be a source of shame: P10 talks about being at a playdate where her son would not eat the foods provided:

> P10:… it's awful. Because again, I worry that my friend's thinking, ooh, why won't he touch my food? Which is silly, I know they're not thinking that, but I still worry. Um, but also it's stressful because I feel like I have to take something with me, or I have to feed him when we get home. I don't know if he's going to accept what I give him, um... and I, I compare to the others. The others are all stood there munching away, I'm thinking, what have I done wrong? Why won't my child do that?

Not only is the logistical challenge stressful, like P4, P10 is worried about what the host might think. The lack of predictability compounds her distress. Again, she brings her child's eating back to herself: As the comparison with the other children happily eating becomes increasingly hard to bear, she wonders what she had done wrong. Where P4 worries that she will be seen as a bad parent, P10 worries that she *is* a bad parent.

For P9, things are not so clear cut. She recognises judgement in others but does not accept it without question:

> P9: My Mum was always like that [*judgemental*]. She was always like, "oh well just do this and just try that and just make him sit there until it's..." I'm sort of saying, "doe'nt work like that" "It does... honest to God, you can try it yourself! [laughs] It doesn't work like that! [laughs]"….. I think I was more judged with O [*older sibling*] but I think that when I pointed out that, well actually I've got an older child and he'll eat anything….. it's not like I'm doing anything different! [laughs]….. yeah, so I 'ant changed, it's not like I give him lots of... I think they, they sort of presume that you've just fed him rubbish, and that's why he won't eat good stuff, I think, er, must have done something wrong. And I have, there is a worry that you must have done something wrong.

P9's initial interpretation of her mother's judgement was to assert that it was the product of her mother's lack of understanding of the issues at hand. P9 has several older children and separates her younger child's eating from her parenting by highlighting that they eat well, although she has parented them in the same way as her child who is an avoidant eater. At first, it seems that P9 is vigorously rebuffing accusations that her

child's limited diet comes down to something she has done. However, this excerpt ends on a much more hesitant note, shifting to the passive tense and more detached third-person pronoun as P9 tentatively explores her underlying fear that there may be truth in the judgements she is so vociferously defending herself against.

This theme has shown how thoughts and feelings about children's eating can become enmeshed with thoughts and feelings about the self. It is perhaps no surprise that perceived judgement by others has a role to play too: If a person sees their child's eating wholly as a product of their parenting, it follows that they will imagine others do too. As P10 pithily expresses in the excerpt which gave the superordinate theme considered in this chapter its name:

> P10: It was very… the begging came from: "I am such a crap parent, please eat so that I can feel not crap"

If child eating behaviours can be so powerfully tied to maternal identity, this has serious implications for maternal mental health and wellbeing.

8.2 Theme: Self-judgement in Relation to Practices

The third theme presented in this chapter concerns how participants' identity may be connected to their feelings about the practices they use. This theme is relevant to all participants. The first subtheme (*Regret*) centres upon maternal regret regarding the practices they have used. The second subtheme (*Grappling with whether current practices are right or wrong)* captures some participants' struggles with the appropriateness and morality of the practices they use. The final subtheme (*Avoidant eating as the parents' fault***)** is connected to the topic of the next chapter, which explores maternal causal models for avoidant eating. It concerns the widely held view in this sample, that the child's food avoidance was the result of the feeding practices employed - that it was something participants have 'done'.

8.2.1 Subtheme: Regret

When looking back on some of the feeding practices they used in the past, several participants expressed regret. For example, P2 made a connection between sweet foods being highly prized by her son and her prior use of them to incentivise eating. There is evidence in the literature (Bauer et al., 2021; Birch et al., 1980) that this connection may be accurate.

> P2: I do regret putting that higher status on sweet, and not terribly healthy foods now, because actually, we want him to enjoy eating healthy food for the reward of that. But I think we've fallen into the trap that a lot of people do, of... you know... bribing him to eat things that he doesn't like, with other food….. which isn't really very healthy.

While taking some responsibility for how her son views sweet foods, P2 also dilutes this sense of culpability by describing it as a passive experience: She 'fell into a trap'. Similarly, she normalises her former approach by mentioning that this feeding practice is common to many people. When asked what had precipitated this shift in her view of the practice of rewarding eating with sweet food, she refers both to the arrival of her second child and her sense that her child's eating was deteriorating.

> P2: we've really tried in... probably since we've had our second child, we've really tried to change that [*bribing with sweet foods*] because we had reached a point where S wasn't really eating anything.

Like P2, P8 also expressed regret in relation to a strategy because it proved to be ineffectual, or even damaging in her case. P8 is largely confident about her feeding practices. However, she regrets hiding nonaccepted ingredients in an accepted food (which later led to its rejection). She did this on the health visitor's advice:

> P8:… I've fallen down a lot with trying to trick him, you know, which is what the health visitors recommend, try and sneak a bit in... 3:115

Her phrase 'fallen down' is reminiscent of P2's 'trap' metaphor. These images bring to mind feeding as an unknown landscape - a constant process of trial and error where even socially condoned or professionally recommended practices can ultimately turn out to be counterproductive.

The nature of P6's regret was different from that of P2 and P8. She seemed to feel bad because her feeding practices clashed with her meaning making in relation to her child's food avoidance, perhaps due to her partner's role as a driver of the practices. See a later excerpt shared in the next section (8.2.2). P6 talks about a former strategy whereby her child was put in his cot while his parents ate dinner, as a punishment for rejecting foods:

> P6: yeah, I wond... I, I'd, I seriously regret the leaving him in his cot crying
>
> R: do you?

> P6: yeah because it's punishment, and you can't punish him for something that he doesn't necessarily understand himself. Because he probably thought, I don't know why I don't wanna eat it, don't know why I'm scared to eat it, 'cos I do genuinely believe he is scared to eat, because I've seen it. I've seen him... he will physically shake and become really distressed if I don't take that food off the table and put it in the bin, so I know he's afraid, so I think it's unfair on him really, to punish him for something he doesn't necessarily understand.

At this point, P6 locates her interpretation of her child's food avoidance firmly within his frame of reference, a concept discussed in the next chapter (9.2). She conceptualises it as borne of anxiety rather than wilful noncompliance. She empathises with her child, imagining the thoughts he may have had alongside the fear that seems so physically apparent to her.

P9, however, does not explicitly express guilt, although she does question what she could have done differently:

> P9: sometimes... I, I, er... I think about: What could I have done when he was younger that might've... avoided it, you know? What could I have, have changed? But I don't...
>
> R:… and do… you think there is anything you could have done differently?
>
> P9: I... I could have been slightly less anxious with him I think….. um, 'cos I think there is that as well. I think once, when they're very young and they, they're not eating what they're supposed to be eating, I think as a parent you become very anxious and I think, up to a point, you can pass that on to them, so food actually becomes a bit more of a big deal. Um... so maybe they pick up on it. And then mealtimes are a little bit more stressful... than they need to be.

Linked with the final subtheme discussed in this chapter concerning the notion of fault (8.2.3) P9's implication that if she had been less anxious, the feeding issues may have been avoided, seems to attribute them entirely to parenting. In this excerpt, P9 moved from a first person account of her own practices to a third person general statement about how she believes feeding can go awry. This insight may be derived from her experience of input from the health visitor:

> P9: um, my health visitor, N, who was working with us on it, she came in and actually observed the meals and she realised how um... you know the phrase, that 'helicopter parents'? ….. hovering ….. an' I...er... didn't realise how much I was hovering and how anxious I looked when I was trying to get him to eat things and she, she's the one that pointed out "look, you're probably passing that on... [laughs] through to him, mealtimes are probably stressful for him because they're stressful for you".

The health visitor observed a meal and helped P9 get an objective sense of her mealtime anxiety. This objective assessment of her mealtime behaviour from a health professional allowed P9 to re-interpret her feeding practices.

8.2.2 Subtheme: Grappling with Whether Current Practices are Right or Wrong

Where the last subtheme explored maternal conceptualisation of past practices, this subtheme has to do with current practices. These practices are necessarily still being used. They are distinct from past practices which are presumably no longer used because a decision has already been made in relation to their appropriateness or utility.

P5 acknowledged that her practice of not consistently including accepted foods in the evening meal and not providing alternatives, results in frequent instances of her child going to bed hungry:

> P5: She does often um, [sighs] rightly or wrongly, she does often go to bed hungry because she will point blank refuse to eat anything

There is a sense of a passive endurance of the emotionally difficult scenario inherent in this outcome. The phrase "rightly or wrongly" pre-empts challenge and may be being used defensively. Whether it is an appropriate strategy or not, P5 seems resigned to using it. Maybe she feels she has no alternative. This would fit with the false binary discussed in the previous chapter.

P11 also seems to lack confidence that her practices constitute the right approach:

> P11: yeah, yeah, and you know, especially when we go out to restaurants and things like that, and you just, you can buy him like a £7 meal and he'll just sit and you'll not, he'll not eat any of it. And then everyone else is going to play, 'cos there's like a play area there, and everyone else's gone to play and they're sitting there eating their dinner and I'm making him sit there until he's actually tried something, and he won't try it, and then I, and then I feel bad for, you know, and then all I kept thinking is, what happens if he has, um... genuinely got something wrong and that's the reason why he can't eat it, and I'm making him sit there and eat it.

For P11, this self-doubt can perhaps be attributed to her shifting sense making in relation to what she perceives to be the cause of her child's avoidant eating. The question P11 poses is one of agency. If her child has "got something wrong" he cannot help but not eat. If he has not "got something wrong" is avoidant eating therefore bad behaviour? And what does 'having something wrong' actually mean? It is as though a fear of disliked and unfamiliar foods is not, in and of itself, a problem, whereas if there

were an associated diagnosis like an Autism Spectrum Disorder (ASD), for example, then eating behaviours become understandable and involuntary. The word “genuinely” suggests that an interpretation of his eating where there is nothing wrong with him, renders his food avoidance manipulative. The importance (to the participants) of understanding their child’s eating behaviours is discussed in detail in the next chapter.

P4 describes her child gagging when being persuaded to eat something that she did not want to eat. Both clinical experience and the data in this study indicate that gagging or even vomiting is a common response to nonautonomous food interactions.

> P4: if you're... not like, forcing her, but if you're saying "look, you try, you have that bit of fish finger and then you can have a bag of Haribo or a yoghurt or something, and then if she really doesn't want it but she's forcing it down, it'll sort of get into her throat….. and then she'll like….. she's not choking on it, but… kind of coughs back up, and you think, well, there's no point in that because obviously she's quite upset by it 'cos she thinks she's been sick and then I'm like, have we forced her to eat it? But then, I think, unless you try these things, you'll always think, I'm not eating that, I don't like that…

P4 initially rejects her own term, ‘force’, but still acknowledges her child’s visceral physiological reaction to eating the piece of fish finger under duress. This excerpt begins with P4’s clear statement that there was no merit in the exposure, as the child was upset at the aversive experience. P4 then questions whether, after all, she has “forced her to eat it”. Finally, she comes firmly back to a generic, third-person statement regarding feeding practices. Drawing on the dogma of exposures discussed in Chapter 6, P4 dismisses her own misgivings. The shift evident in this short excerpt suggests that P4’s interpretations of her feeding practices are in a state of flux. The unanswered question about whether or not the described incident constitutes ‘forcing’ is set against P4’s attempts to pin down what the experience meant for her child: Is the food stuck in her throat? She is not choking, but is it quite coughing? As far as the child is concerned, she has “been sick”.

P6 also grapples with what is right and wrong but this was compounded for her by her partner’s stricter views:

> P6: and that's my worry now, so his Dad will be like, "right, we're not having this anymore, he's going to eat" be all like, really strict about it an'... you know, authorit... authorit-a-tive?
>
> R: yeah, authoritarian?

> P6: and then my worry is, I don't want to make it worse, and I'll say this, I'm like, "I know it's frustrating", but I'm like, "I don't want to... make it like an emotional issue, 'cos even though he hasn't had like a traumatic experience with food, I'm worried now that the way we react to it is now going to... emotionally upset him, and that's...

P6 was presumably referring to Baumrind's (1967) parenting typology here. She questions the way in which her partner is framing avoidant eating as a challenge to their parental authority. Unlike her partner, she is conceptualising feeding as an issue which has the potential to become an emotional problem. It is striking that in conveying her concerns, P6 volunteers that her son has not had a traumatic experience with food. It could be argued that repeatedly sending him to bed as a punishment for not eating may have been experienced as traumatic (see the previous section, 8.2.1). There seems to be a tension between P6 wanting to acknowledge the emotional impact of the feeding practices used, while simultaneously wanting to deny them.

8.2.3 Subtheme: Avoidant Eating as the Parents' Fault

Having explored maternal meaning making in relation to internal and external judgements about feeding practices and child eating behaviours, this subtheme now involves an examination of the broader question of how judgements about practices may extend to a maternal explanatory model of avoidant eating as 'the parents' fault'. A selection of excerpts evidencing this subtheme is presented, with a view to illustrating the nuances in the different ways participants blamed themselves for their child's food avoidance.

For some participants, parenting practices were framed as contributing factors rather than as entirely explaining feeding challenges. For example, P2 partially attributes her child's food avoidance to her own discomfort with mess:

> P2: I know that I was hovering over him with a... a baby wipe….. a lot….. um... and he was constantly having to have a bib on him if he was eating anything and I didn't, wouldn't let him eat a biscuit on the floor in case it got wiped everywhere….. so I do think that probably has had an impact.

P1's child is sensitive to the temperature of foods, something seen in relation to sensory sensitivity associated with avoidant eating (Nederkoorn et al., 2015). P1 wonders whether this is her fault:

> P1: 'cos, um so... it might be our own fault for trying to give him cool food [both laugh]

> R: so you think you might have made a big deal about "we need to cool this down"?
>
> P1: yeah, yeah, "it's too hot" type thing…

Looking back, P4 conceptualised her child's eating behaviours as being entirely a result of parenting:

> P4: and you're sort of [sighs] oh, "what have I done wrong?"
>
> R: oh, is that what you think?
>
> P4: what have I done slightly wrong along the way? And then other, you know like, other people's children, like really good eaters, and they just give them, like, a dinner, and they'll eat it. "How did you do that?" [Both laugh]

Perhaps P4's assessment of parents of "good eaters" is the most revealing element of this excerpt. These children's positive relationship with food is something their parents have 'done'. If 'good' child eating is a parental achievement, P4's child's avoidant eating must be attributable to her.

P10 does not have a notion of the mechanism via which she has impacted her child's eating negatively, and yet she is sure his avoidant eating is her fault:

> P10: I don't know what it is I've done wrong, but I feel absolutely that his eating (or lack thereof) is my fault. I just haven't pinned down what it is yet. That's how I feel.

There is a contrast here, between cognitive and affective responses to the child's eating behaviours. P10 has not reasoned her way to this absolute attribution of self-blame; she does not logically connect specific practices with specific aspects of her child's relationship with food, like P2 and P1. Instead, she feels unequivocally that his avoidant eating is her fault. This emotional response may presumably have more power than any reasoned argument to the contrary.

Other parents move between conceptualising their child's eating as their fault and not their fault. For P5, one of the hardest things about her daughter's eating is the contrast with her older son's eating.

> P5:… completely different child, completely different experience, and I think that's why I struggled with it so much, because I thought, like, "what on earth have I... what have I done wrong here, with this one?"

Counterintuitively, P5 does not use the fact that her other child eats well as evidence for nonenvironmental causes of avoidant eating. Instead, she wonders what she has done wrong with her second child, that she did not do wrong with the first. However, much later in the interview, she attributes her child's eating to her "stubborn" nature, concluding that:

> P5: I sort of feel that actually, I could be the perfect parent and she still would not eat.

The way P5 vacillates between locating 'fault' in herself and in her child foreshadows the connection that is made in Chapter 10, between maternal sense of agency, their attribution of blame, and their explanatory model for their child's eating behaviours.

This final theme, *Judging the self*, has shown that, while it is manifested differently for different participants, there is an overwhelming degree of self-blame in this sample. For some mothers, this was exacerbated by a lack of a clear notion of causal mechanisms. For others, the process of trying to make sense of the impact of the practices was itself a source of difficulty.

8.3 Discussion

Not only were mothers in this study struggling with the problem at hand - their child's avoidant eating - they were also engaged with whether they are dealing with it optimally. For the majority of participants, this included the additional question of whether they had contributed to, or even caused, the avoidant eating. Child feeding and parental guilt have been linked in the weight dysregulation literature. The findings of a qualitative study (Pescud & Pettigrew, 2014) indicated that parents feel guilty about feeding their children foods they (the parents) classify as unhealthy, regardless of child weight status. More recently, guilt has been considered in relation to avoidant eating, also in qualitative research (Rubio & Rigal, 2017; Wolstenholme et al., 2019). More research is merited, especially with a cross-sectional or longitudinal design, to further explore the nature of the relationship between guilt, child eating, parental feeding practices, and parental wellbeing.

8.3.1 Self-blame

The construct of *self-blame* is proposed in an attempt to capture both the guilty and shameful elements of parental negative judgements about both feeding practices used and child eating behaviours. There is a lack of consensus about how guilt and

shame are differentiated (Enikolopov & Makogon, 2013). According to Tangey et al. (2006), the most widely used distinction is that of Lewis (1971, as cited in Tangey, 2006) whereby shame is elicited via a negative judgement of the self and guilt is elicited via a negative judgement made about one's own behaviour. Using these definitions, the findings in the current study provide evidence for both guilt and shame. With this in mind, self-blame is advanced as a means of encapsulating both the identity specific and practice specific facets of negative parental self-evaluation in relation to child feeding.

8.3.2 Social Blame

Stepping back from the immediate experience of parents to take a systemic perspective, the current findings indicate that self-blame may interact with parental perception of social judgement in relation to children's eating. Judgement of mothers specifically, has been examined through a feminist lens in the *mother blaming* literature (Douglas, 2014; Fentiman, 2017; Jackson & Mannix, 2004) which examines how children's health, bodies and behaviour are attributed to poor mothering. This is the case even before a child is born (Sharp et al., 2018). A question is thus raised about the nature of the interaction between these recognised social phenomena and maternal self-blame.

8.3.3 Implications for Support for Parents

Presumably, much of the regret expressed by mothers regarding the past use of feeding practices could be avoided if parents were supported in the adoption of a responsive approach to feeding from the outset. Equally, negative feelings about (and a lack of confidence in) current practices could be surmounted if parents had clear guidance and support in relation to the 'how' as well as the 'what' of child feeding (see 1.1). Guidance on breastfeeding is in place at a national level (NICE, 2008), and, although imperfect (Trickey & Newburn, 2014), breastfeeding support is now an integrated element of maternal postnatal care. Likewise, official guidance on complimentary feeding from the NHS is viewed by parents as good quality (Garcia et al., 2019) and reflects guidance from the World Health Organisation (WHO; NHS, 2015). If information and support regarding responsive feeding could be similarly prioritised (as it arguably has been in the US, see 2.9.1.1), this could have positive implications for the distress experienced by parents attempting to respond to avoidant eating.

In a study examining the efficacy of an intervention for avoidant eating, Segal et al. (2014) found their approach, *the role reversal method*, to be very effective. This method involved treatment of the parent rather than the child, thus conventional roles were reversed. It is a method that dovetails with responsive feeding because it focuses on the prioritisation of child autonomy, attunement to cues and a cessation of the parental use of controlling feeding practices. Improvements in feeding were seen in more than three quarters of Segal et al.'s (2014) sample and over half were said to have fully recovered following the intervention. Segal et al.'s sample was clinical so is not entirely comparable to the current sample but it could be argued that if the role reversal method is effective in a clinical sample, it is even more likely to be effective for nonclinical avoidant eating.

The first step of the role reversal method was termed *absolution* (Segal et al., 2014, Appendix). These authors suggested that parents need to be absolved of any guilt, presumably in relation to their child's eating or the feeding practices they have employed. This has implications in relation to the resources available in an NHS context. Processing self-blame, which the findings of the current study suggest may have complex and deeply-held origins, is likely to be a time consuming process involving trained professionals. Nonetheless, if health professionals can be mindful of the possibility that parents may be experiencing self-blame, social blame, or a combination of the two, this could form an important missing piece in the way that avoidant eating is addressed. Reassurance regarding the child's health may not be enough to counter these powerful feelings.

A further aspect of self-blame is the role of insight, discussed in the next chapter. If a parent does not understand their child's eating behaviours, perhaps this predisposes them to blame themselves. Similarly, the phenomenon of social blame may be linked to a lack of understanding of childhood eating at a societal level. Ideas relating to the understanding of avoidant eating are considered in detail in the following chapter.

9 Findings 4: Trying to Understand: Absolutely No Clue

Table 9.1 provides a summary of the superordinate theme: *Trying to understand: absolutely no clue*. Themes and subthemes are indicated. These are expanded upon and discussed in this chapter.

Table 9.1 *Trying to Understand: Absolutely no Clue - Summary*

Superordinate Theme **Trying to Understand: Absolutely No Clue**	
Theme	**Subtheme**
Looking for reasons	Multiple reasons
	Failing to find the reason
Competing frames of reference	
From a dream to a nightmare	

This chapter deals with maternal meaning making in relation to the child's avoidant eating. All participants, to differing degrees, engaged with the question of what underpinned their child's eating behaviours. In the previous chapter, there was a consideration of mothers' views on their own role in their child's avoidant eating; participants variously wrestled with whether they may have exacerbated or even caused their child's challenges. This chapter is concerned with factors unconnected to parenting. There is a particular focus on what it was like for mothers to attempt to make sense of their child's avoidant eating and - in many cases - to fail to do so.

Three themes are presented in this chapter. First, the theme: *Looking for reasons* explores the multiple causal factors put forward by participants regarding their child's avoidant eating, as well as the experience of not being able to establish a cause. The second theme: *Competing frames of reference*, pertains to the opposing perspectives (adult's and child's) from which participants interpreted their child's eating behaviours. Finally, the third theme: *From a dream to a nightmare*, attempts to capture the experience of participants in relation to the child's shifting relationship with food as they moved from infancy to toddlerhood.

9.1 Theme: Looking for Reasons

This theme includes the subthemes: *Multiple Reasons* and *Failing to find the reason*. The first of these highlights the disparate ways in which mothers posited several simultaneous bases for the child's eating behaviours. For a few participants, this formed a unified model comprising multiple strands. For others, it involved an almost frantic proposal then rejection of one potential explanation after another. The proposition of multiple reasons is juxtaposed with the conclusion on the part of several participants, that they simply do not know why their child is an avoidant eater.

9.1.1 Subtheme: Multiple Reasons

Participants discussed many potential causes of their child's avoidant eating. See Appendix Q, for a table indicating the most common ones, along with their incidence in the data. While it would be interesting to explore these proposed causes in detail, space does not permit this. Only interoception (due to its high prevalence) is examined in this way. Instead, selected accounts of individual participants' meaning making (in relation to cause) will be presented. P6 and P11's fluid and ongoing search for meaning is juxtaposed with P9's integrated and static account of why her child's eating behaviours are as they are. P6 and P11 were chosen as clear examples of typical attempts at sense making (in relation to the cause of avoidant eating) in the sample. P9 was chosen for her divergence. It should be noted that many of P6's proposed causes are not included in table shown in Appendix Q, as they were unique to her.

9.1.1.1 Interoception

Interoception refers to how people assess their physiological state via the processing of internal sense data. In relation to eating, interoception manifests itself as the experience of feelings of hunger and satiety (Tsakiris & Preester, 2018). Many participants discussed their perception that their child had interoceptive deficits, connecting this to the child's avoidant eating. In other words, they did not trust that their child knew when they were hungry or full. P11 describes wondering whether her child knew he was hungry:

> P11: …..when he were younger, I thought maybe, maybe he didn't realise that he was hungry... um, so... maybe, I thought well, maybe that's the reason why, maybe n... may... may... that's the reason why he doesn't want to sit and eat, m.. he d... didn't have time to eat, um, maybe he doesn't actually realise he's hungry

The repetition of "maybe" and her hesitant delivery suggest that this interpretation is a tentative one, as she casts around for an explanation.

P11 has an equal scepticism of her child's ability to accurately assess his own fullness:

> P11: so he'll say to me straight away: "um, how many have I got to eat?" and I'll, and I'll say "all of it" [laughs] you know what I mean? "I'm not giving you a number! Eat as much as you can." Eat a... eat as, I mean it's s... I don't, I don't understand if he knows what I mean, but I'll say, "eat er... eat 'til you're full. If you're full, but then, W's full is that he's have one bite of sausage and "I'm full". You know what I mean? So I'll say "y' need to eat your sausage and you need to eat your Yorkshire pudding"

In this excerpt, P11's feeding practices seem connected to her meaning making in relation to her child's avoidant eating. The shifts in her positioning here are rapid. She moves from rebuffing his question with humour in the first instance, to a claim that she was not going to tell him how much he needed to eat. Next, she segues into the instruction to "eat 'til you're full". Then, perhaps not trusting his ability to do that, she immediately follows up with a very precise direction regarding how much of his meal he has to eat. There is perhaps a tension here, between P11 not wanting to direct her child's eating and yet not feeling able to trust his ability to eat in response to his physical cues. Her statement that "I don't understand if he knows what I mean" suggests that not only is she unsure about his ability to sense hunger and fullness, she is also not confident that he even understands it conceptually.

Like P11, P5's view that her child cannot be trusted to know how much to eat is reflected in her feeding practices:

> P5:…um, but as long as they've tried everything um, and they've eaten sort of a reasonable amount, as what I would say for them is probably about half of what I've put on, um... if they've just sort of poked at it, not really bothered with it and moved it around the plate, then I'll be like "well no, you know, there's nothing else, I'm not…

She talks of a "reasonable amount" which is necessarily parent assessed. In order to have dessert, her children must try everything and eat what she deems to be enough. This implies that P5 views children's energy requirements as consistent because she feels able to externally determine how much her children need. Earlier, P5 described bottle feeding her daughter expressed breast milk when she was a newborn:

> P5: I felt…..I felt reassured by, if she's had a bottle I know she's getting enough and I know that she's had an amount of food, um, and it was sort of better that way

And...

> P5: …..a lot of it was more um, because the... and a lot of my giving her bottles was because...m...more because of my psychological thought that she's not getting enough from me, she needs to have bottles regularly, um, and even when she was gaining weight.

P5's history with her daughter - for whom weight was a concern neonatally due to prematurity - is perhaps revealing. P5 preferred to feed her with a bottle rather than the breast so that she had verification that her daughter had consumed "enough". Her daughter's cues were not sufficient verification and neither was the external metric of weight. P5 shows insight here, terming the reason for this choice "psychological". She is perhaps acknowledging that her decision making was more grounded in her own emotional requirements than her daughter's physical ones. Maybe P5's later need to be the judge of what was a "reasonable amount" of food persisted from this difficult early experience of caring for a premature baby.

P10's perspective on appetite and satiety perhaps also has its origin in prior experience. She reports feeling very differently about hunger and about fullness cues:

> P10: I trust him to tell me when he's full but I don't trust him to tell me when he's hungry

Elsewhere, P10 describes how she was made to go to bed hungry as a punishment in childhood, making links between this, her current relationship with food and her very powerfully held need to protect her child from experiencing hunger.

> P10: I have quite a... mm... my relationship with food now is healthier than it used to be, um, my, the way my parents used to sort of punish us when we were little was, "ok, no dinner". Um, they used to make me feel quite panicky about being hungry, um, so now, if I feel even a little bit... I'm better now, but, I went through phases of, if I even felt a little bit hungry, I'd binge eat.

And later…

> P10: um, around about, I will... I'll ask him after he gets up in the morning, "are you hungry, would you like some breakfast"? Sometimes it's a 'yes', sometimes it's a 'no'. If he says "no", I'll sort of ask him about an hour later. Um, and if he says 'no' again... I'll ask, I sort of ask about every hou... if he says 'no', I keep asking about every hour afterwards.

Asking her child if he is hungry is perhaps her first interaction with him of the day. Her anxiety is apparent in her description of the questioning that punctuates her child's day with clockwork regularity.

Conversely, P10 was made to finish her plate as a child and has powerful feelings about ensuring her child never has his autonomy compromised in this way:

> P10:… it's very much I've, I've, both me and T [partner] are agreed that he will never be told "you have got to finish that before you get down", "you've got to eat another spoonful of peas", "you've got to eat this", "you have to eat this"

The repeated imperatives evoke a vivid sense of how P10 was parented in relation to food. Her own past trauma is apparent both in her parenting practices and the way she conceptualises her child's interoceptive capabilities.

Several other participants describe not being able to trust that their children know if they were hungry or full. In the discussion section concluding this chapter, there is a consideration of possible connections between the use of controlling feeding practices, views on interoception as it relates to eating, and the notion of self-regulation of energy intake, which is so central to responsive feeding. The question of whether children with feeding challenges commonly have interoceptive difficulties is also be considered.

9.1.1.2 Contrasting Accounts

Having looked in detail at one category of causal attribution (flawed interoception), there now follows an examination of two distinct ways in which mothers in this sample proposed multiple reasons for their child's avoidant eating. The first is *fragmented* (illustrated here by P6 and P11), the second, *coherent* (illustrated here by P9). Fragmented meaning making was seen in the majority of the sample, with half of the sample explicitly stating that they did not know why their child's relationship with food as it was (see the next subtheme).

P6 moves from one explanation for her child's avoidant eating to the next, suggesting, then ruling out: a house move; the birth of a sibling; not attending nursery; teething; and a lack of family meals. For example:

> P6: erm... [sighs] [pause] I don't really know [pause] trying to think, 'cos we moved house, he turned t... it would have been about two, just before he turned two, erm, but I d... I d... I don't know, I can't make links that I thought might, I thought it might be because I'd had a new baby and that was his thing that he could control? But he has more attention than what she does, so…

As described in the preceding chapter in relation to other participants, there is a mismatch between P6's expectations and her reality. She cannot see a pattern as she thought she would be able to. Like some other mothers in this sample, P6 is a professional working with children. Perhaps this resulted in higher expectations regarding her insight into childhood challenges. Her sigh and pause at the opening of this extract seem to communicate her frustration at not being able to account for her child's difficulties with eating. Later, she begins to speculate about possible causes of her child's avoidant eating:

> P6: mmhmm... yeah, I've absolutely no clue why he won't eat. Still don't know. And part of me started thinking, is it because he was teething? And maybe one day, he hurt, his mouth hurt when he was eating and that's what put him off?

To use a psychotherapeutic term, the *splitting* evident in her lexis here ("part of me") shows this sense making to be fractured. She cannot wholeheartedly commit to this explanation and it is juxtaposed with an absolute statement about her lack of understanding. She articulates her speculation as questions, further conveying a profound sense of bewilderment.

P6 also feels that delayed verbal communication could be contributing to the problem:

> P6: yeah, he was quite a late talker, wa'n't very good at communicating, which is I think why we struggled so much, because I kept saying "why won't you eat this? Why don't you want... what, what is it that you don't like?" He couldn't tell me.

This relates to the next theme pertaining to an adult *frame of reference*. Here, P6 is looking for a rational explanation, with the implicit assumption that her child knows why he is rejecting foods but cannot articulate it. P11, like P6, put forward, then rejected, many possible causes of her child's avoidant eating. She too looked for patterns, but could not see any:

> P11: no, no, see, I thought it was, I thought it was patterns at first, I thought it was because he were tired. But, er, it doesn't matter how much sleep he has because some days he has slept really well, like, um, it don't matter how early I've put him to bed and he has fell to sleep, he still doesn't eat any better the next day.

Her initial theorising connecting sleep and eating is dismantled by her empirical observations. Other theories are negated with logic:

> P11: oh [sighs] I have no idea, I really don't. I did think maybe nursery was, um, the fact, because, when I dropped him off, he hated it, when I dropped him off at nine o'clock, he used to cry soon as we got into the, the um... the car park, and he used to cry until I picked him up at night. And I thought maybe, um, that was the reason. Plus him not wanting to sit down and eat anyway, and them making him sit down. But then, then I think, well it, y... i... b... I suppose it could've... it could've um, added to it, but then he started before he, it started, the picky eating, before um, he started nursery.

Although P11 acknowledges that her child's negative experience of nursery may have contributed to his avoidant eating, the timeline means that ultimately, she rules it out. In this account, P11 shifted from her exposition of possible causes to a pivotal "but". Her tone changed and she became hesitant both linguistically and in her delivery. It is ironic that, where P6 wonders if her child's lack of nursery attendance has impacted his eating, P11 wonders whether her child's attendance is to blame.

P11 similarly rules out speculative causes suggested by the person from the Healthy Families Team:

> P11:… the lady thought it might 've been a texture thing. But, um, Super Noodles are wet, so it can't be.

And later…

> P11:… I mean she, the lady said, "d'you think he's, d'you think he's pushing boundaries?" But… I don't think he is. I mean, I c... I mean, I don't think boundaries can push from two to... what age he is, and he's not changed, so... and…
>
> R: was that her take on it then?
>
> P11: yeah, well, she says "do you think he may be pushing boundaries?" but I don't think he is, because I, I think, I don't think it'd lasted this long, especially when I'm offering him t... offering to take him out and do things, offering to buy him things an', and he loves, he loves transformers. And he loves Power Rangers. He's almost obsessed about 'em...

P11's repeated "I don't think he is" after the suggestion of boundary testing, is unequivocal. She soundly rejects these suggestions about what may be at the heart of her child's avoidant eating. There is perhaps an echo, in the health professional's speculation, of P11's inability to arrive at a cause or causes. The health professional also seems unsure; according to P11's report, she phrased her conclusion as questions for P11, as though P11 had any more notion than she did.

P9 also discusses multiple causes, but in a very different way. Rather than moving from one rejected explanation to the next, she has created a causal narrative in which multiple factors are synthesised:

> P9: ...yeah, I think it's a mix, I think it's not... his biggest priority. He's not a... a foodie boy, and er, with all the issues he had with weaning to start with and I think, I don't think he has the best of associations with it either, um, which is probably why it's not a big priority, because of the, the times he had difficulty swallowing and, and stuff when he was younger. Er, I don't... ah, I think it's a confidence thing a little bit…

P9 states that "it is a mix", before going on to describe what would technically be termed *low food responsiveness* (Wardle et al., 2001). She also describes negative associations due to early (resolved) swallowing issues. This concurs with what is known about the multifactorial nature of avoidant eating in childhood, as discussed in Chapter 2. Finally, she concludes that his confidence with food is low. It can be seen in the previous chapter that P9 was thoughtful about whether she could have done things differently in terms of her food parenting. However, she did not demonstrate the self-criticality that some participants did. Perhaps a clear explanatory model drawing on her child's history allows her to be reflective about her parenting practices without high levels of self-blame.

9.1.2 Subtheme: Failing to Find the Reason

Despite the many proposed reasons for their child's avoidant eating visible in Appendix Q, half the sample said explicitly that they could not make sense of it. This is discussed in relation to three participants, P11, P12 and P6.

P11 describes her consideration of many potential causes of her child's food avoidance:

> P11: So, I don't know. I've got... that's the thing, I've got so many different things that, that I think may, maybe, may... could've caused it, may, might not have caused it.

The repeated modal verbs of possibility convey an intense feeling of uncertainty. For P11, it is as though the multiplicity of causes (see 9.1.1) is both overwhelming and itself a barrier to understanding. P12 is similarly unclear. She refers to professional reassurance about her daughter's weight and development, when considering the cause of her avoidant eating:

> P12: So I don't really know what the cause is, to be fair. Because I've been told so many times: "She's fine, her developing is good, her weight is absolutely fine".

What this reassurance means for P12's attempts to understand why her daughter is finding eating difficult, is clearer in the context of an earlier excerpt:

> P12: I want to think she's had, if she classifies as a picky eater, I want to think there's a reason behind it. I want to think that... the answer... she doesn't sleep through, she has never sleep through, and I always think there's something with her tummy, I guess it's co…
>
> R: looking for a medical cause?
>
> P12: yeah, or discomfort or whatever, I don't know. I think it's just constantly trying to find a excuse or a reason why things happen, probably.

It seems that P12 would find it easier if there were a physiological explanation for her daughter's avoidant eating. Her repeated use of the verb "want" is an acknowledgement of this. The professional reassurance only serves to remove the possibility that there is a tangible cause that would make sense to her. At the end of this excerpt, P12 shows that she has insight into her attempts at sense making. There is something a little self-critical in the word "excuse", which perhaps implies that P12 feels she is denying culpability: Is she suggesting that her need for a concrete explanation located in her daughter's body is her way of deflecting blame from herself, or is she simply alluding to the fundamental human need to understand?

P10 describes both external and internal attempts to understand her child's avoidant eating:

> P10: there's, there's been a lot of um, diving into... I, I really do, I analyse why he doesn't eat, I analyse... my eating, his eating, um, I, I've googled everything to try and find out why, um, to try and boil it down to, is it me? Is it just because this is him? Is it personality? Is it... nature versus nurture, is it... what is it?
>
> R: and where have you got to with that ? I mean, do you feel like you…
>
> P10: I still don't understand his eating! [laughs] really

She has analysed her own relationship with food as well as her child's. She has sought information online. She used the absolute term "everything", to express just how widely she has researched. With her metaphor "boil it down", she succinctly conveys the ultimate question that she arrives at: Is the avoidant eating her fault or is it inherent in the child? This bald binary of "nature versus nurture" does not seem to leave room for

the more nuanced middle road supported by the literature (Blissett & Fogel, 2013) whereby children's eating behaviours are influenced by an interplay between intrinsic and extrinsic factors.

The theme *Looking for reasons* has shown that participants considered various different causes of their child's eating challenges, in many cases, rejecting them. It seems that making sense of their child's eating behaviours was a key concern for them, as was made explicit by some participants. Given that half the sample concluded that they did not know what underpinned their child's avoidant eating, yet their reported attempts at understanding revealed time and energy dedicated to this endeavour, it is perhaps incumbent upon professionals to be better equipped to meet parents' needs in this regard. This will be further explored in the next chapter.

9.2 Theme: Competing Frames of Reference

Having explored external attributions of meaning concerning avoidant eating in relation to the previous theme, the current and subsequent themes concern maternal notions of how the child views food. There is a multilayered hermeneutic at play in this attempt to interpret maternal interpretations of the child's interpretations of food. The current theme relates to which *frame of reference* the mother is speaking from. The concept of the frame of reference is taken from the psychotherapeutic literature and was first used by Rogers (1959), although it is now used colloquially as well as technically. To see something from another person's frame of reference is to take a phenomenological approach, seeking to get closer to their experience. This is different from seeing things from one's own frame of reference, which is informed by one's own worldview. Rogers (1959) termed these distinct frames of reference *internal* and *external*. However, in the current context, the phrases *adult frame of reference* and *child frame of reference* are used, with a view to highlighting the different ways mothers made sense of their child's responses to food in this sample.

Some interpretations of child responses to food are firmly located in an adult frame of reference. For example, P2 is confused by her child's rejection of Bolognese sauce:

> P2: He isn't keen on Bolognese sauce with the vegetables in, which is mad because he loves vegetables, but he won't have it all mixed together

To her, this rejection is so irrational as to be “mad” because her child likes the vegetables served by themselves. It is known clinically that mixed texture foods with multiple elements are harder for children from a sensory perspective (Boggs & Ferguson, 2016) and yet if P2 is not aware of this, it may be difficult for her to appreciate that the mixed food has become something very different for the child from the same vegetables served separately. Another example of this is provided by P11, who classifies Coco Pops as “the same” as chocolate rice crispy breakfast bars:

> P11: he's started to eat um, breakfast bars, but they're, er, they're not the healthy ones, they're the chocolate rice crispy ones, but he'll not eat crispy cakes and he won't eat Coco Pops, even though they're exactly the same thing

There is a hyperbolic edge to the word “exactly”. P11 presumably knows that this is not literally the case (that these foods are identical) but by stating it so categorically, she arguably conveys just how frustrating this apparent irrationality is to her.

Similarly, P10 describes her child’s distinct reactions to carrot in different forms:

> P10: He will eat the carrot soup. You give him a carrot and he won't touch it. You give him some, you know, or, or he can identify some carrot in his food, he won't touch it. But he'll eat carrot soup. It's really like, "but this is the same as that!" He obviously looks at it and says: "well, no they're not." But for me, I'm like, this, this is carrot…

Here, P10 holds on to the adult frame of reference while alluding to the child’s. It seems, in all of these examples, that participants’ location of their interpretations of eating behaviours in the adult frame of reference is a source of frustration and confusion to them. As seen with P10’s example, this is even the case when the child’s alternative interpretation is acknowledged.

A further manifestation of the adult frame of reference draws on an assumption that liking is consistent and that rejection implies dislike. Again, the child’s responses to food are framed as irrational. For example, P4 described her thoughts in the face of food rejection:

> P4:… then you'd be thinking: You do like it, because you've ate loads of this…

Similarly, P11 says:

> P11: So even though he knows he likes bananas, and even though he knows he will, he does like toast, he'd prefer not to eat it. And so, and then he'd just go without.

From the adult frame of reference, it would seem reasonable to eat a food at the appointed time if that food was generally considered acceptable. Perhaps though, this is located in an adult propensity to make decisions based on future outcomes (awareness of being hungry later). In these short excerpts, P4 and P11 demonstrate meaning making grounded in reason. However, it is likely that for young children, decisions relating to eating have a primarily emotional, appetitive, and sensory basis, as well as far greater immediacy.

From P11's perspective, prior eating implies future eating. The assumption that what was accepted yesterday will be accepted tomorrow is perhaps firmly entrenched in the adult frame of reference. However, P6 describes a movement closer to her child's frame of reference in this regard:

> P6: yeah, so sometimes I can give him, so like, yesterday I gave him banana….. and 'e ate it all, really enjoyed it, put the banana skin in the bin. Today I gave him a banana: "don't like it" and he means "I don't want one now". I've understood now, that's what he means

Here, she attributes her improved insight into his experience to greater understanding of how he communicates. Her interpretation of his statement "don't like it" involves a step away from a literal reading implying long term preference, to a statement applying to the scenario at hand. His recent enjoyment of a banana perhaps helped her reach this more subtle understanding, leaving space for an appreciation of inconsistent food acceptance.

P8, like other participants, interprets her child's eating behaviours from both the child and adult frames of reference:

> P8:… the other day, he had a whole head of broccoli in his mouth and all his dinner came back….. 'cos it's a big piece of something new, and his body's just like, no...

She makes sense of his visceral physical reaction to the broccoli by highlighting that it was "a big piece of something new". And yet later, she reports responding to his rejection of peas and sweetcorn with incredulity:

> P8: um, but I think, what a sad state of affairs, when we're, you know, both of us begging him to eat a, you know, a tiny piece of something that's just like, who

> doesn't eat sweetcorn? You know like, who can't... tiny..., tiny peas that you peel yourself, that you've picked off the garden, that we were doing yesterday. "I don't want that". It's a pea! like, it's a sugary little pea, like what, can you not...? [laughing]

P8's vacillating frames of reference are also apparent in her causal attributions:

> P8: yesterday, they [*nursery*] said he had lasagne, which he would never eat for me. But they said it took some encouragement, but all his little pals were eating it, so there's... so he can do it, um, but he chooses not to. And does... a... also have this such a strong aversion

She both claims that her son has a choice in his food rejections and that he has a powerful aversion to some foods. The abrupt shift to the final statement in this excerpt perhaps reveals a tension between these two opposing understandings of his avoidant eating. She uses emphatic language - he does not just have 'an aversion' but "such a strong aversion".

> P11 also exemplifies a capacity to inhabit the child frame of reference while at other times, remaining firmly in the adult's. Here, she recognises the moment that her child decided he no longer wanted the fish fingers:
>
> P11: …..so you'll say: "what do you want for dinner?" um, "I want some fish fingers" and you'll do him fish fingers and then he'll get it in front of him, he'll be like, "yeah, I don't want them no more". And it's like, it's like the sight of it puts him off. You know, it's almost like, yeah, the sight puts him off

Rather than focusing on the surface irrationality here (he asked for fish fingers then says he no longer wants them) her tone becomes thoughtful. She repeats her speculative suggestion - located in her child's frame of reference - that he is possibly put off fish fingers when he actually sees them.

This theme has shown that participants can view their child's eating habits from either the adult or child frame of reference, in some cases moving between the two. It seems that in this sample, interpretations located in the former commonly gave rise to frustration on mothers' parts.

9.3 Theme: From a Dream to a Nightmare

The final theme presented in this chapter concerns participants' experience of the change in their children's eating behaviours as they moved from infancy to toddlerhood. Excepting two cases (P2 and P9) the children reportedly did well with eating when solids were introduced. P2 and P9 had problems from the start. For P8,

early feeding was not problematic but was described as a little stressful. Otherwise, it was a positive experience in this sample. Positive early feeding is relevant to maternal meaning making because for some participants, the shift from food acceptance to food rejection in early childhood seemed to compound their sense of mystification.

In this excerpt, P6 discusses her reaction to the change in her son's eating behaviours:

> P6: I just didn't know... I didn't know what to do. I'd suddenly gone from this child that'd eat anything and now I'm like planning things and trying to, I was like, googling different recipes….. thinking, right, how can I, and I started thinking, and I still do it now, I now will put like linseeds and things in his Weetabix and things, so he doesn't know it's there….. so I'm like hiding foods, which I never had to do before.

Here, there seems to be a connection between her not understanding the altered eating behaviours and not knowing how to respond to them. The imperative "had to" suggests that P6 felt (and continues to feel) forced to hide foods in order to optimise her son's nutritional intake. Elsewhere, P6 describes being a keen and knowledgeable home cook, and yet she found herself searching for recipes online to help her navigate her child's newly established responses to food.

Later, P6 talks about the impact of this change in her son's eating behaviours. She expresses disappointment:

> P6: yeah, it's disappointing. It's really disappointing. No, I think because he was such a good eater, that's what's made it so hard. If he was always not great at the start, um, 'cos like one of my friends, she's got a child the same age and she tried to feed, like a baby led weaning like me, she was like, "she just won't eat! She just wants me to put it on a spoon and put it in her mouth". So I think if he was a bit like that, it wouldn't have bothered me so much but because he was so good…

P6 herself connects the difficulty she has with her son's avoidant eating to the way his eating behaviours have dramatically changed.

Similarly, P10 uses the word "sudden" to describe the change in her child's eating behaviours:

> P10: he'd been a dream up until about one and a half and would eat and try everything and then one day, just like a switch had flipped, suddenly he was rejecting certain things he'd normally have…

The simile of the flipped switch speaks to a phenomenon which is absolute, instantaneous, and externally controlled; P10 was left bemused and in the dark as though someone has suddenly turned the lights out. In comparison to early feeding as "a dream", the subsequent challenges experienced by P10 are "a nightmare":

> P10: it's a nightmare. So um, yeah... it's you, you just never, never know... you wake up in the morning, you don't know if he's gonna eat breakfast and, and you don't know if you're gonna get through the day without him just constantly asking for chocolate biscuits.

For P10, the lack of predictability seems extremely hard. The day is something to "get through" - a nightmare ordeal characterised by the Sisyphean task of feeding her child. Likewise, P12 describes the change in her child's eating as absolute:

> P12: so because all of these things have changed, like, she was very good eater, or if you can classify as a 'normal eater' when she had, when she was younger, but everything has changed.

The phrase "All of these things" refers to the foods P12 said her daughter used to accept but no longer does. There is a certain resignation or a finality in "but everything has changed", as P12 tries to make sense of her daughter's altered eating behaviours.

Given that a change in eating behaviours after the end of the first year is a widely recognised transient phenomenon (see 2.7.1) it is notable that only two participants talked about avoidant eating as a 'stage' or 'phase'. P2 was unusual in this sample by dint of not being especially concerned about her child's relationship with food. She frames the problems with food avoidance as a past experience. In the below excerpt, she normalises her child's eating and explains it as typical stage of development, exacerbated by his temperament:

> P2: …I reckon all children go through a fussy phase….. or a lot of them, and it... it's just that S was, it was made worse by… he's quite strong willed, he's quite an anxious little soul.

As discussed previously (9.1.1), there may be a connection between having a clear explanatory model or narrative, and how mothers feel about their child's eating behaviours. P2 is unique in seeing avoidant eating as a normal developmental stage. Most participants do not even mention this concept, and for P6, the notion of a phase is just another in a long series of explanations that she rejects:

> P6: I just thought, I think I thought right, he's bound to go through stages of things, 'cos they do, not just with eating, it's everything …..I thought, he'll come out of this, it'll be fine um, and then it just never got any better. It just got worse and worse.

Notably, P6's observation that her son's eating deteriorated rather than improved constitutes her evidence that it was not simply a phase. Conversely, P2 was seeing improvements in her child's eating which supported her conceptualisation of it as temporary.

This theme has shown that the majority of participants experienced a change in their child's eating behaviours as the child moved from infancy to toddlerhood. Apart from P2, this change was not interpreted as normal by the mothers in this sample and neither did any of them seem to expect it.

9.4 Discussion

The findings presented in this chapter relate to the second objective of the study: to explore parental meaning making in relation to the child's eating behaviours. As alluded to in the previous chapter, for most participants there was a strong sense of mystification about why the child's eating was as it was. Half of the sample overtly said that they did not know. This was despite the overlap between the causes contemplated by participants (summarised in Appendix Q) and the known contributors to childhood avoidant eating set out in Chapter 2: sensory processing, child temperament, and genetic factors relating to taste perception. Data concerning these attributions were not considered in this chapter, however. Parental attributions of avoidant eating have previously been explored in qualitative research (Rubio & Rigal, 2017) and a decision was made to focus on the process and experience of sense making rather than the attributions themselves. This was with the exception of interoception, which was considered in detail in this chapter, due its prevalence in the data. In this section, therefore, the implications of maternal views on child interoception are discussed, as is the notion of avoidant eating as noncompliance (relating to the theme *Competing frames of reference*), and the significance of mothers failing to anticipate a developmentally normal shift in eating behaviours in early toddlerhood.

9.4.1 Interoception

Difficulties with interoception have been documented in relation to Autism Spectrum Disorders (ASD) although more research is needed into awareness of hunger (and interoception in general) in the context of Autism Spectrum Disorders (ASD

(DuBois et al., 2016) For neurotypical children, no primary research on nonorganic poor appetite was identified. However, the allied concepts of high *satiety responsiveness,* meaning feeling full quickly, and low *food responsiveness*, meaning low interest in or enthusiasm for eating, are measured by the Child Eating Behaviour Questionnaire (CEBQ; Wardle et al., 2001) and are associated with *food fussiness* (Wardle et al., 2001). Given the bidirectional relationship between nonresponsive feeding practices and avoidant eating considered previously (3.1.2), it is reasonable to assert that children's responses to food are related - at least in part - to the feeding practices they are subjected to. It cannot therefore be assumed that high satiety responsiveness and low food responsiveness are driving avoidant eating, or indeed that high satiety responsiveness is problematic: It has been suggested that it may simply be the result of effective self-regulation of energy intake (Finnane et al., 2017; E. Jansen et al., 2014). This is likely, given findings showing that in the main, avoidant eaters are not concerningly underweight (Taylor et al., 2018).

In guidance for paediatricians, alongside recommending assessment for medical causes of paediatric feeding problems, Kerzner et al. (2015) referred to several categories of nonorganic low appetite as potential drivers of avoidant eating. The first is *misperceived* low appetite, whereby parents wrongly assume that the child is not eating enough. Kerzner et al. argue that this has the potential to cause feeding problems via ensuing maladaptive feeding practices. The notion of misperceived low appetite fits with findings regarding pressure to eat being used as a response to concerns about child underweight in the absence of low child body mass index (BMI; Gregory, 2010a). Non-organic low appetite is then split into two sub-groups based on child characteristics: The *energetic, active child* and the *apathetic, withdraw child*.

These classifications by Kerzner et al., (2015) of nonorganic low appetite are highly problematic. Nine citations were provided in their support, but only one (Wright and Burks, 2000) was an empirical, peer-reviewed study with primary data concerning hunger or appetite. Indeed, one of the studies cited (Baker-Henningham et al., 2009) solely examined malnutrition and child temperament in children under the age of 2 years in rural Bangladesh. Another (Drotar & Eckerle, 1989) explored mother-child interactions in 1–9-month-old babies. Returning to the only cited study that measured anything related to appetite (Wright & Birks, 2000), these authors measured low food interest and levels of hunger in toddlers, using maternal report without a validated instrument. They found a connection between failure to thrive and low hunger levels

but themselves acknowledged that maternal perception could be inaccurate and low appetite could be caused by malnutrition, concluding: “these results must be viewed with caution, to generate new hypotheses for future examination rather than establish new certainties “ (p13).

In summary, Kerzner et al., (2015) provide no evidence for nonorganic low appetite as a stand-alone cause of avoidant eating. This is significant given how widely cited this paper is (98 citations at the time of writing, according to Scopus). Similarly, a systematic review (Cole et al., 2017) of correlates of food avoidance in children, referred to an association between avoidant eating and low appetite. However, the sole study cited in support of this was by Wright et al. (2007), who again relied on parental perception of appetite. It is known that there is individual difference in appetite in children (Carnell et al., 2008) but it is also known that parents do not trust children’s appetites (P. Jansen et al., 2014). Further research is needed in order to establish whether nonorganic low appetite in childhood is simply misperceived or can be a cause of avoidant eating. There is also a third option whereby poor appetite could be a consequence of an unpleasant eating environment or a conditioned stress or anxiety response. Future research should control for nonresponsive feeding practices and should either include objective data regarding adequacy of food intake or avoid reliance on parental report of appetite.

9.4.2 Avoidant Eating as Noncompliance

The view of avoidant eating as noncompliance is arguably located firmly in the adult frame of reference. The contention in relation to the findings presented in this chapter, is that viewing eating from the adult rather than the child frame of reference potentially makes it harder for mothers to understand and accept the child’s relationship with food. For many participants, the apparent lack of reason in children’s eating behaviours made them a source of frustration. A lack of acceptance and understanding - also possibly linked to a lack of integrated narrative about why the child is an avoidant eater - may make it more difficult for parents to adopt responsive feeding practices. Perhaps if parents understand their child’s responses to food, this may foster empathy and acceptance. Conversely, while they are feeling bewildered and frustrated that their child is rejecting foods, they may feel a need to ‘make’ them eat those foods. As shown in Chapter 2, nonresponsive feeding practices are likely to maintain or exacerbate the very problem the parent is seeking to address.

9.4.3 Developmentally Normal Changes in Eating Behaviours

The findings presented in this chapter highlight another area where a lack of insight and understanding seemed to cause distress: the shift from accepting a variety of foods in infancy to rejecting many foods in early childhood. This pattern is well recognised. As discussed in Chapter 2, neophobia emerges in early childhood as part of normal development (Birch & Doub, 2014), as does avoidant eating (Cardano Cano, 2015) with remitting avoidant eating in early childhood considered an aspect of normal development (Cardona Cano et al., 2016). In this sample, however, participants did not seem to be aware of or anticipate this. As with other qualitative findings (Fraser et al., 2021), the sudden change in child eating behaviours was experienced as frustrating and concerning.

As well as indicating the potential value in helping parents understand their child's eating behaviours, the findings presented in this chapter highlight the importance of establishing whether nonorganic poor appetite is in fact a cause of avoidant eating. The current study adds to other qualitative research (Wolstenholme et al., 2020) indicating that beliefs about whether a child can be trusted to know when they are hungry or full may be connected to feeding practices. If problems with interoception in neurotypical children are rare, this would be important information for parents to have. Similarly, if (as these findings suggest) parents may not be anticipating a developmentally normal change in eating behaviours as children enter toddlerhood, this may prove distressing and confusing. Again, feeding practices may be influenced as a consequence. This too, has implications for health professionals supporting families of young children. In summary, there are gaps in the academic understanding of the aetiology of avoidant eating in childhood but much is known nonetheless. This is in stark contrast to the mystification expressed by many mothers in this sample: a lack of knowledge which is seemingly distressing and may be connected to feeding practices.

10 Discussion and Conclusion

10.1 Summary of the Programme of Research

The empirical element of this thesis was conducted with a view to contributing to knowledge about parental meaning making in the context of avoidant eating, both in relation to feeding practices used and child eating behaviours. As exemplified in the preceding four chapters in which the findings of the study were presented, the use of Interpretative Phenomenological Analysis (IPA) facilitated a detailed and in depth interpretation of participants' experience. The account of this primary research was preceded by a systematic review of the literature. This review examined how pressure to eat is conceptualised. It was found that pressure to eat is assessed inconsistently, reflecting a lack of consensus about whether certain feeding practices are adaptive or not. It was also argued (3.5.4) that the notion of pressure to eat should be seen as dynamic rather than static, with child characteristics, relationship with food, and context potentially affecting whether certain feeding practices are experienced as pressureful or not. A pressure spectrum was proposed, encompassing any practice where an adult tries to directly influence a child to eat or try foods.

In the next section, the findings of the IPA study are summarised with a view to considering how superordinate themes may relate to one another. Next, the findings are positioned in relation to extant qualitative literature in the field, and novel findings are highlighted. Conclusions drawn in the systematic literature review are considered in the light of the study findings, and limitations are discussed.

10.2 Summary of Findings

In accordance with the commitment to a meticulous, case by case approach to analysis associated with IPA (Smith & Eatough, 2007) a huge volume of findings were produced, only some of which were reported in detail. See 6.1.2 for a diagrammatic summary. Chapter 6, the first findings chapter, included a descriptive account of maternal feeding practices, as well as an exploration of aspects of rationales for their use. In particular, the findings relating to the subtheme *The dogma of exposures* is considered to be significant in the light of the feeding literature. Many participants seemed to drive taste exposures on the basis that they believed this to be best practice, even when such exposures led to aversive experiences, such as the child gagging or vomiting. It is argued that this interpretation of exposure theory may rest on a

significant omission - the need for a positive socioemotional context for the exposure. This is relevant both in terms of the contemporary parenting canon and professional guidance. Perhaps this belief in exposures 'at any cost' goes some way towards explaining why so many mothers in this study continued to use nonresponsive practices despite saying that they felt bad about them and they did not work.

Following the first findings chapter, with its focus on feeding practices and the maternal rationale for these practices (grouped under the superordinate theme, *Getting the food down the child*) in the subsequent three findings chapters (Chapters 7, 8, and 9) three further superordinate themes were considered. These concerned the broader issues of maternal sense of agency, maternal sense of self, and maternal attempts to understand the child's eating behaviours. These concepts were discussed individually at the end of their respective chapters. However, a suggestion of how they may be interrelated is now advanced.

10.2.1 How the Superordinate Themes Relate to One Another

The following excerpt from P10's interview is shared by way of a preface to this section:

> P10: …I feel, I feel like it's unsolvable. Like it's completely uncontrollable, um, I feel like somewhere out there, there must be an answer as to what I've done wrong, but I don't feel like there's an answer as to why he won't eat, until he can just say to me "this is what I don't like about it" or "this is why". I feel like nothing on google, nothing in books, nothing in articles, nothing can tell me why he won't eat, only he can, and he can't tell me yet, so... er... er... in the meantime, I feel like I'm just wading through sludge.

P10 has no sense of agency whatsoever. This seems connected to her lack of insight into her son's eating challenges. Perhaps consequently, she assumes she has done something wrong; her inability to make sense of her son's eating behaviours, or to influence them in any way, renders her culpable. Thus, the three latter superordinate themes are apparent - interwoven and inextricable. Here, knowledge is power, and until P10 knows why her son is rejecting foods, she is left "wading through sludge". P10's evocative simile seems to communicate just how demanding the task of child feeding feels to her. It also conveys a sense of feeding as an impenetrable mystery. Sludge is muddy and impossible to see through or to move through easily. Reminiscent of the military imagery used by some participants, child feeding is portrayed as a relentless and burdensome task.

This excerpt, therefore, brings together some of the key findings of this study. Arguably, if mothers do not understand why their child's eating is as it is, this may precipitate self-blame and a lack of agency, which has implications for maternal identity. Parental knowledge and agency have been connected previously in relation to self-efficacy (Conrad et al., 1992; Hess et al., 2004). Furthermore, in a review of the self-efficacy literature, Vance & Brandon (2017) found that parental knowledge was both an antecedent to and an attribute of parental confidence and self-efficacy[10]. Self-efficacy has been examined in qualitative research both in relation to parenting avoidant eaters (Wolstenholme et al. 2020) and child feeding more generally (Hayter et al., 2015). There will be a consideration later in this chapter of the implications of the role of knowledge for parental agency and identity.

As shown in Chapter 9, most participants felt that they had no idea why their child was an avoidant eater. They were "clueless". This gives rise to serious questions regarding the importance of teaching parents about developmental eating norms in early childhood, as well as common causes of avoidant eating which could potentially be screened for. In summary then, most participants did not know why their child was an avoidant eater; they did not feel that anyone has any answers regarding how to tackle avoidant eating; and they found themselves engaged in a futile battle with two options: give in or use pressure. This could be expressed as the choice between adopting an authoritarian or a permissive feeding style (S. Hughes et al., 2005). This choice was termed the *false binary* in Chapter 7. Such a sense of powerlessness and lack of knowledge may be connected to the high levels of self-blame expressed by participants, although, as discussed in Chapter 8, this may have a sociocultural component too. These phenomena have implications at both a practice and policy level and are discussed later under the following headings: education regarding child eating norms, education regarding responsive feeding, and beyond education - facilitating parental behaviour change. Finally, a mindset shift in relation to exposure is discussed. First though, there is an analysis of how the current findings have extended or reiterated previous qualitative findings, and the study's contributions to scholarship in the field of avoidant eating are highlighted.

[10]According to this review (Vance & Brandon, 2017) parental self-efficacy and parental confidence are overlapping concepts denoting parental belief regarding their capability to parent successfully

10.3 Study Findings and Existing Qualitative Evidence

Findings which underscore or extend existing qualitative work relate to the following topics:

- the use of nonresponsive practices
- a perceived lack of alternatives to nonresponsive practices
- a lack of knowledge
- parental agency
- feeding as a battle

Chapter 3 included an examination of parental use of pressure to eat as a qualitative finding. The conclusion drawn is that both quantitative and qualitative work show that parents employ pressure to eat in response to avoidant eating. The study, therefore, echoes what is already known about what parents do in relation to avoidant eating. Nonetheless, it offers additional value regarding meaning making in relation to both these practices and the child eating behaviours that they are used in response to.

10.3.1 Descriptive Accounts of Feeding Practices

As previously mentioned (2.11.1), several qualitative studies include findings on the use of pressure to eat (Berge et al., 2016; Carnell et al., 2011; Goodell et al., 2017; Jarman et al., 2015; S. Moore et al., 2007; Russell et al., 2015; Trofholz et al., 2017). Some studies were designed simply to ascertain which strategies were used rather than how parents made sense of them (S. Moore et al., 2007; Russell et al., 2015) and so necessarily did not report parental interpretation of (or feelings about) practices used. Goodell et al. (2017) only explored parental rationale as it related to demographic factors. Other studies had a design that precluded in depth analysis: Berge et al. (2016) and Trofholz et al. (2017) reported findings from the same content analysis using a large sample (n=88), with description rather than interpretation as its stated goal; S. Moore et al. (2007) only conducted 20 minute interviews; Jarman et al. (2015) analysed qualitative data from focus groups in the context of a mixed methods study and (based on its limited prominence in the reported findings) proportionally little emphasis was placed on the qualitative aspect of the study. Feeding children perceived to be avoidant eaters was found to be stressful in multiple sources (e.g., Jarman et al., 2015; Trofholz et al., 2017). While this pertains to participant experience, it is argued that this is still a descriptive rather than interpretative finding because it does not consider latent meaning.

10.3.2 A Perceived Lack of Alternatives

As in the current findings, other recent qualitative work suggests that parents recognise the ineffectiveness of pressure to eat, yet use it regardless (Fraser et al., 2021; H. Harris et al., 2020). This apparent contradiction is important and can be understood against the backdrop of a sense of a lack of alternatives. This may be reinforced by the *dogma of exposures* whereby, despite pressure to eat not working in the short term, parents may cling to it as a long term strategy that they believe to be adaptive. Similarly, qualitative studies have found variously that parents lack the responsive strategies required to nurture a long term positive relationship with food (Tartaglia et al., 2021) and are "learning on the job", when it comes to child feeding (S. Moore et al., 2010, p. 192). They feel unsure about how to respond to avoidant eating, saying that they are "'at a loss', 'don't know what to do anymore' or [are] 'at their wits end'". (Fraser et al., 2021, p. 7).

Such uncertainty maps on to the theme *Futility - nobody knows*. This theme extended the notion that parents simply do not know what to do, by suggesting they may believe no one knows what to do; they have tried everything and there is simply no solution. There is a big difference between feeling one does not have requisite knowledge and believing that such knowledge does not exist at all. Arguably the latter is tied to the absence of hope, and it may have implications for parental help-seeking behaviours. The study findings also indicate a link between this perceived lack of a solution and a lack of agency.

10.3.3 A lack of knowledge

Considering a lack of knowledge further, it can be broken down in line with the study findings and existing qualitative evidence, into knowledge relating to feeding norms, knowledge of children's self-regulatory ability, and an understanding of what commonly underpins avoidant eating (*attribution*). With the theme *From a dream to a nightmare*, the study findings highlight that the majority of participants had children who ate well when solids were first introduced, then eating deteriorated in toddlerhood. As discussed previously (9.4.3), this phenomenon is recognised and normal. This knowledge gap has been highlighted in other qualitative work (Fraser et al., 2021; Norton & Raciti, 2016; Tartaglia et al., 2021). Notably, Fraser et al. (2021) found that, in some cases, parents did in fact view the shift in eating behaviours as an aspect of normal development, but nonetheless sought emotional support from peers in relation to

it. This implies that there may be a twofold support need emerging from a lack of insight into developmental norms: a need for parents to be given information but also a need to support them as they navigate these disconcerting changes. A final challenging aspect of the shift in eating behaviours identified in this study and elsewhere (Rubio & Rigal, 2017) is the suddenness of the change. This lends weight to an argument for anticipatory guidance for parents.

The findings demonstrated that ineffective interoception was a common attribution of avoidant eating, although, as argued in Chapter 9 (9.4.1), there is scant evidence for nonorganic poor appetite as a cause of eating problems in neurotypical children, as opposed to a consequence of nonresponsive feeding practices. Believing that children could not be relied upon to know when they were hungry or full is perhaps equivalent to (or at least constitutes an aspect of) a lack of faith in their self-regulatory ability. In their systematic review and synthesis, Wolstenholme et al., (2020) found that multiple qualitative studies connected feeding practices to beliefs about what these authors called *hunger regulation*, a term that appears to be used synonymously with Birch et al.'s (1991) now widely adopted term, *self-regulation of energy intake*, often shorted to *self-regulation* in a feeding context (see 2.1.3).

A lack of faith in children's ability to self-regulate may be inferred from the use of controlling feeding practices, including pressure to eat. However, previous qualitative work suggested that the goal of facilitating self-regulation is not necessarily alien to parents. In the context of parenting older children (6 to 10 years of age) it was found that providing autonomy in order to foster self-regulation could be an overt goal for parents, but one which clashed with the opposing goal of increasing food consumption (Wolstenholme et al., 2019). Similarly, other qualitative research (not specific to avoidant eating) found that parents may learn to trust children to self-regulate with experience (Bergmeier et al., 2017). It is possible that, as with negotiating the common shift in eating behaviours in early toddlerhood discussed above, parents do not simply lack knowledge about self-regulation, they also lack the support needed to maintain a responsive approach in the face of competing anxieties, which may be more pressing in less experienced parents. It should be noted that such knowledge of self-regulation was not evident in the current sample.

Wolstenhome et al. (2020) found similar attributions to those identified in the current findings (see Appendix Q), these being: food preferences, sensory processing, and temperament. As with hunger regulation, they found evidence for these being

linked to parenting practices. As mentioned in Chapter 9, these attributions are largely accurate. Although there is some qualitative evidence for avoidant eating being framed as noncompliance (Rubio & Rigal, 2017), it is notable that, aside from some misinformed beliefs about self-regulation, parents seem to have a good understanding of common causes of avoidant eating. It would seem reasonable to infer from this that they would not, therefore, blame themselves. Yet, this study and other qualitative work (Rubio & Rigal, 2017; Tartaglia et al., 2021) found that parents demonstrate self-blame in relation to both their feeding practices and their child's eating behaviours. Similarly, if parents have a good understanding of root causes of avoidant eating, this seems inconsistent with the lack of agency evidenced in the current study and elsewhere (Fraser et al., 2021). The study perhaps offers new insight into attributions by highlighting that, in this sample, these were often made tentatively or put forward as part of a process of seeking to understand that frequently did not end with a concrete explanatory model. This has implications for screening which are discussed later.

Feeding as a battle

In keeping with findings regarding parents not feeling in control (Tartaglia et al., 2021), this was not the first qualitative study to consider feeding as a battle. Bergmeier et al. (2017) found that parents in general (not specifically parents of avoidant eaters) saw meals as potential arena for battles and sought to avoid this. H. Harris et al. (2018) framed parent-child conflict around food as a battleground whereby children were seeking control over their eating, parents were framing this as negative behaviour and parent and child were consequently in opposition to one another. They referred to the "highly charged emotional underpinnings of mealtime interactions associated with fussy eating" (H. Harris et al., 2018, p.36), conveying how, in their sample, being in battle was very distressing for parents with high levels of concern about avoidant eating. Fraser et al. (2021) also reported parents feeling like they were engaged in "dinner time battles" and that parents in these conflicts used nonresponsive feeding practices (Fraser et al., 2021, p. 6).

Acute maternal distress at finding themselves in an unwinnable quotidian battle also permeates the findings of the current study. This is both affective and cognitive; participants described many negative emotions in response to their child's eating and their inability to understand or control it. They also reported cognitive schemata whereby they saw themselves as responsible for their child's relationship with food and failure to improve it was consequently framed as their own failing. They were often

distressed by their child's distress and some felt very usure about the right way to proceed. H. Harris et al. (2018), in the context of fathers, highlighted the important role of parental concern as a driver of nonresponsive feeding practices and as a contributor to parental distress. They also examined parental sense of agency in relation to child autonomy-seeking behaviours. The current study, however, shines a light on the related but distinct questions of what avoidant eating may mean for maternal sense of self, as well as the role of failed attempts at attribution. The battle is indeed a control battle, but what this then implies for the maternal self-concept may be an important additional aspect of why the battle is so distressing, beyond the unpleasant nature of the conflict itself.

10.4 Novel findings

Having discussed how the findings from the IPA study echo and extend previous qualitative findings, novel findings are now discussed.

10.4.1 The dogma of exposure

Questioning the merit of advancing exposure as a strategy to address avoidant eating (in the absence of a concurrent emphasis on the socioemotional climate of that exposure) is an original contribution to the field. Exposure is so widely described as adaptive as to be classifiable as a ubiquitous recommendation (Dovey et al., 2008; Lafraire et al., 2016) although, as shown earlier (6.4.2), many academic sources have drawn attention to the importance of the affective context of the exposure. Perhaps the lack of clear definition of what constitutes an exposure contributes to the problem. In the literature, specifications for the nature of the exposure range from a taste exposure, where the child has to have tasted a small amount of the food (Birch, 1987) to repeated offers of a food (Russell et al., 2015).

Given evidence for the potential value of visual exposures (Houston-Price et al., 2019), it is argued that the research demonstrating the role of parental modelling in food acceptance is relevant here (see 2.10.2). Modelling via parents eating a varied diet at mealtimes with children, facilitates visual (and olfactory) exposures which do not thwart child autonomy, building familiarity as well as conferring the benefits of seeing attachment figures carrying out a behaviour. Recent qualitative work (Tartaglia et al., 2021) organised its thematic analysis around the basic psychological needs posited by self-determination theory (SDT): *Autonomy*, *competence* and *relatedness* (Deci &

Ryan, 2004)[11]. Drawing on SDT, the concept of an *autonomy supportive exposure* is put forward as a means of challenging parental (and professional) belief in the merit of exposures without consideration of their socioemotional context.

To be in line with responsive feeding, it is argued that an exposure must not compromise autonomy, in that the child has not been made to do something they do not want to do. Their competence (felt sense of capability) has not been negatively impacted because they have not been asked to do something that they feel is too difficult for them or that has an aversive consequence, like gagging. Relatedness is prioritised as the emphasis on the meal is on connectedness and an attuned parent-child relationship rather than encouraging nonautonomous exposures or food consumption which may result in aversive consequences or conflict. As argued in Chapter 6, the literature on exposure as a means of increasing liking of certain foods (typically fruit and vegetables) uses general population samples. Extrapolating from these findings to avoidant eaters risks missing a potentially different emotional response to the exposure. Indeed, as discussed in relation to the relevance of context in relation to the conceptualisation of pressure to eat (3.5.4), it is known that the impact of exposure varies according to child characteristics. Finally, the argument for autonomy-supportive exposures is supported by research examining recalled episodes of forced consumption (Batsell et al., 2002). In Batsell and Brown's study, college students recalled negative emotions and a sense of being out of control when made to eat rejected foods in childhood. Furthermore, almost three quarters of their sample said they did not eat the food they were made to eat in childhood, as young adults.

10.4.2 The false binary

In their qualitative study, Jarman et al. (2015) found that parents either used controlling feeding practices or abandoned control completely. Similarly, H. Harris et al.(2018) reported that parents either responded to their anxiety regarding their child's avoidant eating by using nonresponsive feeding practices or by the serving of foods their child wanted. The current study comes to similar conclusions but takes them further, framing this dichotomy not simply in terms of what parents do, but in relation to what they perceive their options to be. As described in Chapter 2 (2.9.1.2), the

[11] This study (Tartaglia et al., 2021) drew on a recent paper by the researcher and colleagues (Cormack et al., 2020) in which the use of the basic needs as a framework for a responsive approach to feeding was considered.

Division of Responsibility (sDoR; Satter,1986,1990) mechanises a responsive approach to feeding. It allows parents to make structure and content decisions while giving children autonomy over their eating decisions within that context. This constitutes the 'middle way' that mothers in the study did not seem to see. When they stated that they had "tried everything", they had not tried this. This fits with qualitative work (Loth et al., 2018) examining whether the parent or child had responsibility for content and structure decisions, which found that a small number of participants (parents of preschoolers) in their sample followed the sDOR (Satter, 1986,1990), most did not. This was a US sample and, as discussed previously (2.9.1), this model is embedded in US policy and practice in a way that it is not in the UK.

The notion of the false binary has implications for both agency and identity. The findings indicate that several mothers in the study felt that they could either do nothing about their child's eating, equating to being a bad parent, or they could drive exposures and consumption, which may then give rise to self-blame as it clashes with parental empathy. For many participants, their lack of agency in relation to feeding also clashed with their wider sense of self. Otherwise competent mothers with high levels of self-efficacy (and in some cases, specific professional knowledge of health and childcare) were left feeling utterly without agency in the face of their child's avoidant eating. Education and support for parents in the adoption of a responsive approach to feeding could give parents a sense of self-efficacy and reduce self-blame.

10.5 Methodological Reflections

Having examined novel contributions to knowledge in relation to the findings of the IPA study, novelty in terms of design is now considered.

10.5.1 Novel Aspects of the Design of the IPA Study

As discussed in Chapter 2 (2.11), there has been a recent increase in qualitative enquiry in the field of avoidant eating. However, although IPA has been used to investigate adult avoidant eating (Fox et al., 2018) this is the first time it has been used in relation to parenting and avoidant eating. The sample is also novel; three qualitative studies with a sample solely made up of parents of avoidant eaters were identified, and one had a sample of children who were neophobic (Russell et al., 2015). These are distinct from general population samples which include parents of avoidant eaters. (Russell et al., 2015) explored parental attempts to influence children's food preferences, subdividing the sample based on prior work assessing child neophobia. As

discussed previously (2.2.1), neophobia and avoidant eating are related but distinct constructs. (Trofholz et al., 2017) was a content analysis with 88 parents of avoidant eaters. The third (H. Harris, Ria-Searle, et al., 2018) was an analysis of calls about avoidant eating to a helpline for parents. The fourth (Fraser et al., 2021) was an analysis of parents' discussions of avoidant eating on the online discussion platform, Reddit. Bearing these four studies in mind, the sample is original in relation to small-scale qualitative studies examining the experience of parents of nonclinical avoidant eaters, in which data are gathered using semistructured interviews. The UK primary care context was also unique in relation to qualitative enquiry on this topic. This is important because health visitors are parents of young children's first port of call if they are concerned about avoidant eating (NHS, 2020a).

10.5.2 Limitations of the IPA Study

Perhaps the most significant limitation of the study was the inadvertent recruitment of an exclusively female sample. The aim of the study was to explore parental as opposed to maternal meaning making, however, all of the 32 people who responded to the research invitation were women. This was disappointing but perhaps not surprising, given that mothers are primarily responsible for child feeding (Blissett et al., 2006). The important role of fathers in relation to avoidant eating has been highlighted (H. Harris et al., 2018) but paternal feeding practices are largely neglected in feeding research (Khandpur et al., 2014). It is unfortunate to contribute to this omission, albeit unintentionally.

Notably, seven of the participants shared information about their professional roles in their interviews. These details were not sought so were not reported in detail and data on employment and training were not gathered from participants who did not volunteer them. However, of those participants who discussed their professional role, two worked with young children in an educational or childcare setting, one was a general health professional and three further participants were health professionals working with children. This is possibly explained by self-selection bias but also perhaps affected the data. It could be that these mothers were more likely to be familiar with exposure theory (although participants who did not say they worked with children or in healthcare also referred to it). Future studies exploring parental help-seeking for avoidant eating (in a primary care context) should seek to recruit parents less likely to be comfortable and familiar with healthcare professionals.

A unique challenge to the minimisation of bias was the fact that one of the participants said she was a member of the researcher's Facebook group during the interview. In this Facebook group, parents can access free learning units which include information about responsive feeding. It is not known whether this participant had accessed these. However, it is possible that through contact (which is presumed to be coincidental) with the researcher's online resources, this parent may have had more exposure to responsive feeding theory than might be typical for a UK parent.

10.5.3 Novel Aspects of the Literature Review

Alongside the IPA study findings, the literature review constituted an original contribution to knowledge, having not been carried out before. A systematic review of instruments used to assess responsive feeding in the context of obesity has been conducted (Heller & Mobley, 2019), but the focus of that review was to examine which aspects of responsive feeding were measured rather than how any of those aspects (such as pressure to eat) were conceptualised. Additionally, the systematic review included in this thesis was methodologically novel in that it employed a systematised snowball citation approach (see 3.3.1) alongside traditional database searches. This strategy garnered more results, thus reducing the risk of missing older research that may be absent from databases or not classified in a way that facilitates retrieval.

10.5.4 Limitations of the Literature Review

This systematised strategy has several limitations. It was only feasible due to the relatively small number of studies in the field and would not be recommended for literature searches in relation to broader topics or heavily researched areas. Similarly, this search was carried out over an 18 month period and would be prohibitively time consuming in most research contexts. Another limitation of systematised snowball citation searches is that more recent studies are harder to capture as the process necessarily goes backwards in time. Conversely, the identification of older material which is potentially not included in modern databases can be seen as an advantage. It would also have been advantageous to examine the conceptualisation of pressure in tools and instruments which assess pressure to eat but which have not yet been used in the context of avoidant eating. This was not done due to the scale of such a task.

10.6 Implications for Practice and Research

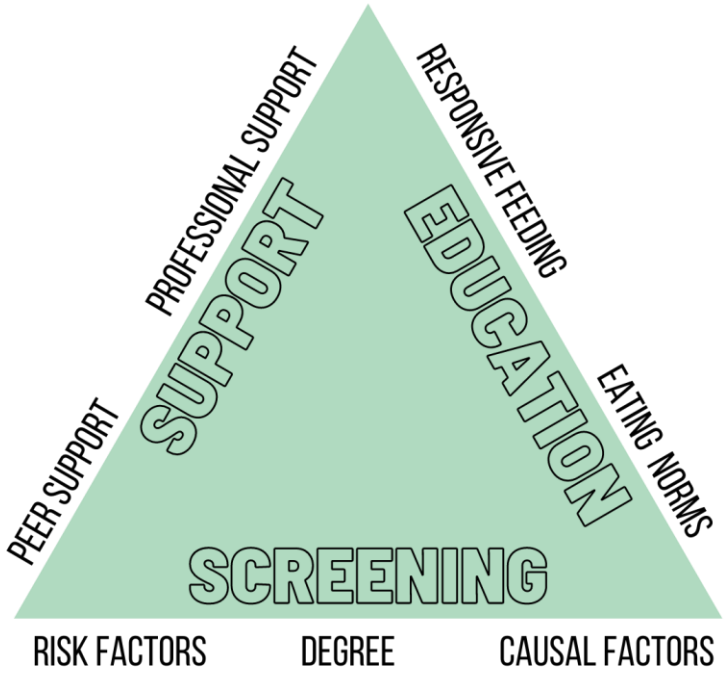
There has been some consideration of the implications of the IPA study findings for practice and research in the individual chapter discussion sections. However, in this

section, there is an attempt to draw these together. This takes the form of a recommendation of a multifaceted approach to supporting parents of avoidant eaters in primary care. It is argued that the implications for practice are far reaching and represent a significant challenge to current practice. The questioning of advocating exposure regardless of context is perhaps the most notable aspect of this.

10.6.1 A multifaceted Approach

As described in Chapter 2, influences on child-feeding practices in the context of avoidant eating are complex. The IPA study findings imply that mothers may feel hopeless, helpless, blame themselves, and feel judged by society. The following tripartite model for primary care interventions is proposed, drawing on both the findings and literature in the field. The precise nature of interventions would need to be developed and piloted through further research.

Figure 10.1 *A Tripartite Intervention Model*



10.6.1.1 Education

Sharing evidence-based information about adaptive feeding practices and child eating norms is key, as has been argued and addressed previously (Haycraft et al., 2020). Early provision of anticipatory guidance may also reduce parental stress and anxiety as the child transitions from infancy to toddlerhood. Simple things like knowing

in advance that typically developing young children are often neophobic, or that they can regulate their own energy intake and so their food consumption may fluctuate, may make a big difference to anxious parents.

There needs to be a focus on conveying accessible messages about child feeding through models like the sDOR (Satter, 1986,1990), the SDT basic needs (Deci & Ryan, 2004) and a stark but simple message that for avoidant eaters, the culturally normal notion that inducing a child to eat or try a food will improve eating, is wrong. Instead, an emphasis on modelling, autonomy-supportive exposures and the creation of a positive socioemotional eating environment is paramount. This constitutes a radical mindset shift for parents, which would need to be underpinned by a review of public health messaging in relation to exposure theory.

10.6.1.2 Support

The findings on both maternal self-blame and social blame lend support to the idea expressed elsewhere (Tartaglia, 2021; Mitchell et al., 2013) that social support may be beneficial and that normalisation is important to parents of avoidant eaters (Fraser et al., 2021). Perhaps a practitioner-led group intervention would help both normalise avoidant eating and reduce parental self-blame. It would also be advantageous from the perspective of optimising use of resources. Given the sensitivity and complexity of child-feeding challenges, such group interventions would need to be led by trained professionals. In terms of supporting parents in the adoption of a responsive approach to feeding, information combined with support may be more effective than information alone.

Further to this, the findings have implications for parental support-seeking itself, and questions are raised regarding how to optimise engagement with interventions and how to increase faith in advice provided in a primary care context. If parents believe there is no solution to avoidant eating, that no one knows the answer, and that there are no options besides a permissive or an authoritarian approach to child feeding, this could render reaching some parents who need support very challenging indeed.

10.6.1.3 Screening and Assessment

Screening for child and parental risk factors for avoidant eating, such as child temperament, sensory processing challenges, low weight, and parental anxiety, could aid the identification of parents who may benefit from additional support from their health visitors. Similarly, if parents approach their health visitor for help with avoidant

eating, skilled assessment of the degree of the problem to identify whether it reflects normal development or a moderate (or severe) feeding problem, is warranted. This perhaps has implications for the training health visitors receive. Even where the problem is misperceived, the study findings indicate that if a mother considers that their child has an eating problem, this can have a negative impact on their sense of self. Equally, because avoidant eating is so often a normal phase of development, clinically significant eating problems may be missed. In every scenario, careful assessment, underpinned by knowledge of avoidant eating, is key.

The findings show that ongoing attempts at attribution of avoidant eating left most mothers in this sample either in an endless cycle of information-seeking without a satisfactory conclusion, overwhelmed with a sense of not understanding, or both. This had implications for agency and identity. If health visitors were able to dedicate time and resources to establishing causal factors through appropriate training and validated measures, this would not only help them give focused advice, it would also liberate parents from a sense of not understanding and potentially even from feelings of culpability.

10.6.2 Implications for Policy

These qualitative findings lend weight to the call made for information for parents of avoidant eating to include the 'how' as well as the 'what' of child feeding introduced at the outset (1.1). Indeed, most avoidant eaters are adequately nourished (see 2.8.1.1) and parental concern has been shown to fully mediate the use of pressure to eat and avoidant eating (H. Harris, Jansen, et al., 2018b). This supports the idea that helping parents nurture their child's long term positive relationship with food should be prioritised over messaging regarding nutrition. Or perhaps or at the least, the two should run in tandem, with an emphasis on responsive feeding. The findings regarding exposure exemplify this point: Mothers may be pushing children to eat because they believe this will facilitate optimal nutrition and is therefore a part of being a 'good' parent. The reality may - conversely - be that an emphasis on modelling, the facilitation of autonomy-supportive exposures, and relaxed and connected mealtimes is a more effective path towards children's acceptance of a broader diet.

The findings also indicate how distressing the use of the nonresponsive feeding practice of pressure to eat is for mothers. Partly because the mothers in this sample found they do not work, thus a lack of self-efficacy in relation to feeding impacts

identity and fosters self-blame. Partly too, because the very use of nonresponsive practices (which most mothers considered to be their only option) felt bad. They were only using them because they believed them to be in the best interest of their child and did not know what else to do. Mothers in this study believed that there is no way of successfully addressing avoidant eating. This is mistaken, however. If the UK were to follow the US in embedding responsive feeding as best practice in official guidelines, this disturbing notion (reflecting a profound research-practice gap) may be slowly eradicated.

10.7 Future research

Participants in the IPA study disproportionately represented healthcare and childcare professionals. On this basis, they were arguably more likely to approach their health visitor for help with a parenting challenge than most parents and may have a higher than average level of confidence in professional services. It would be useful to learn more about parental support-seeking behaviours in a larger sample of parents who perceived their child to be an avoidant eater, and who were not recruited via the NHS. By definition, all the parents in the current sample had decided to approach their health visitor and it would be interesting to learn about those who had not. Likewise, it would be useful to carry out a similar study with fathers or a purposive mixed gender sample.

It would also be very useful to carry out a study examining the guidance on avoidant eating provided by health visitors in different NHS Trusts across the UK. The current findings imply that it may be very inconsistent and rarely in accordance with evidence-based responsive principles. However, the study design did not include a focus on advice provided by health visitors and so this is an incidental finding. The sample is also far too small to draw any conclusions in this regard. Future research should seek to inform a protocol-driven primary care response to avoidant eating, with consistent guidance from the NHS on a par with that provided in relation to breastfeeding and complimentary feeding.

It would also be interesting to carry out a study further exploring whether there is a connection between a coherent attributive narrative and reduced self-blame. Similarly, various interventions with different emphases on the support, screening and educational aspects of the tripartite model would help establish which aspect, or combination of aspects, are the most important in terms of supporting the adoption of responsive feeding practices, and indeed, whether the tripartite model captures all requisite aspects

of an effective intervention. Evaluations of health visitor training based on the tripartite model, would add to this. There is also a need for case studies illustrating responsive feeding interventions in the context of avoidant eating, as well as outcome studies of such interventions. Finally, further studies are needed to test the notion that the benefit of nonautonomy supportive exposures is negated by the negative socioemotional context, for avoidant eaters.

10.8 Study and Review Findings Considered in Tandem

The findings from the systematic literature review regarding the delineation of pressure to eat give rise to recommendations regarding the development and validation of a more nuanced instrument to measure pressure to eat. Further research is needed to assess the differential impact of subtly different types of encouragement, and how these interact with child characteristics, including children's relationship with food. Although maternal report of child eating behaviours was shown to be reliable, maternal report of feeding practices used was not (Powell et al., 2018). More work is called for which assesses feeding practices by means other than self-report.

A notable overlap between the findings from the systematic literature review and the IPA study concerns the conceptualisation of food trying as a goal. In the review, it was argued that the pressure spectrum should include pressure to try as well as pressure to eat. In the IPA study, it was found that mothers seemed very engaged with the task of inducing their children to try foods. This involved various aspirations, including the facilitation of exposure and ensuring that the child's behaviours were 'polite'. Inducing food trying was an endeavour characterised by the maternal use of pressure. By taking a broad approach to the assessment of pressure in quantitative research, such practices are likely to be captured without any prior assumptions about less coercive practices, such as encouragement and praise, being inherently adaptive.

10.9 Conclusion

Avoidant eating is very common problem and, drawing on the findings from the IPA study, may render mothers "clueless" and, perhaps consequentially, powerless. This is highly distressing and may have an impact on maternal sense of self, with high levels of self-blame in evidence. Health professionals, such as health visitors, have an opportunity to 'translate' the wealth of research knowledge in order to help parents adopt a responsive approach to feeding and understand their child's eating behaviours,

moving to a position of empathy with the child rather than seeing themselves as engaged in a battle. If parents are not trying to make avoidant eaters consume and try foods, they will not feel powerless and guilty because they cannot achieve this goal. They can swap one explanatory model (the obligation to make children eat or try foods, or else give in completely) for another (responsive feeding and its goals of supporting child autonomy and eating enjoyment). The study presented in this thesis reflected an attempt to take advantage of a highly interpretative methodology and a homogenous, novel sample to extend and add to previous qualitative work. It has been demonstrated that this constitutes an important contribution to the literature in the field; it is hoped that a deeper understanding of maternal sense making in this context can inform clinical practice, policy, and research.

11 Appendices

11.1 Appendix A: The Prevalence of Avoidant Eating

The following table summarises studies examining the prevalence of nonclinical avoidant eating beyond the period encompassed by the reviews discussed in Chapter 2 (Cole et al., 2017; Samuel et al., 2018; Taylor et al., 2015).

Study	**Location**	**Sample size**	**Sample age**	**Prevalence rate**
Steinsbekk et al., 2017	Norway	Time point 1: 997 Time point 2: 775	Time point 1: 4 years Time point 2: 6 years	25% at both time points
Chao, 2018	Taiwan	300	2 to 4 years	54%
Zohar et al., 2020	Israel	1055 at baseline (time point 1) 109 at time point 2 and time point 3	Time point 1: 2 to 4 years Time point 2: 4 to 6 years Time point 3: 6 to 8 years	17.5% of the sample were perceived by parents to be avoidant eaters at time point 1. 57.5% of the sample were perceived by parents to be avoidant eaters at at least one of the three time points. 3.94% of the sample were persistent avoidant eaters.
Kutbi, 2020	Saudi Arabia	195	1 to 7 years	37.4% of the sample were perceived by parents to be severely avoidant eaters
Machado et al., 2021	Portugal	2687	6 to 18 years	23.1% but was more common in the younger portion of the sample therefore this percentage may be misleading when considering younger children

11.2 Appendix B: Qualitative Research – Search Flowchart and Results

This flowchart relates to the search for qualitative studies that examine parenting practices in the context of avoidant eating or including avoidant eating.

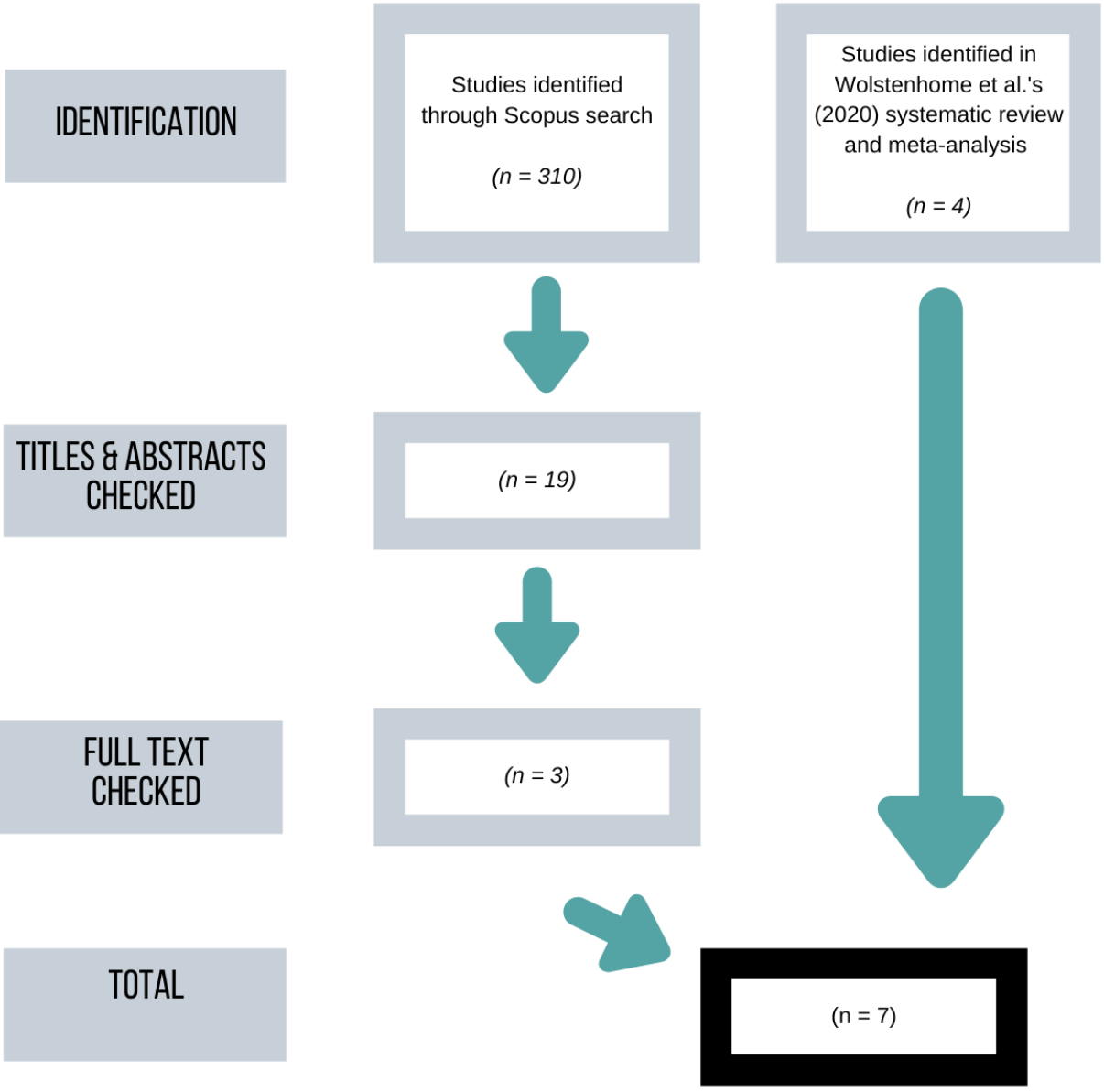


Table showing results:

From Scopus search	From Wolstenholme et al.'s review (2020)
(Fraser et al., 2021)	(Berge et al., 2016)
(H. Harris et al., 2020)	(H. Harris, Ria-Searle, et al., 2018)
(Wolstenholme et al., 2019)	(Rubio & Rigal, 2017)
	(Trofholz et al., 2017)

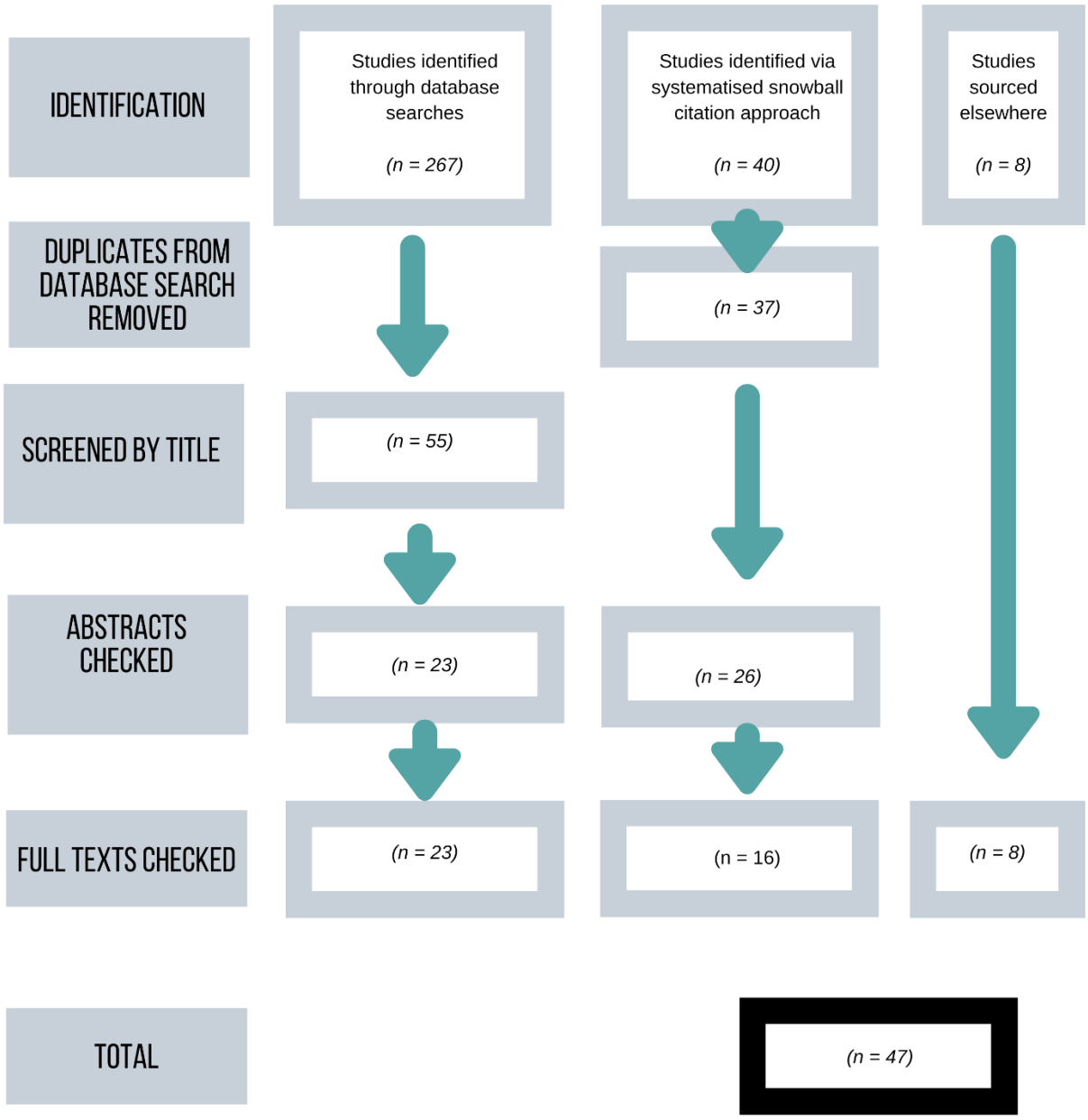
11.3 Appendix C: Systematic Review (Chapter 3) - Supporting Information

Boolean Phrases Used

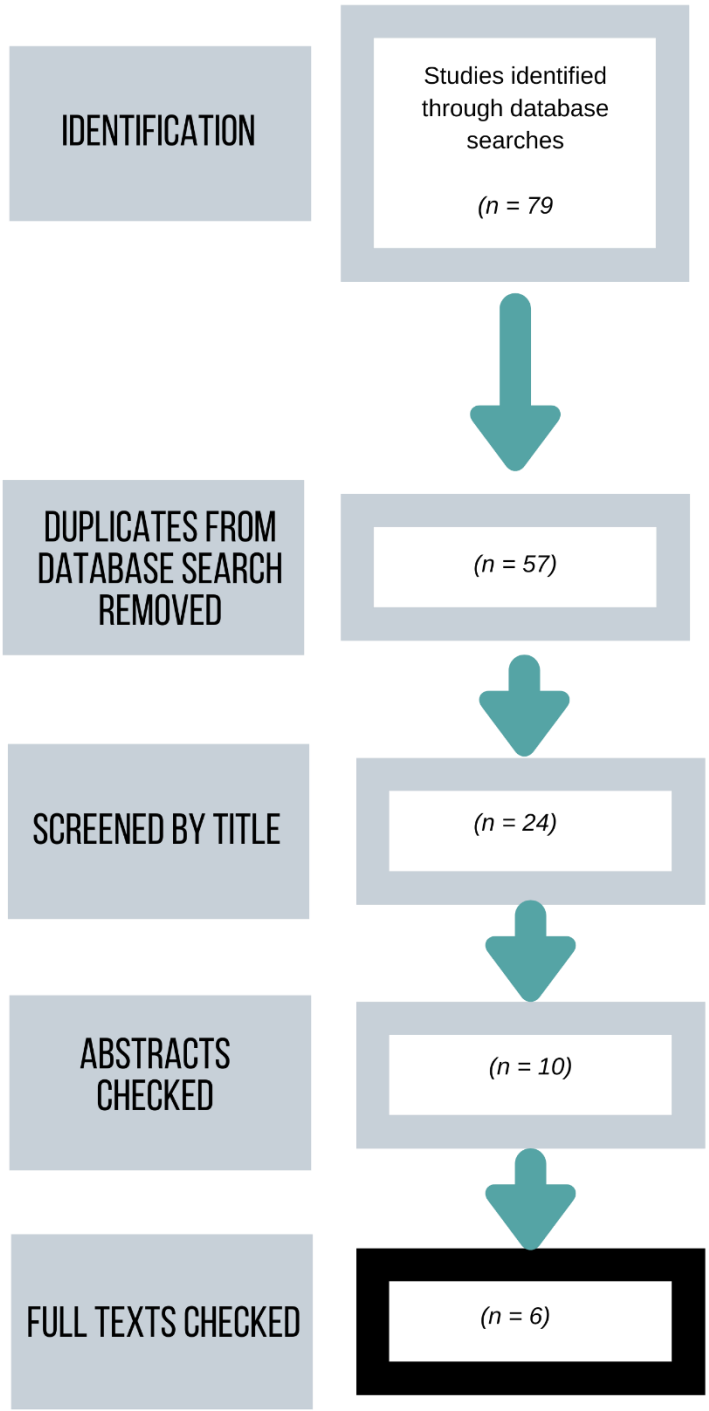
"parent* feeding practices" AND ("picky eat*" OR "fussy eat*" OR "selective eat*" OR "avoidant eat*")

"child* feeding" AND ("picky eat*" OR "fussy eat*" OR "selective eat*" OR "avoidant eat*")

Search 1: Flowchart



Search 2: Flowchart



11.4 Appendix D: Summary of Studies Identified in the Systematic Review

Study	Relevant (not comprehensive) aims / objectives	Design	Sample	Measures of child eating behaviours	Measures of parental feeding practices	Key findings
(Antoniou et al., 2016)	To determine relationships between avoidant eating, child weight, and parental feeding practices	Prospective Multiple time points between the ages of 5 and 9 years	KOALA Birth Cohort Study Netherlands	Simple parental report questionnaire, based on Galloway et al. (2005).	CFQ (pressure to eat, restriction & monitoring subscales, and an additional stimulation subscale (Gubbels et al., 2011)	No associations between child weight status and parenting practices were found. Parents of avoidant eaters used more pressure and restriction than parents of typical eaters.
(Berge et al., 2020)	To compare associations between parental feeding practices, parental stress and depression, and child eating behaviours in food secure and food insecure households	Mixed methods: Various variables assessed as well alongside Ecological Momentary Assessment Procedures	Ethnically diverse parent-child dyads (n=150) Age of children: 5-7 years USA	Yes / no single question answered at meals: Did the child refuse to eat any of the food you offered him/her?	Pressure to eat was assessed by an adapted question from the CFQ, answered at meals: Did you have to encourage [child's name] to eat more food at this meal?	In food secure households, parental stress was associated with avoidant eating and pressure to eat. This relationship was not seen in the food insecure group, where increased stress was associated with restriction. Parental depressed mood was not associated with pressure to eat in food secure families.

(Berger et al., 2016a)	To determine relationships between child avoidant eating, growth, and nutrition and parental use of pressure	Longitudinal Girls were assessed twice a year over for 10 years	Non-Hispanic White girls and their mothers (n=163 dyads) Child age 5 -15 years USA	Three 24 hour dietary recalls at each assessment point CFQ (picky eating subscale)	CFQ (pressure to eat subscale)	Persistent avoidant eating was positively associated with maternal use of pressure to eat. The authors speculated that the relationship is bidirectional.
(Bergmeier et al., 2016)	Adapt the Mutually Responsive Orientation (MRO) observational coding system to the food context and assess its validity and sensitivity. It measures child and mother responsivity to one another as well as mutual positive affect.	Prospect-ive T1 was 12 months after T2	Mother-child dyads (n=93 dyads) Child age at T1 ~3 years Australia	CEBQ (food fussiness and enjoyment of food subscales)	CFQ (restriction and pressure to eat subscales)	Higher MRO was associated with less avoidant eating (framed as 'noncompliance') and less use of controlling feeding practices, including pressure to eat.
(C. Brown & Perrin, 2020)	To determine relationships between constructs of which avoidant eating is comprised; child weight and BMI; and parental feeding practices	Cross-sectional	Parents of children attending routine weight-recording visits to paediatric clinics (n=260) Child age: 2-8 years USA	Study specific questionnaire including commonly used measures of avoidant eating	CFQ (pressure to eat subscale)	Avoidant eating was associated with the parental perception that the child ate insufficient quantity. Parental concern about children eating insufficient quantity was positively correlated with pressure to eat, but was not associated with unwillingness to

						try new foods or food preparation requirements
(C. Brown et al., 2016)	To determine relationships between maternal concern for child undereating and parental feeding practices. To examine correlates of maternal concern for child undereating.	Mixed methods? Cross-sectional analysis including data from questionnaires as well as quantitative data extracted from semi-structured interviews	Low income mother-child dyads (n=286) Child age: 4-8 years USA	CEBQ (food fussiness subscale)	CFQ (pressure subscale) and observation Concern was assessed using semi-structured interviews	Mothers of avoidant eaters were more likely to be concerned about their child not eating enough. Concern was associated with pressure to eat and bribery.
(Camfferman et al., 2019)	To determine relationships between maternal health cognitions, maternal feeding practices, maternal self-efficacy, children's eating styles, and child weight	Cross-sectional	Mother-child dyads (n=251) Child age 4- 6 years Netherlan-ds	CEBQ	CFQ	Mothers with high self-efficacy used less pressure to eat. Health cognitions were associated with restriction. Pressure to eat was positively correlated with avoidant eating.
(Carruth et al., 1998)	To determine the relationship between parental perception of avoidant eating status and child diet. To determine relationships between maternal socio-economic status, family	Longitudinal (2 x interviews at random times (24, 28, 32, or 36 months)	Mothers from upper socio-economic group (n=74) and lower socio-economic group (n=44) USA	Feeding history and habits questionnaire (Pelchat & Pliner, 1986) Dietary recall	Feeding history and habits questionnaire (Pelchat & Pliner, 1986) Study specific questionnaire, including questions abut frequency of persuading	Mothers of avoidant eaters scored higher (than mothers of non-avoidant eaters) on persuasion but not reward

	environment and avoidant eating.				the child to eat and frequency of incentivising eating	
(Chan et al., 2011)	To examine parents' views on their feeding practices and their child's eating behaviours.	Questionnaire	Randomly selected sample of parents (n=740) Child age: 12-36 months Australia	Study specific questionnaire (including perception of avoidant eating status)	Study specific questionnaire (including insisting on eating and encouraging with food and non food rewards)	Findings were descriptive – associations were not assessed. Roughly three quarters of parents used 'coercive' practices: Half of the parents frequently insisted on eating or on a meal being finished. Slightly less than half used reward for eating and a fifth felt their child was an avoidant eater.
(Ek et al., 2016)	To determine the relationship between between parental perceptions of preschoolers' eating behaviors and parental feeding practices	Cross-sectional	Parents (n=478) Age of children: 3-8 years Sweden	CEBQ	CFQ	Parental pressure to eat was strongly associated with avoidant eating in children. Parent perception of a small appetite correlated with pressure to eat. Authors noted that small appetite may be misperceived.
(Evans et al., 2009)	To determine relationships between child-feeding practices and demographic factors (including ethnicity)	Cross-sectional	Randomly selected parents (n=721) 50% Hispanic Child age: 1-5 years	Preschooler Feeding Questionnaire (PFQ) Includes parent assessment of	Preschooler Feeding Questionnaire (PFQ) Includes assessment of "pushing child to eat"	In this sample, the most common practices were pushing children to eat and 'dealing with picky eating' (assessed as a practice rather than a child eating behaviour).

			USA	avoidant eating and concerns about undereating		Relationships between avoidant eating and parenting practices were not examined in this study design.
(Farrow & Blissett, 2012)	To examine the consistency and stability of parental feeding practices and child eating behaviour	Longitudinal Two time points: T1 - Age 2 years and T2 age 5 years	Parents (general population) (n=31) UK	CEBQ	CFQ	Mean maternal pressure to eat increased significantly between T1 and T2 but was stable Pressure to eat and eating enjoyment had a negative correlation at T1 and T2.
(Farrow et al., 2009)	To determine whether differences in feeding practices within families are linked to differences in eating behaviours among siblings	Cross-sectional	Parents of siblings (general population sample) (n=80) Child age: 3-6 years UK	CEBQ	CFQ	Pressure to eat was determined to be an aspect of the nonshared environment More pressure to eat was used with siblings who ate more slowly, had higher levels of avoidant eating and lower levels of food enjoyment.
(Fernandez et al., 2020)	To examine trajectories of avoidant eating and determine relationships between avoidant eating, child characteristics, and maternal feeding practices	Longitudinal T1 – 4 years T2 – 5 years T3 – 6 years T4 – 8 years T5 – 9 years	Low income mother-child dyads (n=317) USA	CEBQ (food fussiness subscale)	CFQ (pressure to eat and restriction subscales) and CFSQ both used at T2, T3 and T5	Avoidant eating was associated with restriction and demandingness. There was no significant association between the pressure to eat trajectories and avoidant eating trajectories. Authors speculate demandingness measured by the

						CFSQ may have picked up examples of pressure to eat not captured by the CFQ.
(Finnane et al., 2017)	To determine relationships between feeding practices concerning structure and nonresponsive feeding practices, and child eating behaviours	Cross-sectional	Parents (online international sample, but majority New Zealand or Australia) (n=413) Child age: 1-10 years	CEBQ	FPSQ-28	Persuasive feeding and lower structuring correlated positively with avoidant eating and lower eating enjoyment. Feeding practices accounted for 28% variance in avoidant eating . Feeding practices accounted for 21% of the variance in enjoyment of food.
(Fries et al., 2017)	To determine relationships between feeding practices (according to observation and parental report) and food refusals in toddlers	Cross-sectional (self-report and observation)	Families – ethnically diverse but majority Caucasian and high income. (n=60) Child age: 12 – 36 months US families (research conducted in Switzerland)	CEBQ (food fussiness subscale) Observation	CFSQ Observation	More prompts to eat of any kind (including neutral prompts) correlated with more food refusals.
(Galloway et al., 2005)	To determine relationships between maternal fruit and vegetable consumption and maternal	Longitudinal (in relation to avoidant eating – other elements assessed cross-	Mother-daughter dyads (n=173) Non Hispanic	CFQ (picky eating subscale)	CFQ (pressure to eat subscale)	Maternal fruit and vegetable consumption was negatively correlated with maternal use of pressure to eat and child

	use of pressure to eat when the child was aged 7 years, and child avoidant eating at 9 years of age.	sectionally. Child age T1: 7 years T2: 9 years	White girls USA			avoidant eating.
(Gilmore, 2006)	To examine trajectories of eating behaviours and explore the relationship with parental control and mealtime conflict	Cross-sectional	two groups of children Group 1: aged 2-4 years (n=304) Group 2: Aged 7-9 years (n=319) Australia	Study specific questionnaire	Study specific questionnaire	Results are unclear due to how items are grouped (e.g., family involvement factor includes 'insists child eats everything') and nonresponsive practices are framed as adaptive (e.g., coaxing a child to eat more).
(Goulding et al., 2014)	To assess maternal feeding practices by means other than parental report. To determine relationships between maternal depressive symptomatology and use of responsive feeding practices	Cross-sectional Observational	Low income mothers (n=295) Child age: 4-8 years USA	CEBQ (food fussiness subscale)	Researcher administered questionnaires: CFQ & CFSQ semi-structured narrative interviews videotaped observations (home and lab)	Maternal depressive symptomatology was associated with less use of responsive feeding practices. Maternal depressive symptomatology was associated with greater self-reported pressure to eat and demandingness. Laboratory observations showed no associations between depressive symptomatology and encouragement or discouragement of eating.

(Gregory et al., 2010a)	To determine relationships between maternal perception of child weight, child BMI, child eating behaviours and maternal feeding practices	Cross-sectional	Mothers (n=183) Child age: 2-4 years Australia	CEBQ (food fussiness and food responsiveness subscales)	CFQ (restriction, pressure to eat and monitoring subscales)	Pressure to eat was significantly associated with maternal concern about underweight. Avoidant eating partly predicted pressure to eat, a relationship partly mediated by concern about underweight. Child BMI alone did not predict pressure to eat, therefore the authors concluded that pressure to eat was driven by perceived rather than actual child weight.
(Gregory et al., 2010b)	To examine relationships between maternal feeding practices, child eating behaviour and child weight through longitudinal research	Longitudinal T2 was 2 months prior to T1	Mothers (n=156) Child age: 2-6 years Australia	CEBQ (food fussiness and food responsiveness subscales)	CFQ (restriction, pressure to eat and monitoring subscales)	Pressure to eat predicted reduced food interest. No prospective association between pressure to eat and avoidant eating was identified. The authors highlight that their sample size was small given the study aims.
(H. Harris, Jansen, et al., 2018b)	To determine the role played by concern in parental use of nonresponsive feeding practices in the context of avoidant eating and socioeconomic	Cross-sectional	Socio-economically disadvantaged families (n=208) Age of children: 2-5 year Australia	CEBQ (food fussiness subscale)	FPSQ 28 (persuasive feeding and reward for eating subscales)	Maternal concern fully mediated the relationship between avoidant eating and persuasive feeding. Concern (maternal and paternal) fully mediated the relationship between avoidant

	disadvantage					eating and reward for feeding. Perceived degree of avoidant eating was consistent across mothers and fathers but levels of concern were higher in mothers.
(H. Harris, Jansen, et al., 2018a)	To examine level and concordance of nonresponsive feeding practices in mothers and fathers, and their relationship with child avoidant eating in this population	Cross-sectional	Socio-economically disadvantaged families (n=208) Age of children: 2-5 year Australia	CEBQ (food fussiness subscale)	FPSQ-28	Mothers and fathers who were concordant in their lack of use of nonresponsive feeding practices reported lower levels of chid avoidant eating. In families where either the father, mother or both parents reported high levels of persuasive feeding, reported levels of child avoidant eating was also higher.
(Haszard et al., 2015)	To determine relationships between child problematic eating behaviours, dietary intake and parental feeding practices	Cross-sectional	Parents of children assessed as overweight (n=203) Age of children: 4-8 years New Zealand	Questions relating to 'problem food behaviours' in the Lifestyle Behaviour Checklist (LBC)	CFPQ	'fussy eating' was negatively associated with monitoring. Fussy eating' was defined on the basis of behaviours considered problematic to the parent rather than limited dietary variety. 'Fussy eating Behaviours' (e.g., whining) were associated with less monitoring and more parental use of pressure and restriction.

(Haycraft et al., 2017)	To compare maternal feeding practices and child eating behaviours in groups of mothers who are classified as obese / everweight, and who are not	Cross-sectional	Mothers (n=437) Child age: 2-6 years UK	CEBQ	CFPQ	Maternal weight and use of pressure to eat were not associated. Mothers classified as obese / overweight reported higher levels of avoidant eating (as measured by the CEBQ) in their children.
(Jacobi et al., 2003)	To validate the concept of parent-reported picky eating using objective, laboratory-based measures and to identify both child and parental precursors and concomitants of picky eating	Longitudinal Children monitored annually from birth to 5.5 years	A cohort of newborns followed up to the age of 6.5 years (n=135) USA	Stanford Feeding Questionnaire (unvalidated, study-specific instrument)	Stanford Feeding Questionnaire and laboratory assessment	There was a strong correlation between frequent struggles over food and avoidant eating. Parents of avoidant and nonavoidant eaters were similarly likely to use reward to incentivise eating. Avoidant eating positively correlated with child negative affect. Laboratory assessment concurred with parental report of avoidant eating.
(Jani et al., 2014)	To determine relationships between maternal use of controlling feeding practices and their concerns and perceptions about child weight and	Cross-sectional	Indian migrant mothers residing in Australia for 1-8 years Child age: 1-5 years (n=230) Australia	Single item question about the parents' perception, with four responses: Very picky, somehwh	CFQ (restriction and monitoring subscales) CFPQ (pressure subscale)	Parental perceptions of child weight did not correlate with parental use of controlling feeding practices. There was a positive correlation between the use of pressure to eat

	avoidant eating.			at picky, not picky, not sure		and maternal assessment of the child as an avoidant eater.
(Jani et al., 2015)	To determine relationships between maternal use of controlling feeding practices and child appetitive traits, including avoidant eating. Child diet was also assessed.	Cross-sectional	Australian-Indian mothers (n=203) Child age: 1-5 years	CEBQ	CFQ (restriction and monitoring subscales) CFPQ (pressure subscale)	There was a positive correlation of pressure to eat and avoidant eating. Pressure to eat correlated negatively with eating enjoyment. Pressure to eat was associated with less food consumption.
(E. Jansen et al., 2014)	To construct and carry out initial validation of the feeding practices and structure questionnaire (FPSQ)	Cross-sectional	First time mothers and their and children (n=462 dyads) Child age: 21–27 months From the NOURISH trial Australia	CEBQ 24 hour dietary recall (based on a food list provided)	Drew on several extant measures including: CFQ CFSQ PFSQ And Satter's sDOR model	The four nonresponsive feeding practices *(distrust in appetite persuasive feeding, reward for eating, reward for behaviour)* and overt Restriction were positively correlated with fussiness, persuasive feeding and reward for eating were also negatively correlated with enjoyment of food.
(P. Jansen et al., 2017b)	To assess the direction of the relationship between avoidant eating and parental use of pressure to eat	Longitudinal T1 = 1.5 years T2 = 3 years T3 – 6 years	Mothers and children from the population-based Generation R cohort (n=4845 dyads)	Child Behaviour Checklist (CBCL)	CFQ	significant bi-directional associations between pressure to eat and avoidant eating were found Pressure conceptualised as including:

						• gentle encouragements • gentle prompts • rewards • punishment • food-trying rules • rules about finishing meals
(P. Jansen et al., 2014)	To determine relationships between children's eating behaviours, parental feeding practices and child weight	Cross-sectional	Same sample as P.Jansen et al., 2017b (n=4987) Child age: 4 years Netherlands	CEBQ	CFQ	Pressure to eat was negatively correlated with (objectively measured) child BMI. Part of the association between children's eating behaviors and BMI was explained by relations between parental feeding practices and child BMI. The authors concluded that this implies complex patterns of association between these variables.
(Kutbi, 2020)	To examine bidirectional relationships between child eating behaviours (avoidant eating) and maternal feeding practices	Cross-sectional	Convenience sample of mother-child dyads (n=195) Age of children: 1-7 years Saudi Arabia	FNS CEBQ (picky eating subscale)	Adapted subscales of the CFPQ, including the pressure to eat subscale	Positive two way associations between pressure to eat and avoidant eating were found.
(Kutbi et	To determine	Cross-	Mothers of	CEBQ	CFPQ	Found a

al., 2019)	the relationship between *socioenvironmental factors and avoidant eating*	sectional	children with no health issues or allergies. Convenience sample from schools. (n=216) Child age: 3-7 years Saudi Arabia	(picky eating subscale)		bidirectional relationship (positive two way association) between pressure to eat and avoidant eating *Note: this study found an unusually high prevalence rate of avoidant eating.
(Lumeng et al., 2018)	To determine patterns of association between maternal use of pressure feeding, child growth, and avoidant eating	Longitudinal T1: 21 months T2: 27 months T3:33 months	Cohort sample (low income) (n=244) USA	Food Fussiness Subscale Items from CEBQ-T Food refusal and limited variety items from BAMBI	Infant Feeding Styles Questionnaire (IFSQ; Thompson et al., 2009, pressuring to finish subscale)	'Pressure feeding' was associated with avoidant eating concurrently but did not predict growth. Avoidant eating did not predict future pressure feeding or vice versa. Authors highlight that measures used may not have captured more coercive examples of pressure to eat. Also highlighted that research over a longer follow-up period is required to further explore any causal links between pressure and avoidant eating.
(Mascola et al., 2010)	To determine the prevalence, trajectory and characteristic	Longitudinal Annual assessment between the ages of 2 and	Children and their parents (n=120 dyads)	Stanford feeding questionnaire	CFQ and Stanford feeding questionnaire	Avoidant eating was associated with struggles with their child over the types of foods eaten

	s of avoidant eating	7 years, then at 9.5 and 11 years	Population sample. Reecruited as newborns – Stanford Infant Growth Study		Parenting style also assessed	Parents of avoidant eaters were not more likely to use pressure to eat in this sample Note: the first finding seems to contradict the second. Parents of boys who were avoidant eaters were more likely to offer rewards for eating
(McPhie et al., 2011)	To examine maternal correlates of child eating behaviours and BMI	Cross-sectional	Mothers (n=175) Child age: 2-5 years Australia	CEBQ (food fussiness and eating enjoyment subscales)	CFQ Mother/child interactions also assessed: With a subscale of the Parenting Stress Index Parenting style also assessed (warmth and control subscales from a measure used in an earlier study)	Pressure for her child to eat was significantly positively correlated with avoidant eating and negatively correlated with child eating enjoyment.
(Moroshko & Brennan, 2013)	To determine relationships between maternal controlling feeding practices,child eating and child weight	Cross-sectional	Mothers child dyads (n=90) Age of children: 2-5 years Australia	The Child Food Neophobia Scale (Pliner, 1994) CFQ (Picky Eating	CFQ (restriction and pressure subscales) CFSQ Authoritarian Feeding subscale	Food avoidance was associated with an authoritarian Feeding style Pressure to eat was significantly associated with avoidant eating

				subscale)		Note: the controlling feeding practices did not account for all the variance in child eating behaviours, therefore the authors conclude that other factors or mechanisms may be at play.
(Morrison et al., 2013)	To determine relationships between maternal feeding practices, maternal eating behaviours and child weight	Cross-sectional	Headstart children and their mothers (n=222 dyads) Age of children: 2.8-5.8 years Ethnically diverse sample - 50% (approx) Latino, 50% African American USA	CEBQ	CFQ CFSQ	External maternal eating correlated with child avoidant eating and this was mediated by the use of controlling feeding practices. Proposed causal model: mothers with higher levels of external eating attempt to control their children's eating to a greater degree, resulting in more avoidant eating.
(Mosli et al., 2021)	To examine the hypothesis that mothers' mealtime stress mediates the association between avoidant eating, maladaptive feeding practices and concern about the child's diet	Cross-sectional	Mothers (n=100) Age of children: 3-5 Saudi Arabia	CEBQ (Food Fussiness subscale)	CFQ – A (Arabic version of the CFQ) Food as reward was measured by The Meals in Our Households (MOH) Questionnaire instead of the reward	Concern about child's diet and maternal mealtime stress levels were both positively associated with avoidant eating. Maternal mealtime stress was associated with the use of pressure to eat. Maternal mealtime stress

					question from the restriction subscale of the CFQ	mediated the association between avoidant eating and concern about the child's diet with maternal pressure to eat.
(Pelchat & Pliner, 1986)	To examine variables associated with child-feeding problems (including parenting practices)	Cross-sectional	Mothers (n=79) Age of children: 2-7 years Canada	Feeding history and habits questionnaire (including: finickiness, neophobia and consumption of insufficient quantities) Food preference questionnaire (both study-specific)	Feeding history and habits questionnaire – developed in this study	Parent-perceived feeding problems and reduced dietary diversity were associated with prodding, rewarding for eating and punishing (categorised under the 'contingency' factor). The authors highlighted that the causation of the relationship between contingency and feeding problems could be in either direction.
(Podlesak et al., 2017)	To determine relationships between parenting style and parent and toddler mealtime behaviours	Cross-sectional	Parents (n=525) Age of children: 2-5 years USA	Question in the MAS: "Is your child a picky eater" (no definition provided).	Mealtime Assessment Survey (MAS; Boquin et al., 2014) Parenting Styles and Dimensions Questionnaire	Negative mealtime strategies (including rewards and pressure) were positively correlated with avoidant eating and both a permissive and an authoritarian parenting style, Reward being connective with the former and pressure with the latter.

						Authoritative parenting correlated with children looking forward to meals (a proxy for eating enjoyment?).
(Powell et al., 2011)	To determine the relationship between maternal feeding practices and child avoidant eating, after controlling for child temperament, and maternal dietary restraint	Cross-sectional	Mothers (n=104) Child age: 3-6 years UK	CEBQ	CFPQ	Higher levels of food avoidance were associated with significantly more use of pressure to eat (after controlling for child temperament and maternal dietary restraint). The authors speculated that the relationship between pressure to eat and avoidant eating is bidirectional.
(Powell et al., 2018)	To determine the reliability of mothers' reports of their feeding practices and their child's eating behaviours. To examine the stability and continuity of maternal feeding practices and child eating behaviours (via both maternal report and researcher observation)	Longitudinal T1: age 3 T2: age 4	Parents (n=65) UK	Observation: Child Mealtime Coding System And A scale adapted from the Behavioural Coding Inventory CEBQ (subscales: food fussiness, slowness in eating, satiety responsiv	Observation: Family Mealtime Coding System (counting: use of pressure, use of physical prompts and use of contingencies like rewards) And The Feeding Interaction Scale	Both child eating behaviours and maternal feeding practices (according to maternal report and researcher observation) were stable and continuous over time, apart from child difficulty to feed and mothers' use of pressure to eat, which reduced significantly from T1 to T2. Maternal report of child eating behaviours was in agreement with observations. Maternal report of

				eness, enjoymen t of food)		feeding practices used (rewarding and use of pressure were assessed) was not in agreement with observations. The authors speculate that this could be due to the impact of the presence of the observer or a tendency in parents to underestimate their use of coercive practices.
(Rigal et al., 2012)	To validate a measure of feeding practices and child eating difficulties in a French sample. To determine relationships between feeding practices and child eating behaviours	Validation study	Mothers of children attending daycare (n=502) Child age: 20-36 months France	Develope d own instrumen ts	Developed own instruments	Validated questionnaires relevant to research question: Feeding style questionnaire - Outcomes: permissive, authoritarian, or authoritative) Feeding strategy questionnaire (to elicit information about the inducement of food-trying). Outcomes: coercion, explanation, contingency and preference. Child eating difficulties were associated with permissive and authoritarian approaches but the direction of causation was unclear.
(Sandvik et al., 2018)	To determine relationships between	Cross-sectional	Parents (n=1272)	CEBQ (food fussiness	CFQ (version valid in	Where avoidant eaters were assessed as

	child weight, avoidant eating, and child factors (including parental feeding practices)		Child age: 3.3-7.9 years Sweden	subscale, with new cut offs)	Swedish samples)	overweight / obese, parents used less pressure to eat. Pressure to eat was only associated with avoidant eating where child weight was low or typical. Avoidant eaters in all weight groups had lower eating enjoyment scores.
(Schmidt et al., 2018)	To determine categories of restrictive eating and examine relationships with shape concern.	Cross-sectional	Population-based sample Leipzig Research Center for Civilization Diseases (LIFE) cohort (n=799) Child age: 7-14 years Germany	Eating Disorders in Youth-Questionnaire (EDY-Q) - includes measures of avoidant eating.	CFQ	Parents of children who were in the low and high avoidant eating groups without shape concern, used more pressure to eat than parents of restrictive eaters with shape concern. The focus of this study was not parental feeding practices, although these were measured they were not reported on in detail.
(Seiverling et al., 2016)	To validate the BAMBIC in a nonclinical sample	Cross-sectional – comparison across groups	Parents of children in a Non-clinical group (n=356) Of whom: 212 - no special needs 58 - ASD 86 - other special	(The Brief Assessment of Mealtime Behavior in Children; BAMBIC; Hendy, Seiverling, Lukens, & Williams, 2013)	PMAS	Insistence on eating was associated with higher levels of avoidant eating. Children without ASD or special needs had less eating challenges but the patterns of association were similar across groups.

			needs Child age: mean 44.1 months			
(Tharner et al., 2014)	To develop a profile of avoidant eaters, and ascertain their characteristics	Cross-sectional, but considered data from 14 months also.	Population-based sample (n=4914) Child age: 4 years	CEBQ (version valid in Dutch samples)	CFQ (monitoring, restriction and pressure to eat subscales)	Avoidant eating was positively associated with pressure and negatively associated with monitoring.
(van der Horst, 2012)	To examine whether eating enjoyment and cooking enjoyment may reduce avoidant eating.	Cross-sectional	Parents (n=305) Child age: 6-12 years Switzerland	CEBQ (fussy eating and eating enjoyment subscales)	CFQ (pressure and restriction subscales)	Pressure was positively correlated with avoidant eating but this relationship was partly mediated by eating enjoyment
(Webber et al., 2010)	To examine alleged relationships between food avoidance (as measured by the CEBQ) and pressure to eat, and food responsiveness and restriction	Cross-sectional	Families (n=531) Child age: 7-9 years UK	CEBQ	CFQ	Food enjoyment was negatively associated with pressure to eat and food avoidance (food fussiness subscale of the CEBQ) was positively associated with it.
(Wright et al., 2007)	To examine the prevalence of feeding problems in toddlers and parental approach to feeding	Cross-sectional	Parents and children in a Population-based sample (Gateshead Millenium Baby Study) (n=455) Child age: 30 months UK	Study specific questionnaire examining parental perception of child-feeding challenges (including avoidant eating)	Study specific questionnaire including questions about how parents encourage children to eat and how they manage food refusal	A wide range of practices were used, including force and punishment in a minority of participants These practices were used more with children considered (by parents) to have eating challenges
(Zohar et al., 2020)	To determine the prevalence of avoidant	Longitudinal T1: approx. 3 years	From an original sample (n=1055)	Child Behaviour Checklist (CBCL)	CFQ CFSQ	Despite significant differences between the

	eating, as well as associations between parent and child characteristic	T2: approx.. 5 years T3: approx. 7 years	parents of children identified as avoidant eaters were selected for this study (n=109) as well as a group with children who were not avoidant eaters (n=106) Israel	including questions pertaining to eating behaviours CEBQ Child self-report (Foods I Like and Dislike; FILAD)		mothers of avoidant eaters in this study and the remainder of the sample from which they came, maternal feeding practices did not predict avoidant eating (or vice versa) in this study.

11.5 Appendix E: Pilot

Using the Minigroup to Refine the Methodology for a Qualitative Research Project Exploring Parents' Experiences of Picky Eating

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Abstract

This research case describes how the minigroup, or small focus group, method can be used to refine methodology for a qualitative research project. It was undertaken

during the first year ofthe first author's PhD exploring parental feeding practices in relation to picky eating. Although some researchers argue that a robust consultation process is an important element of carrying out sensitive and ethical research, the participant voice is seldom heard in relation to methodological considerations. This case outlines the process of conducting a minigroup which aims to prioritize the participant voice, to ensure that research is as sensitive and ethical as possible. There is also a consideration of some of the challenges inherent in consulting on qualitative methodology. Some practical suggestions for researchers and students wishing to use a similar approach are offered. Finally, this case provides an overview of the methodological changes made as a result of this consultation process.

Learning Outcomes

By the end of this case, students should be able to

- Appraise the value of using a consultation process such as a minigroup to refine methodology
- Understand how the minigroup method can contribute to methodological development in qualitative research
- Appraise the importance of ensuring that the participant information sheet is engaging, interms of recruitment
- Understand the value of refining interview questions with a view to enhancing sensitivity and clarity

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Project Overview and Context

As part of my funded PhD at Bishop Grosseteste University (BGU), Lincoln, UK, I (Johanna Cormack) am planning to carry out a qualitative study exploring how parents approach feeding children, whom they describe as "picky eaters." Although researchers have not agreed on a definition of picky eating, key characteristics of picky eating include the acceptance of a limited range of foods, fear of unfamiliar foods, and strong food preferences. I am intending to recruit my participants for this study (which I will refer to as my "main study" to avoid confusion) via health

visitors across Lincolnshire and Nottinghamshire National Health Service (NHS) Trusts. I will be using semi-structured interviews to explore what it is like to parent picky eaters, from both an emotional and practical point of view. This case describes how I used the minigroup method to refine the methodology for my main study. A minigroup is a small focus group with fewer than six participants.

Feeding children, as with many aspects of parenting, is a potentially emotive subject. I was keen to ensure that my (main study) interview questions were sensitive to this, as well as being clear and accessible. I also wanted to make my participant information sheet as engaging and easy to understand as possible, to enhance the recruitment process and proceed ethically.

This led me to carry out this consultation exercise using the minigroup method, before finalizing my methodology. Furthermore, to recruit via the NHS, I need to meet the required standards for the United Kingdom's Health Research Authority (HRA) ethical clearance. Using peer-led research to seek feedback on my methodology will be beneficial in this respect, as well as helping me to carry out sensitive research.

To consult on my methodology, I invited people who are similar to potential participants in my main study, to take part in a focus group. The purpose of the group was to talk about my main study participant information sheet and interview questions.

I hoped to gain some insights into how the information sheet and interview questions would be experienced by my main study participants, with a view to amending them in response to the group's feedback. My initial aim was to carry out a focus group with between six and eight people, as David Morgan (2005) states that this is the number of participants typically selected for focus groups. Seven people agreed to take part, three of whom canceled either on the day before the focus group was due to take place or the morning of the group. This left me with four participants. I decided to go ahead with the research because the literature on small focus groups (or "minigroups") indicates that low numbers are a viable approach to

data collection. Thomas Greenbaum (1998) suggests that they even offer potential advantages to researchers. Through the use of the minigroup, I was able to reflect on four key research questions:

- How can the minigroup be used to refine methodology in qualitative research?
- How can the minigroup be used to enhance ethics in qualitative research?
- How can I improve my participant information sheet?
- How can I improve my interview questions?

Theoretical Background Underlying the Case

The Minigroup Method

As noted earlier, a minigroup is essentially a small focus group. Focus groups are used in many areas of academic research. Henrique Freitas, Mirian Oliviera, Milton Jenkins, and Oveta Popjoy (1998) describe the focus group as "a type of in depth interview accomplished in a group" where the emphasis is on group interactions facilitated by a moderator (p. 2). They cite some practical advantages to this method of data collection, for example, that focus groups are relatively quick, inexpensive, and easy to conduct (however, it could be argued that it is easier to organize interviews and surveys).

Freitas et al. also describe advantages concerning face validity and the opportunities presented by focus groups, for the exploration of the topics of interest to the researcher. Here, "facevalidity" means the extent to which a method appears to explore the topic it purports to explore (Lewis-Beck, Bryman, & Liao, 2003). Equally, Freitas et al. summarize some disadvantages associated with focus groups, including the assertions that the atmosphere is not natural, interviewers must be carefully trained, and the data can be difficult to analyze.

Isabella McLafferty (2004) states that there is some disagreement regarding how a focus group should be organized, including in terms of the optimum number of

participants. Indeed, arguments range from prescriptive accounts of how many people a focus group ought to contain to the notion expressed by Paul Gill, Kate Stewart, Elizabeth Treasure, and Barbara Chadwick (2008) that focus groups can be effective with anything from three to 14 participants.

However, Lia Litosseliti (2003) describes how focus groups used in research in the social sciences usually fall into one of two categories: the full focus group, with between six and 10 participants, and the minigroup, with between four and six participants. Greenbaum (1998) defines the minigroup as "essentially the same as a full group, except that it generally contains4 to 6 persons" (p. 2). He describes some advantages of using the minigroup method, one being its format, which enables the collection of richer data. He also cites recruitment and other logistical challenges as possible reasons for opting for the minigroup.

The Participatory Ethos of the Minigroup

The participant voice is not currently prominent in relation to research ethics. According to Gianina-Ioana Postavaru (2017), participants' feedback about how they experience research and how they can contribute to the research design as experts has not been widely explored. Therefore, asking people for their views on research methodology specifically is not common practice. Malcolm Hill (2006) acknowledges that it is even less usual to publish feedback, where this has been sought. He suggests that this lack of consultation fits with a positivist paradigm where researcher is "the expert." From a social constructivist perspective, seeking feedback on methodology is in keeping with a view of research as co-created.

Research Practicalities

The minigroup took place at BGU and participants were recruited from among BGU staff. Having sought and gained institutional ethical approval, I made practical arrangements in terms of space and equipment (including the use of a whiteboard and audio-recording devices) and enlisted the help of an observer. The observer's

role was to note down any aspects of group interactions or non-verbal behavior, which would not be captured on the audio recording. This included my behavior, as well as that of the participants. She was also asked to note down any insights of her own. As the observer was not facilitating the minigroup, she was able to observeit with more detachment than I was. I was interested in any insights she gained from observing.

I intended to recruit minigroup participants who were as similar to the participants in my main study as possible. With this in mind, I invited parents of children aged between 24 months and 5 years, to take part. As the pool from which I was recruiting only included university staff, this in itself meant that my participants were not representative of the general population. However, by inviting expressions of interest from staff in any role at the university (rather than just academic staff), I hoped to increase diversity. I anticipate that the parents whom I will invite to take part in my main study will come from a range of socio-economic and ethnic backgrounds.

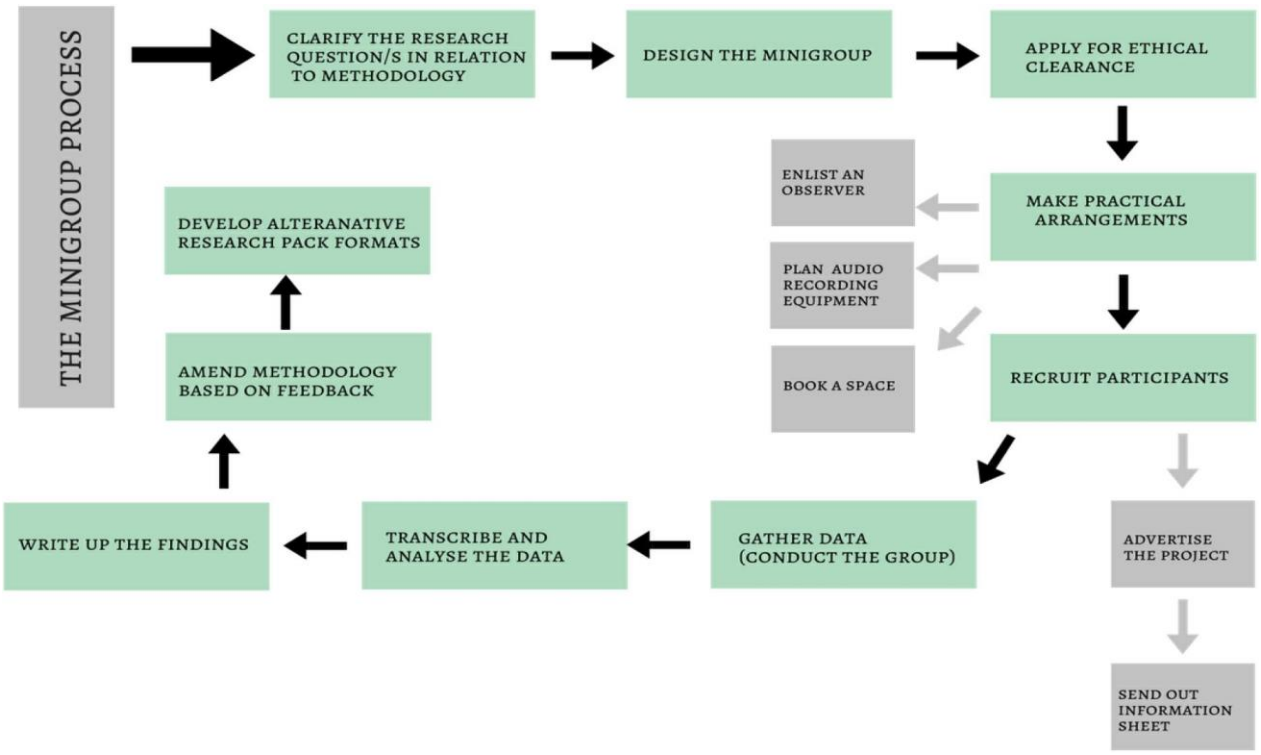
I created a colorful pdf poster advertising my project and used the staff portal—an online internal announcement system—to share my poster, inviting expressions of interest. I then sent the focus group participant information sheet to everyone who replied to my advert. This was to give potential participants a clearer idea of what the project was about and to help them toassess whether they felt they met my inclusion criteria and wanted to be part of the research.

I sent two email reminders, as well as an internal calendar invitation to all those who said they wanted to participate. This meant that the focus group would appear automatically on their electronic calendars (used by all BGU staff). In addition to planning the structure and timings of the focus group, I prepared slides using PowerPoint. Each slide featured one of my draft interview questions. I displayed these slides on the whiteboard during the part of the minigroup where I sought feedback on my interview questions so that participants could see the questions they were discussing and did not have to try and remember them.

Minigroup in Action and Data Collection

Figure 1 illustrates the stages and processes of the minigroup. The minigroup took place in a room on the BGU campus and lasted 90 min. I used two kinds of audio-recording devices tohave a back-up, in the case of any technical problems. I began with an introduction, where I offered everyone refreshments and welcomed them. I explained that I would be seeking feedback on the information sheet (for my main project) during the first half of the minigroup and on my interview questions during the second half.

Figure 1. The stages and processes of the minigroup.



I proceeded to go over the information sheet (relating to the minigroup), ensuring that everyone had read and understood it. I allowed 10 min to answer questions about the information sheetor any other aspect of the minigroup. I asked everyone to sign the consent form if they were happy to proceed. This was a separate document from the information sheet. It asked whether participants had understood the information sheet, whether they understood that participation was voluntary,

whether they were happy to be audio-recorded, and whether they were happy to consent to the research findings being shared.

I then assigned each participant a number and gave them a sticky label with their number written on, to attach to their clothes. I asked participants to refer to one another by their numbers to preserve anonymity and make it easier for me to establish who said what, when transcribing the data. We agreed upon ground rules such as remaining respectful, even when opinions differed. We also agreed that participants would respect confidentiality and would not disclose anything shared by other participants, outside the group. I gave an overview of whatthe remainder of the time would entail.

After a brief exercise exploring participants' initial responses to the short title of the main study, I asked for feedback on my main study information sheet. I asked all the participants to comment on any aspects of the information sheet that they felt were unclear or potentially insensitive. I was aiming to facilitate interaction and discussion among the participants, to better understand their views.

Having spent approximately 0.5 hr talking about the information sheet, I moved on to the draft interview questions for my main study. I displayed a PowerPoint slide of each of my 10 questions in turn. I wanted to know whether participants could understand the questions easily and whether they felt that the tone was sensitive and appropriate. Where the group commented on other aspects of the questions, I allowed this to unfold, but used my focus on clarity andtone as a basic structure for this part of the minigroup.

To bring the minigroup to a close, I thanked everyone for their contributions and reiterated some of the points on the information sheet, regarding dissemination of the findings and how participants could be kept informed if they wanted to be. Finally, I checked whether anyone wanted to ask me anything further. I also made sure that no one felt upset in any way, having spent time reflecting on some issues that were potentially emotive. I did this by verbally inviting any participant who felt distressed to talk this through with me before leaving, if they felt they needed to.

Data Analysis

After having transcribed my audio-recorded data, I analyzed it using thematic analysis (TA). According to Virginia Braun and Victoria Clarke (2017), TA is a flexible approach to data analysis, which works well with qualitative approaches such as focus groups. The authors also state that it is suited to both small and large data sets. As such, it seemed to be a good fit for this project.

Findings

In relation to the participant information sheet, I was surprised that participants talked about a lack of trust. Several people felt that academia itself can be alienating to some. For example, the term "PhD" could be experienced as distancing and confusing. Participant 2 said of PhDs:"*A lot of people are gonna put themselves outside of that—they're gonna not even know what that means*." Equally, there was a sense that potential main study participants may distrust me, as researcher. They would want to know more about who I was and what my motivations were. For example, with reference to my statement "we will be happy to discuss these [any questions about the information sheet] with you," Participant 1 said, "*I don't know who "we" are … straight away … who are you?*" Participants also felt that the traditional information sheet was not very engaging. They used the color pdf poster I had used to recruit for the minigroup as a comparison. There was a strong sense that attractive design and the use of color would make the information sheet much more interesting to potential participants. For example, Participant 2 called for: "*Visual, pictures—do you want to get involved in blah blah blah*?", suggesting an information sheet which was "*more leaflety, with bullet points*."

There was also a shared need to make the information more accessible and interesting, as well as having it disseminated through different channels and in different formats (specifically formats which are accessible online, like a video or a Facebook page). For example, Participant 4 was very positive about the idea of an online video version of the information sheet, saying, "*you could just click on a link*" and "*People can click on it on their phone*." Equally, some participants felt that the

information sheet should not be too long. Participant 2, talking about the detailed inclusion criteria on the information sheet, said that "*people don't often read it*" (lengthy paperwork).

Although all participants spoke enthusiastically about the concept of a video and leaflet version of the information sheet, some people also felt that there was still a role for the traditional, A4, black-and-white information sheet. They talked about how people use their mobile phones asthe primary means of accessing information these days. Providing the information sheet in different formats, such as a video, also caters to divergent levels of literacy.

Along with a consideration of its format and presentation, participants discussed the emotional sensitivity of the information sheet. This was something I was anticipating, as it was one of the key areas I asked them about. They were very tuned into how potential participants might feel when reading the information sheet. They talked about a fear of judgment and the importance of making sure that emotional discomfort was kept to a minimum.

For example, on the subject of possible distress to my main study participants, I had written on the information sheet: "if speaking with the researcher [after the interview] has not resolved your difficult feelings, you will be given details of local counselling services." Participant 1 felt that my phrase "difficult feelings" was problematic, saying,

> I don't know quite … it was the wording of it I found difficult—[quoting] "If this does not resolve your difficult feelings"—for some reason it's the word "difficult feelings" … I don't know … . I recognize it's not being judgmental but you could take it as being judged.

Much of the feedback participants offered in response to my draft interview questions was also concerned with emotional sensitivity. Their ideas seemed to reflect a powerful empathic imagining of how my main study participants might feel when taking part in my study. For example, in relation to my interview question "How do you respond to your child's eating?", Participant 1 said, "*I think actually, you might get a lot of emotion from that question!*" Later, in relation to my

question “How supported do you feel in relation to your child’s eating, by your friends, family and partner (if you have one)?”, Participant 2 commented, “*I think there might be tears at this point as well, to be honest*.”

There was an awareness of how personal some of my questions may feel and the possibility of participants having many challenging emotions about their children’s eating, including guilt. In response to my question “How confident to you feel about how to manage your child’s eating?”, Participant 2 said,

> Again, that might elicit some emotional response, in that … you know … I tried X strategy and it was the worst thing I could have done, and I feel terrible about that. I think there might be some of that there.

Word choice was seen as important and was in fact the other area I had asked about explicitly, along with emotional sensitivity. Although I let conversation flow and did not attempt to highly structure minigroup participants’ feedback on my interview questions, I did ask them specifically for their opinions on the clarity of each interview question and the emotional sensitivity of each interview question.

An example of feedback about my choice of words is Participant 3’s illustration of how my useof the term “feeding” to talk about feeding pre-school children felt odd to her. She hears“feeding” and thinks of breast feeding: “*Yeah, like if this book’s on feeding, yeah, let’s talk about breast feeding*.” “Feeding” is a technical term in the context in which I was using it, and the feedback about how this may be heard and understood by a lay person was very useful to me.

Discussion

Reflections

The minigroup method proved effective for my consultancy exercise for several reasons. First, it

suited my personality; as an introvert, I am much more comfortable facilitating discussions in small groups. During the minigroup, I felt relaxed and focused in a way that would have been much harder for me in a larger group. Second, perhaps

partly because I was at ease, thegroup felt intimate and friendly. There was a lot of humor used by all participants, often immediately juxtaposed with the sharing of emotional or personal feedback.

Perhaps the small number facilitated this convivial dynamic, helping the group form connections early on and bond through humor. Finally, there was room for dissent in the group

discussions. I tried to encourage this by asking participants with differing opinions to expand upon their points of view. Participants seemed comfortable with expressing divergent opinions. It is questionable whether they would have been as able to disagree with one another in alarger group.

Throughout the minigroup, there appeared to be a tension between my research aims and the needs of the minigroup participants. Participants were often keen to actually answer my draft interview questions, in relation to their personal experience, rather than consult on the tone and clarity of the questions. It was striking that three out of the four participants had personal experience of parenting a child who was a picky eater, although this was not one of my inclusion criteria for the minigroup.

The fact that the majority of my minigroup participants were parents of picky eaters suggests that they were especially interested in taking part in this project because of their personal histories. It also meant that they had a lot to say about the subject of picky eating. This both helped them identify with participants in my main study and meant that they had strong feelings about the subject area. Sometimes this made it hard for me to guide participantstoward staying with the task of discussing the questions rather than answering them.

I tried to maintain a balance between allowing the participants to express themselves andremaining focused on the areas of feedback I was asking for. I am not sure how successfully I managed this. If I were to consult on methodology in the future in a similar context, I wouldhope to be clearer about the task at the outset and would perhaps try to take more control over the direction the conversations took.

It was also difficult—especially initially—to be clear about the distinction between the information sheet relating to the minigroup itself and the information sheet relating to my main study, about which I was seeking feedback. This led to misunderstandings at times. With hindsight, I would have made more effort to explain this difference. For example, I could have verbally checked that all participants understood that there were two information sheets in the room and why. This potential confusion is a challenge inherent in consulting on methodology; the methodology employed for the consultation process must be distinct from the methodology being consulted upon.

Similarly, before the minigroup took place, a potential participant emailed me to find out whether she would be asked about her child's eating. She felt that this was unclear even though I had attempted to clarify it in my advert and information sheet. Other participantsactually arrived thinking they would be asked about their child's eating behaviors. In a situation as potentially confusing as this, I think I could have done more to explain the remit and purpose of the minigroup. Perhaps alongside the written information contained in my pdf poster and participant information sheet, I could have arranged a brief telephone conversation with the participants prior to the minigroup. This would have enabled me to reiterate exactly what the minigroup was about and would have provided an additional opportunity for participants to ask questions.

Humor was a key feature of the minigroup and it was my impression that all participants bonded as a group very quickly. There was a lot of laughter and a lot of sharing of personal stories. An example of humor was the reaction to my question "can you tell me a bit about your relationship with food?":

> [whole group laughs]
> Participant 2: "Oh my word!"
> Participant 1: "You will need a lot of tissues!"
> Participant 3: "You are going to take 5 hours for these interviews!" [whole group laughing loudly]

Perhaps participants' shared experience of parenting young children and ability to laugh together contributed to the sense of the group being a safe space where potentially difficult topics could be discussed. This was supported by minigroup members' comfort with expressing divergent opinions discussed previously—an intrinsic element of what makes focus groups such a successful approach to data collection. Jenny Kitzinger (1995) describes two purposes served by dissent: it encourages participants to further explain their views and it helps them become clearer about why they may hold certain opinions.

The observer shared her insight that at times, I had been keen to justify my main study design and methodology when this was questioned, rather than remain in a facilitative role. For example, when a participant questioned why I was not also researching the connection between sleep and feeding, I tried to explain the need for a narrow research focus. I also found it hard to keep my responses neutral and non-evaluative, responding, for example, "That's a great idea." Richard Krueger (1994, cited in Litosseliti, 2003) describes how this can lead to bias because participants may attempt to say things that are similar to earlier responses which were met with praise, to please the facilitator.

Finally, there was a tension between what I needed to include to meet my obligations as an

ethical researcher and what participants felt was appropriate. Again, it was hard not to justify my rationale for what I had included on the participant information sheet. For example, several participants felt that the mention of "risk" would be experienced negatively by my main study participants. However, an essential part of ethical research practice is an honest and direct appraisal of any potential risks to participants, including emotional distress.

Changes to My Information Sheet

As a result of the feedback gained from the minigroup, I made several changes to my information sheet. Some of these changes were at a textual level. These usually concerned the amendment of specific words which participants felt could be experienced as insensitive, hardto understand, or judgmental.

The most significant change concerned the format of the information sheet. I decided to develop a simple website (https://pickyeatingresearchbgu.com/) to host multiple versions of it (the traditional information sheet, a leaflet, and a video). This was in response to call for the information sheet to be presented in different formats and the feedback regarding the value of having information available to access online. The leaflet and traditional information sheet are available to download as pdfs and the video is embedded on the website.

I began the video with an overview of who I was, what a PhD was, where I was studying, and why I was doing this particular piece of research. I included a photograph of myself and narrated the video myself, thinking this may address the issues of distrust which came up in my data analysis. I found that a key benefit of the video format is that I was able to verbally unpack some of the more complex elements of the information sheet in a way that may have been more difficult in writing. This medium also allowed me to juxtapose the more formal elements of the information sheet with a more informal and friendly tone. For example, I included a piece ofmusic (with appropriate permissions) as the video opens.

I developed a pdf leaflet which was colorful and accessible, with information presented as briefly as possible. I used photographs to illustrate it,in the hope of making it more eye-catching and relatable. I also made a few changes to my actual information sheet in terms of language and what information was presented at the beginning, starting with a statement about me and my affiliations. This was an attempt to give participants some context for the project at the very outset, to diminish possible suspicion about me or my research.

Changes to My Interview Questions

While keeping the content of my draft interview questions essentially the same, I made changes in two key areas. The first had to do with the order of the questions, beginning withmore general, factual, and less personal questions, as well as bearing chronology in mind. The second concerned word choice, moving away from any language that participants had highlighted as potentially insensitive or judgmental. I also changed some terminology that could be seen as jargon. In some cases, participants not only identified potential issues withmy wording, they

also suggested alternatives. For example, the participant who objected to the phrase "difficult feelings" (quoted earlier) suggested I use "concerns" instead.

Practical Lessons Learned

Over-recruit. Whether planning a focus group or a minigroup, it is important to recruit the maximum number of group members which you could accommodate. This is to allow for people deciding not to attend at short notice.

Be extremely clear about the purpose of the group, both during the recruitment process and at the outset of the group, before participants sign the consent form. When consulting on methodology in relation to another study, it is essential to be very clear that you are not recruiting participants for the study being consulted on. You may need to reiterate this message several times, as well as checking participants' understanding.

Be extremely clear about the distinction between the participant-facing paperwork for the minigroup and the paperwork you are consulting on. It is easy for misunderstandings and confusion to arise as a result of potentially having a consent form and information sheet whichyou are seeking feedback on, and a consent form and information sheet which relate to the minigroup.

When consulting on interview questions, be very clear about the fact that you do not want participants to answer the questions themselves. It is a natural reaction when faced with a question that is relevant to our own experience, to think about how we would answer it. When that question relates to an issue which is potentially emotive, this phenomenon is even more powerful. To avoid participants' instinctive urge to answer interview questions which you are consulting on, discuss this explicitly at the outset.

While attempting to keep to a plan and retain focus, some flexibility is important. There will be some issues upon which participants have a large amount to say and others where they are less forthcoming. Some discussions will take surprising turns and this may be where the most interesting data emerge. It is important to be able to strike a balance between being led by participants to an extent while maintaining an appropriate level of structure.

Conclusion

The minigroup is a method of data collection which novice and student researchers may want to consider using. Through my use of the minigroup, I found that I was able to gather feedbackon my (main study) participant information sheet and interview questions, in an environment where minigroup participants seemed relaxed and willing to share their opinions.

Alongside the benefits of the minigroup method, I have attempted to describe some of the challenges I experienced along the way. If you are considering using this method of datacollection to consult on methodology, your minigroup needs to be carefully planned and executed. Clarity is essential because there is a lot of room for confusion when asking participants to comment on questions and documentation relating to another study.

The central findings from this minigroup were that my main study interview questions need to be asked in a way that is sensitive to participants' feelings and that the main study information sheet needs to be accessible and engaging. I was especially interested to learn how thisaccessibility and engagement could perhaps be achieved through a recognition of how people prefer to communicate these days: using mobile phones and the Internet.

Exercises and Discussion Questions

1. When consulting on methodology using a minigroup, what steps could you take to ensure that minigroup participants understand the nature of the exercise and do not mistakenly assume they are being asked to take part in the study being consulted upon?
2. What are some advantages and disadvantages of using a minigroup to gather data? 3.What is the role of the minigroup facilitator?
4. In what ways can interview questions be improved through seeking feedback?
5. What other formats would you recommend for the participant information sheet, thinking particularly about social media and how people use the Internet these days? How would you go about "testing" these formats?

Further Reading

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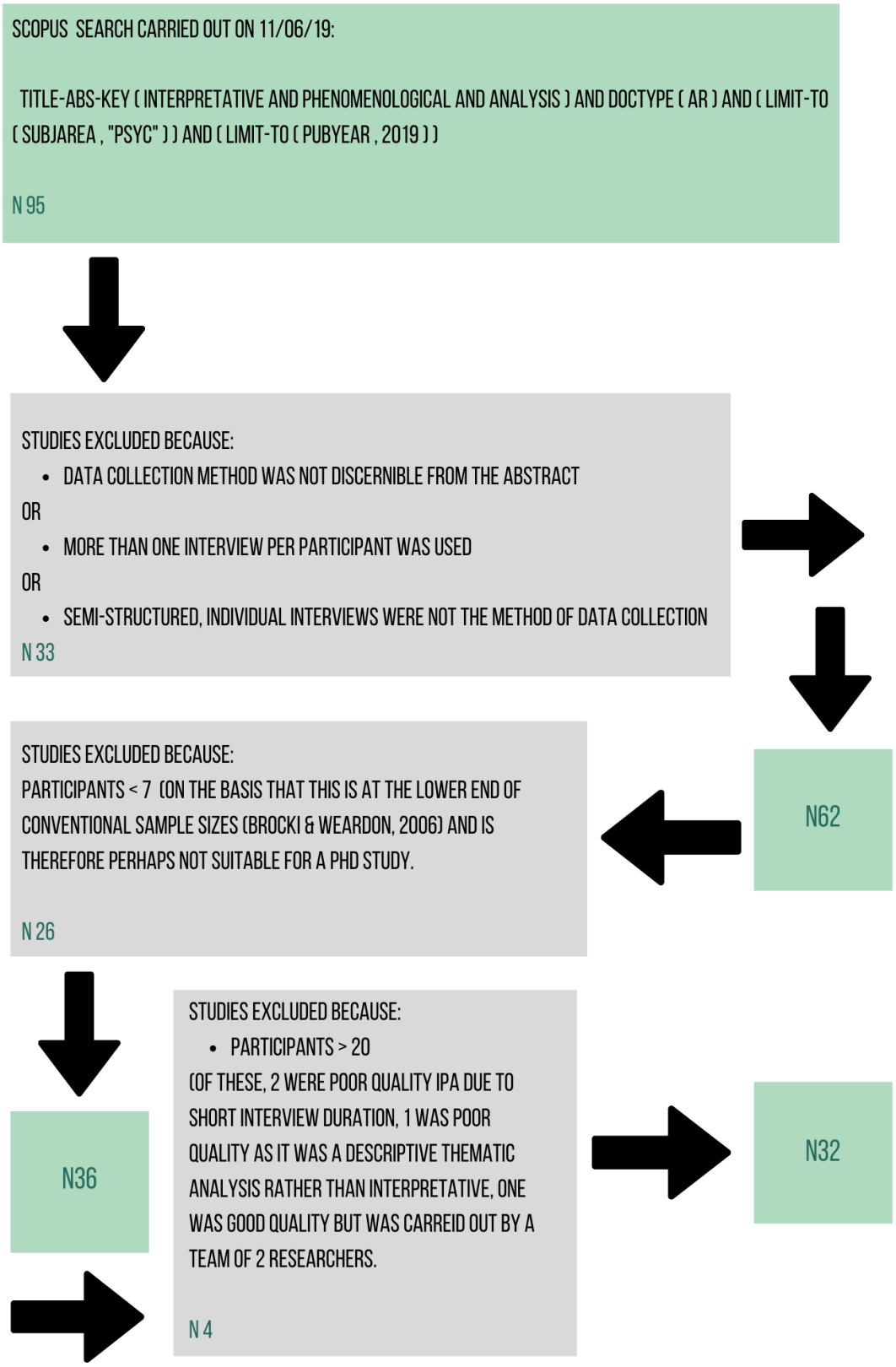
11.6 Appendix F: Flowchart re Sample Size Search



This search was repeated for 2019 to June, 2021 and it yielded over 2,000 results. It was not possible to analyse the sample sizes used in these studies due to the volume of results. This is, however, evidence for the proliferation of IPA in psychology in recent years.

11.7 Appendix G: Recruitment Flyer for the IPA Study

BISHOP GROSSETESTE UNIVERSITY

v2 19/12/17

Invitation to take part in a research project

Hi! My name is Jo Cormack and I am a PhD student at Bishop Grosseteste University, Lincoln. Your health visitor has given you this invitation because you may be a suitable participant for my research project.

"I am researching picky eating and I really want to understand this stressful problem from your point of view. I believe that in order to support parents, we need to know more about what they think and feel. I'm a mum of three myself, so I know that parents have some very important insights which we can learn from..."

Would you like to be part of this project?

If you think you may be able to help, you can either email me for more information, telephone me (01522 583782) or visit the project website to find out more.

www.pickyeatingresearchbgu.com

johanna.cormack@bishopg.ac.uk

- Is your child aged between 24 months and five years (but not yet at school) ?
- Would you describe them as a 'picky eater' ?
- Would you like to be part of research which may help families in the future?

Can you help? Get in touch today.

Taking part will involve a 60 - 90 minute interview with Jo (the researcher). Your expenses would be covered. Your decision will NOT affect the support you will get from your health visitor and what you say will be confidential.

11.8 Appendix H: Covering Letter to Health Visitors

BISHOP GROSSETESTE UNIVERSITY

Bishop Grosseteste University
Longdales Road
Lincoln
LN1 3DY
www.bishopg.ac.uk

Telephone +44 (0)1522 527347
Fax +44 (0)1522 530243
Minicom +44 (0)1522 583682

Health Visiting Team

07/11/17 v1

Dear Health Visitor,

I am writing to ask for your help and support in relation to a research project I am conducting as part of my PhD. I am a full-time PhD student at Bishop Grosseteste University and the focus of my research is how parents approach feeding children who are picky eaters. As you will be aware, picky eating is an extremely common parenting challenge and I want to learn more about how parents feel about it and how they respond to it.

I would be extremely grateful if you could share my project invitation with parents who approach you for help with picky eating.

Detailed project information can be found on the attached Participant Information Sheet (PIS). However, for your convenience, I have summarised the inclusion criteria relevant to you, as follows:

Please give parents my project invitation if you can answer 'yes' to all the following questions:

- They have a child aged between two and five years (who is not yet statutory school age)
- They have approached or been referred to you for help with picky eating
- You are happy that their child's weight or growth is not a concern
- You have not suggested that they seek an onward referral (eg. To the GP)
- Their child is not adopted or in a foster placement
- Their child has no clinical diagnosis or health problem that explains their picky eating

Please note: this is not a comprehensive list of inclusion criteria for this study, but includes those which you may reasonably be able to consider in the course of your standard service provision. Suitability for inclusion will be assessed by me once a potential participant has responded to my invitation.

Yours faithfully,

Johanna Cormack

BA(hons) MA MBACP
PhD Student (full time)
Bishop Grosseteste University

11.9 Appendix I: Participant Consent Form

V2 - 14/12/17 IRAS ID: 217450

RESEARCH CONSENT FORM

BISHOP GROSSETESTE UNIVERSITY

Title of research project
Short title: **Exploring parents' experiences of picky eating**

Name of researcher:
Johanna Cormack

	YES	NO
1. I confirm that I have read and understand the information sheet for the above research project and have had the opportunity to ask questions. If I have had any questions, these have been answered to my satisfaction.	☐	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my child's medical care or my legal rights being affected.	☐	☐
3. I consent to the data I share being used as the researcher sees fit, including publication. I understand that all data will remain confidential apart from in exceptional circumstances where confidentiality needs to broken due to a risk to myself or someone else. I understand that my name and any identifying details will be changed, in order to keep what I share confidential.	☐	☐
4. I agree to being recorded (audio only) during this research	☐	☐
5. I agree to taking part in this study	☐	☐

Name of participant :

Signature:

Date:

Name of researcher:

Signature:

Date:

11.10 Appendix J: Interview Schedule

08/11/17 v1

Johanna Cormack – Exploring Parents' Experiences of Parenting Picky Eaters

The bullet points are prompts to use as needed. Information in square brackets are reminders for the researcher.

1) **What does 'picky eating' mean to you?**
   [*How is it defined by the participant, what would they consider 'normal' eating etc.*]

2) **Can you tell me about your child's eating to date?**

- How did feeding go when your child was a baby?
- What was weaning like?
- How has their eating changed over time?
- When did you first notice signs of picky eating?

3) **Can you tell me about what your child's eating is like on a day-to-day basis?**

- Who usually eats with your child? Do you often have family meals?
- Are mealtimes stressful?
- In total, how many foods will your child reliably accept?
- Tell me about a typical day for your child in terms of meals and snacks
- How does your child let you know that they don't like a food they have been served?

4) **Can you tell me about how your child's picky eating makes you feel?**

- If you have an emotional reaction to your child's eating, how (if at all) do you express this?
- Do you ever feel emotional about your child's eating away from meals?

5) **How do you respond to your child's picky eating?**

- Do you try to get your child to eat, and if so, how?
- During meals, how much of your focus is on your child's eating?

- How do you understand your role as a parent in relation to feeding your child? *[is it your job to 'get food down' your child? What is the rationale / driver for this?*]
- Have your reactions to your child's eating changed over time (if so, how)?

6) What do you think is behind your child's picky eating?
[*If they don't have any ideas, explore what that sense of 'not knowing' is like]*

7) How confident do you feel about how to manage your child's eating?
- Do you have consistent strategies? [*If so, can you describe them? How do you feel about them?*] (I will explain what I mean by 'consistent strategies')
- How do you feel about how you parent in relation to food?

8) How supported do you feel in terms of being able to get professional help and advice about picky eating?
- Where have you gone for advice (apart from the Health Visitor)?
- What influenced your decision to go to the Health Visitor? [*when did you realise you needed support? What surrounded that decision?*]

9) How supported do you feel (in relation to your child's eating) by your family, friends and partner (if you have one)?[*Look at each of these in turn*]
- Have you approached friends and family for advice? [*Tell me about that*]
- Have you gone online looking for feeding advice? [*Tell me about that*]
- Have you read any books about feeding? [*Tell me about that?*]
- Have you ever felt judged by others, about your child's eating?
- Have you ever felt judged by others, about how you parent in relation to food?

10) Can you tell me a bit about your relationship with food?
- What were the 'food rules' when you grew up?
- Do you have different parenting approaches to food compared to your experience as a child? [*are experiences emulated / rejected?*]
- What role does food play in your life?
- Can you tell me a bit about your eating habits [*structure, content, feelings about eating...*]?

11) If you could wave a magic wand and make any changes you liked to your child's eating, what would their eating look like?

11.11 Appendix K: Participant Information Sheet

08/11/17 v1

Participant Information Sheet

Exploring parents' experiences of picky eating

Introduction

I'd like to invite you to take part in a research project. This research is part of a full time PhD at Bishop Grosseteste University, Lincoln (BGU). It is entirely up to you whether you choose to participate and your decision will not affect the support you will get from your Health Visitor.

Before you decide whether you would like to take part, please read this information sheet which explains the project in more detail. This will be emailed to you if you express an interest in being part of this study. It is also available to download from the project website: www.pickyeatingresearchbgu.com**.** Anyone who agrees to participate will also be given a printed copy of this information sheet.

It is important that you understand what will be expected of you if you take part, and what will happen to the information gathered during this research project. This information sheet will help with this. If you have any questions or if there is anything you don't understand, I will be very happy to talk to you. You can either ask questions via email or arrange a telephone call with me (the researcher) by email. You are free to talk to others about this study if you wish.

PART ONE of the Participant Information Sheet tells you the purpose of the study and what will be expected of you if you take part.

PART TWO will include more detailed information about who is suitable for this study and how this research will be carried out.

PART ONE

Summary of the research

The study aims to find out more about what it is like to be the parent of a picky eater. Picky eating is an extremely common challenge for parents of young children. There has been a lot of research into how parents approach feeding children who they would describe as 'picky'. However, researchers need to look at what parents themselves have to say. The more we can learn about what parents think and feel about picky eating, the better we can hope to support them.

You will be asked to take part in an interview lasting sixty to ninety minutes. The interview will be recorded (audio only) with your permission. Interviews will take place either on an NHS site local to you, or on the campus of Bishop Grosseteste University. It is easy to get to by public transport and there is parking if you are coming by car. Detailed directions will be provided.

PART TWO

You will be a suitable participant for this research if:

- You have a child aged between two and five years (who is not yet statutory school age) at the time of interview
- You have approached your health visitor for help with that child's picky eating
- Your health visitor has not expressed concern about your child's weight or growth
- Your health visitor has not suggested that you seek a referral to another health professional
- You have British citizenship
- Your child is not adopted or in a foster placement
- You have parental responsibility for your child
- You have primary (or equal) responsibility for feeding your child
- If your child is not eating a varied diet, this is NOT because you don't have enough knowledge of cooking and food preparation
- If your child is not eating a varied diet, this is NOT because you lack the means to afford the kind of food you want them to be eating
- Your child has no clinical diagnosis or health problem that explains their picky eating

Will there be any benefits in taking part?

Participants will be part of a project which seeks to help us understand how to support parents of picky eaters. Participants will not be paid, but reasonable food and travel expenses will be covered.

Will there be any risks in taking part?

Feeding children is an emotional subject and as you have already expressed concerns about your child's eating by going to the health visitor, this is something you are likely to be worried about. It can be difficult to talk about parenting challenges and there is a risk that the interviews may be upsetting.

In order to help you think about whether you may find taking part in this study distressing, here is an indication of the kind of areas the interview questions will cover:

- What your child's eating is like day to day
- How you feel about your child's eating
- What you think about your child's eating
  How you handle your child's eating
- How supported you feel in relation to your child's eating
- Your history (including your relationship with food)
- Your child's history (including any health problems they may have had and their feeding history)

Care will be taken to be as sensitive as possible and if you did feel distressed at any point, you will have the opportunity to discuss this with the researcher. If you feel that you want to talk to someone who is not involved in the research, or if speaking with the researcher has not resolved your difficult feelings, you will be given details of local counselling services.

Confidentiality

The BGU Research Ethics Policy and the BPS Code of Human Research Ethics will be adhered to throughout. This means that the researcher has committed to behave in an ethical way at all times.

Anything you share will be safely stored in a locked filing cabinet if it is a written record or physical recording, or in a password-protected file if it is electronic.

The interviews will be anonymised; this means that we will never use names or any other identifying features, so privacy will be protected. The only time confidentiality would ever be broken is if there were grounds for concern about your safety or the safety of someone else.

Plans for the data

The data from this study (what you tell the researcher during the interviews) will be analysed and written up with a view to being published in an academic journal. The study may also be presented at research conferences and shared in the press and through other outlets like social media. You will be kept informed about publication and will be given a copy.

Who is the researcher?

Johanna Cormack (PhD student) - BGU, Lincoln

Contact details: johanna.cormack@bishopg.ac.uk (email)

Supervisors' contact details:

Participants can contact the researcher's supervisory team if they have any questions which cannot be addressed directly to the principle researcher.

Dr Graham Basten: graham.basten@bishopg.ac.uk (first supervisor)
Dr Emma Pearson: emma.pearson@bishopg.ac.uk
Dr Gianina Postavaru: gianina.postavaru@bishopg.ak.uk

Independent contact: Dr Caroline Horton, Bishop Grosseteste University
caroline.horton@bishopg.ac.uk

Important things that you need to know

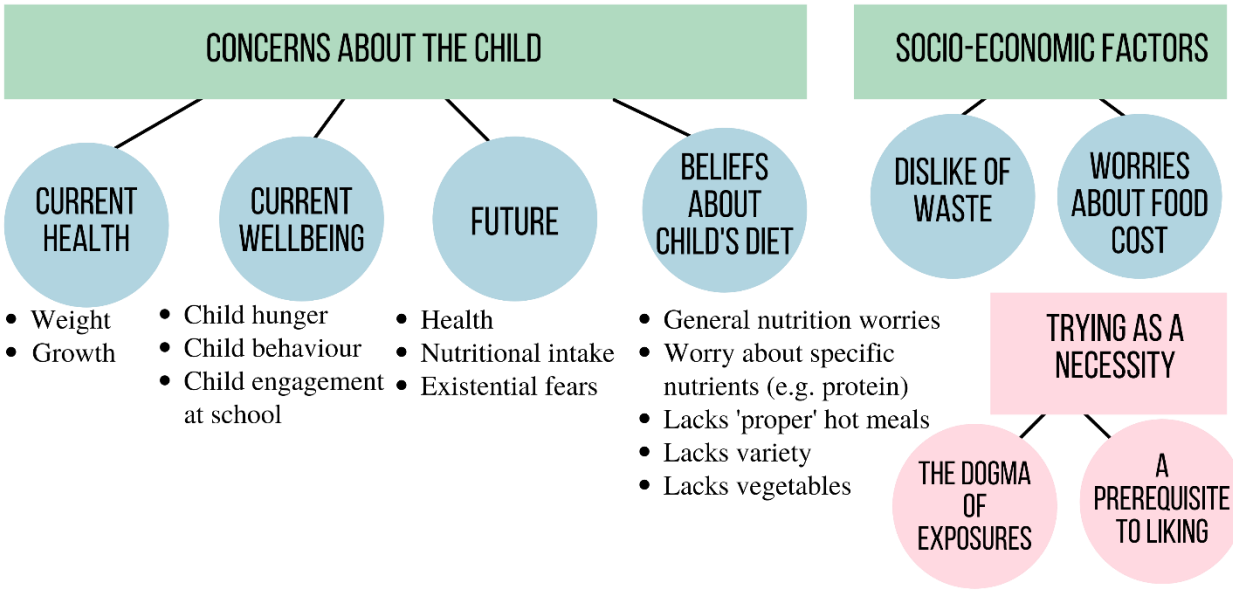
- ❏ By taking part (or not taking part) in this study, you are not affecting the support you are entitled to from the NHS in any way

- ❏ If you participate in this study, you cannot get feeding information, help or advice from the researcher - you need to continue to get the support you need from your health visiting team

- ❏ You can withdraw from this study at any time. If you decide you no longer want to take part and you don't want your data to be included, you have ten days following the date of your interview to let us know.

Thank you very much for considering taking part in this study

11.12 Appendix L: Unreported Findings Re Rationales



11.13 Appendix M: Unreported Findings Re Structure and Content

Structure largely set by parent. Child has options over content within parent-set parameters			
Participant	Summary	Structure	Content
P8	P8 serves foods at set times and tries to minimise snacking (on the basis that she believes this optimises her child's appetite). She makes an exception if she fears the child will be hungry at bedtime, providing Weetabix. Content is sometimes agreed via giving the child limited choices. It is then influenced by the child's reactions to initially served foods.	R: so he's missed pudding [*as a punishment*], but he can have Weetabix later if he's still hungry? P8: yeah, yeah. 'cos I don't want him up in the night. Not that he would, probably, he sleeps really well. Um, but I don't want him to be hungry 15:573 P8: yeah, and my mum. You know, she wants to give them chocolate, see a picture when they're out, it's a, like a full size adult Magnum at two in the afternoon. Of course she wants to treat him, [but now] he won't have his dinner tonight when he comes back to me 'cos he's had too much snacks during the day, so if I can't, he will eat dinners if I can restrict his snacks 'n' package the environment properly so he can't see anything else, and if he's hungry enough, he will eat things.	P8: …..so we might put that in front of him and then he sits there stroppy until we produce something else because... he's not gonna touch those foods. R: at what point do you bring the alternative out? P8: I don't know, a few minutes 24:948 <u>Limited choice</u> P8: um, sometimes I ask them. Mostly I give, mostly I give them two or three choices of things we've got in 34:1363
P12	For P12's child, the way meals and snacks are structured differs at home and at nursery. P12 is alarmed at the high number of eating opportunities provided by nursery. At home, she makes decisions about snacks based on prior eating. This is on the health visitor's advice. She has asked nursery to implement the same policy. Content decisions are inconsistent. They are largely child-led, but recently at weekends P12 has been solely serving foods that are not accepted by the child without providing alternatives if the meal is rejected.	P12: …..She would not have, in nursery she have breakfast, eight / quarter past eight, snack, half past nine / ten. Er, lunch, eleven. Then they have a nap, another snack and tea around three. And then a snack, a snack...or one or two snacks. R: this is all at nursery? P12: yeah. I always thought, for somebody like M, that's never been interested in food, um, it's like... a lot of food R: how many eating opportunities is that through the day then, altogether? P12: a lot... I think a lot. But R: I've just tried to count it - so they have... breakfast... P12: breakfast, snack, lunch, snack, dinner, snack, and these things, and maybe another snack, if it's half past five and you haven't picked her... R: is this eight? P12: seven R: seven P12: six, definitely. Maybe seven. 10:378	P12: …..Um, sometimes, most of the day, we ask her "would you like this? Would you like that?" And we try to stick with, er, things that we know she likes. 17:681 Or other extreme (at weekends) P12: …..Over the weekend, we try to, we try to introduce, well, introduce like, proper food or pasta Peppa Pig [branded pasta shapes] or I don't know, a stew, I don't know... R: and would you serve that by itself or with things she likes? P12: no R: just by itself? P12: the same we eat. we try to give her the same. R: how do you... how does that work, then at the meal, what happens? P12: she will probably not even touch it. R: and then how do you respond to that, if you know she hasn't eaten it? Do you give her something different or do you just leave it, or...

		P12: …..'Cos the health visitor was very clear, just leave it. Eventually, she will get hungry and that makes sense. Eventually she will have something, she will like something to eat. And that's what I said to nursery, like, reduce or not give her any snack. If she doesn't have the next meal, for the next one, don't give her a snack, and for the next one, she will be hungry. R: just explain that again - so you're saying if she rejected her lunch, you would then not give her the next snack, is that right? P12: yeah. That's the... what the health visitor suggest to me. R: so skipping the next meal because she'd rejected the one... the first one? P12: yeah, yeah. She, if she rejects the lunch, don't give her the next snack and go straight to the tea. 15:623	P12: no, not any more. Before, we tried to offer something else. 17:684
Child has some control over structure and some control over content, both within parent-set parameters			
Participant	Summary	Structure	Content
P2	Multiple factors influence P2's decisions about how meals are structured, including the younger sibling's needs, the child's prior eating (if he ate his dinner, he can have more to eat later) and whether the child requests a snack. P2 only provides snacks on request and frames them as negative; they are something to be avoided. The multiple eating opportunities the child has are also influenced by the way in which he was fed in infancy – a pattern that P2 has never really abandoned. The choices the child is given in relation to content, relate very directly to the nutritional categories of the food in question.	P2: yep, yep... and then um, he normally will start asking for a snack at about 9 o'clock and I'll say: 'come on, let's... we'll... you know, we'll make sure that we've done everything we need to do first in the morning, then we'll have a snack. R: so do you give him a snack because he's asked for it, and if he didn't ask for it, would you not give him one? P2: I wouldn't offer him a snack, no R: you wouldn't? P2: no 23:1157 R: If you had to give me an average for the amount of um, what technically you would call 'eating opportunities' so that could be a meal, a snack... glass of milk... how many eating opportunities over a day would you say on average, he will have? P2: .... probably 5 or 6 R: quite a few? P2: yeah, for a child his age. I think he's just... the routine has stuck from when he was a baby, of kind of, you know, you give your baby milk then they have breakfast	P2: ….. And now we can have a conversation. So what we say to him now is, we, we... I've sort of explained food groups to him in a very simple way. So we say: you've got 'growing food' which is your protein, and there's 'mending food', so to help you feel better if you're poorly, or to stop you getting poorly, which is sort of fruit and vegetables and vitamin-containing things, and there is 'energy food' to help you play, which is your carbs... and I say to him, 'you have to have something of each thing at your meal. If you don't like the growing food we've given you at each meal, you can swap it for another one' 7:355

		then they have snacks... 27:1381	
P4	Both structure and content are negotiated and inconsistent. P4 grapples with whether it is right to give food when it is requested. There is a tension between her hesitancy regarding what she perceives to be giving in to her child, and her discomfort at the thought of her being hungry. Similar tensions are at play in relation to content decisions. P4 wants her child to have enough accepted foods to fill up on, while also not wanting to jeorpardise her consumption of the foods she (P4) would rather her daughter were eating.	P4: and then it would be, we had it a few times, you know, this seven O'clock "I'm really hungry, I want something" and you're thinking, do I give it her because she's hungry? And she's... you don't... it's not a comfortable feeling to think she's going to bed really hungry. R: it doesn't feel good to you? P4: no, but then equally, you think well, if she knows, she can just say "I don't want that" and at seven O'clock, she'll get some toast, then she's kind of got what she wanted in the first place? So... you don't really know what to do for the best. 27:1072	P4: I try and reach a bit of a compromise, so let her have a bit of choice in it and let us... R: and how might that go? So she might say: "I want bread" and you might say "well,..." P4: "okay, you can have some...you can have a sandwich thin, because... they're not too big". R: I see P4: "and then, we'll have some potato waffles... some sweetcorn... and you can have that as well and some cheese" P4: [pause] well, some days she does get what she wants to eat, 'cos if I'm cooking something...for like, adults, that they won't eat, so I think well, what is it you want? Beans on toast? Right, you can have that. Because you're never going to eat what we're eating. Whereas on other days, it's more of a negotiation. 28:1095
P9	P9 allows her child to snack at any time if she considers the snack to be nutritious. However, he is rarely interested in snacks. She also serves main meals at conventional times. The child does not have the verbal ability to request specific foods. Instead, he indicates his choices through gestures, thus his options are limited to foods shown to him by his mother.	P9: …..I don't mind, I don't mind how much he snacks as long as he's snacking on something that's nutritious for him. 31:1258	P9: I wave it at him and he's like "no, I don't want that!" [denoting hand gesture not literal speech] but, no, he's not very specific in saying "I want this" or "I want that" 21:825
Structure and content led by child			
Participant	Summary	Structure	Content
P1	P1 is so concerned about her child's weight and growth (although health professionals are not) that she feels confident her approach of letting him eat what he wants, when he wants is appropriate.	P1: it shifted into snacking where he just wanted to snack on things rather than... I mean, he w... it's not just sweet stuff he snacks on R: yeah, yeah P1: s... he snacks on everything, but he... he'd rather snack and graze all day than sit down and have a meal. 4:165	P1: um, making what he wants, or what he, what you th... what we think he wants R: yep, yep P1: just giving him food every time he's asked for it R: yeah P1: or giving him, um, walk into the kitchen and saying "now it's... do you want this?" Um... 15:819
P5	P5 is heavily influenced by her child in both structure and content decisions. She frames this in terms of seeking child input in family	P5: yeah, I will always give her a snack if she's hungry, um... R: really? P5: ...depending obviously on how	P5: Um, the only thing that I will really, really put my foot down on is, so for example if, um, she's asked for something, for example,

	decisions. Once the child has requested a food, however, she will not provide alternatives.	soon we're going to be having a meal, um... R: what's your cut-off? P5: probably about half an hour or so? R: so if it's sort of within that half hour before you've got tea ready... [It's a 'no']? P5: yeah [or I will say "I'll start making tea now if you're hungry, I'll start making tea now." R: you'll bring tea earlier P5: yeah, um, I'm, I am quite flexible with when we eat meals and what we have, um, I will take their input because I sort of think, yeah, actually we're a family, we make these decisions together, I'm not - although I am - in charge, "I'm not in charge of you, if you really don't want beans on toast then we don't have to have beans on toast, we can have something else" 39:1581	she's asked for a cheese sandwich and I've made her a cheese sandwich, if she then turns round and says "I don't want that" I will say: "well no, that's, that's what you're having for dinner, you've asked for that 38:1524
P6	Regarding structure, P6 describes initially feeling discomfort with departing from her stated aspiration of family meals where the whole family enjoys good quality food together. She rationalises her current approach to feeding by challenging social norms. Content is also dictated by the child – it seems that P6 considers this to be the only way to induce him to eat.	P6: mmm... yeah, because actually... R: like, 'people ought to eat at certain times' P6: yeah, 'cos like, yes, we do naturally, we fall into a pattern of eating breakfast, lunch, tea, don't we? We might have a snack in between, but...when you think of like, an animal world, they would just graze throughout the day, wouldn't they? They'd eat when they're hungry. And I think, well actually, why should I tell my toddler to sit down at a certain time and eat certain foods, that... you know, it's not necessarily how he would feel comfortable. So now I'm trying to just be a bit more relaxed about it and just think, well if he's going to eat all day that's fine, but you know, still not eating... he's not eating many foods, but um... 17:673	P6: …..normally in the afternoon he would say "can I have a snack", so I'd take him, we've got a pantry, so I'd take him in the pantry and I'd say "yeah, what do you want for your snack?" So I'm... I let him choose 19:733 P6: …..And then tea time, we always say, I just say now, "what do you want for tea?" 'Cos he won't eat what I give him and most of the time it's "nothing" or he might say "a crumpet" or "fruit toast" and most of the time, I'll put it in front of him... 24:933
P10	P10's child does not have the verbal ability to ask for specific foods, but communicates his preferences with gestures. Nonetheless, he still has a large degree of control over the content of his diet.	P10: yeah, it's um... uh... he doesn't... he doesn't necessarily stick to three meals a day, um, or even necessarily stick to meals and snacks or... he, he tends to eat when he's hungry, which is fine 1:14 P10: um, I very much go off of... I	P10: …..getting him to eat something when he's hungry is difficult, 'cos he'll say he's hungry and you'll offer him fifty million choices and he doesn't like any of them, um, so he's, he's all over the place. 1:18

		ask him if he's hungry, and he will say "yes" or "no" R: and how often do you ask him? P10: um, around about, I will... I'll ask him after he gets up in the morning, "are you hungry, would you like some breakfast"? Sometimes it's a 'yes', sometimes it's a 'no'. If he says "no", I'll sort of ask him about an hour later. Um, and if he says 'no' again... I'll ask, I sort of ask about every hou... if he says 'no', I keep asking about every hour afterwards. Around about 12, one o'clock, I ask if he's hungry for lunch and around about five or six o'clock, I ask if he's hungry for dinner.	P10: he... yeah, he can sign... um, sort of all of the main types of food. If I've got something in and we don't know the sign for it, I take him to the fridge, open the fridge, point to things... um, do you want this? 20:816
P11	P11's decisions regarding structure were influenced by the professional advice she received from the Healthy Families Team. The child is allowed to eat whenever he says he wants to. P11 asks her child what he would like to eat. In common with other participants, this can be a source of frustration if he subsequently rejects the food he has chosen.	P11: …..So, I try and keep it... and then the lady [from Heathy Families team] said to try and do s... um... less, er... a little bit less and more often. So I tried doing that. R: and how often was she recommending? P11: um, I don't know, just snacks, again. So I'd say, four, six, well, whenever he says he's hungry, I suppose. 14:562	P11: …..it all depends... if he feels like eating it, he'll say that he wants it, so you'll say: "what do you want for dinner?" um, "I want some fish fingers" and you'll do him fish fingers and then he'll get it in front of him, he'll be like, "yeah, I don't want them no more".

11.14 Appendix N: Descriptions of Parental Feeding Strategies Used

- **Persuasive strategies** - where there was an underlying assumption that the child could say "no" but the parent tried to persuade them to eat or try foods, remind them to eat or engage them in the eating process.
- **Authoritarian strategies** - where the parent viewed eating or food-trying as a behaviour they required the child to perform, thus noncompliance was framed as disobedience.
- **Contingent strategies** - where the parent made an offer to the child whereby if they ate or tried a food, there would be a food or non-food reward. This includes making dessert conditional on eating other foods.
- **Reasoning** - where the parent used rational arguments to convince the child to eat or try foods.
- **Negotiation** - where parent and child had discussions about how much the child needed to eat or what they had to try. This again characterises eating or trying foods as a required behaviour, but one where the child has input into the decision-making process about precisely what must be consumed.
- **Begging** - where the child is seen as having all the agency and the parent pleads with them to eat. This was only used by one participant. Notably, this participant was also one of only two parents to report mental health issues, sharing that she had been diagnosed with postnatal depression. Her pleading with her child to eat can be seen as a poignant reflection of just how desperate and out of control she may have felt.
- **Physically feeding the child** - where the parent feeds the child although the child is both developmentally capable of self-feeding and chooses to do so in some circumstances. This practice was surprisingly common given that all children were over the age of two years, an age by which the oral-motor, fine motor and gross motor skills needed for self-feeding would have been mastered in normal development (Carruth and Skinner, 2004).
- **Distraction** - where toys, books or screens were used to distract the child as a means of inducing eating. This was also only described by one participant.
- **No pressure or food focus** - where parents consciously ignore the child's eating behaviours or adopt a pressure-free approach. Paradoxically, this was sometimes used

instrumentally (as a means of getting the child to eat), although at other times it was framed as more of a principled stance.

11.15 Appendix O: Excerpts Illustrating Feeding Practices

Feeding Practices relating to the theme: Get Food Down Child		
	Illustrative excerpt 1	**Illustrative excerpt 2**
Encouragement	P9 describes over-riding her child's cues when she is spoon-feeding: P9: and then after a couple of spoons when he realised it was something I was trying to give him he didn't want, that's when he would turn his head away, and he wouldn't... "no, not having that anymore!" R: and how did you respond to that? P9: I'd encourage a little bit P9:8:293	P4: I say: "you going to have some strawberries and raspberries?" And sometimes she'll say "no" and I'm like, "well, you just going to have some raspberries?" And then I'll kind of, keep pushing it, "you really need to just have some." And then...kind of, persuade her into it. P4:21:820
Prompting	P11: yeah [laughs] but it's, it is, it's, it drives you mad because... there's... you just can't, you know, no matter how much you try, and I've tried reminding him "come on, you need to eat a little bit more, you need to eat a little bit more" P11:16:689	P1 describes reminding her child to continue eating, especially towards the end of the meal: R: so you... tell, tell me more about that. What kind of things do you say to B? P1: um, eh, "are you gonna, er, are you eating? Um, are you gonna, are you gonna eat?" P1:7:353
Food PR	P10: I'll sort of, I'll take a forkful and I'll go "mmmm! yummy!" or y'know, "this tastes like this" or "wow... ooh yum!" and sort of um, a lot of hand gestures or... a lot of excited noises and um...	R: how would you encourage her? What would you...? P12: "come on! Let's try! Mmmm, delicious! Mmmm, Daddy, this is lovely, mmmm". And it was, to be fair, probably all focus about food.

	R: so quite animated? P10: yeah, very much so. Um, there's very much "ooh look!", i...i... I dunno, "sweetcorn! Look, bright yellow sweetcorn! And that's really yummy!" P10:24:975	P12:9:349
Praise	P2: …..We do a, he'll.. we say "hasn't he done well! Haven't you done well!" then he will say to us, "haven't I done well, Mummy, with mine, with my food!" P2:14:717	R: and what do you do in that situation [*where child tries a nonaccepted food*]? How do you respond? P5: I go absolutely crazy! [Both laugh] R: crazy with praise for her, or..? P5: yes. Uh, lots of praise: "what a big grown up girl you are", um, how, you know, "how brave of you to try something new" P5:22:850
Play and fun	P11 describes things she has tried to get her child to eat. P11…..”if you, if…” you know, "if you can just try and eat this bit" or, playing games, for instance... I used to play games with him, um, and then obviously I had to do it with F [sister] because she wanted me to do it with her. And I'd be like, I'd stab something and I'd go "don't you eat that, don't you eat that" [playfully] and then, and then I'll pretend to do something "that's mine, don't eat it!"	P12:.....We've tried, we've tried to present things like, as they I, the brocol... the veg. Play with them and I, I've even try, not a lot of times, but I've seen some photos of preparation of like, rice, in, with a shape of a panda bear, things like that. Or yeah, try to do um, rainbow with fruits or try to, I don't know, stupid things like, she will see a picture on there, she will touch it, she will play, but she won't eat it. P12:23:950

	and he would eat it, he would. And y'know, he'd get really, he'd laugh about it and it were getting him to eat it, he'd eat it. But it didn't last. P11:22:930	
	Authoritarian strategies	
Insistence	P2 describes her use of pressure in the past P2: um.. I, I think all of our tactics were about pressure when he was younger, really. R: really? Wow. P2: I think it was just all "we're in charge and you will eat" P2:10:507	R: would you say that meals are stressful? P1: er, yes. R: yeah? P1: yeah, it's a, it's a constant battle of "eat", "no", "eat", "no"... P1:7:348
Punishment	P6 describes how she used to punish her child for refusing food by putting him into his cot for the remainder of the meal: P6: …..So we did that for a couple of weeks maybe, every single tea time. We'd sit him down at the table and then he'd just put him straight in his cot and leave him crying while we ate. 31:1232	P1 describes how she discovered that using a 'time-out' was ineffectual: P1: yeah. Doesn't work. "If you, if you eat that, if you don't eat it, you're going on the stairs" that sort of thing. [That doesn't work]. R: [does that work]? P1: no. It just makes him upset so it just doesn't... 16:837
Forcing the child to stay at the table	P6: …..we've tried sitting him at the table and saying "just have a spoonful" um, and I've always... he's always had to ask if he can leave the table. He's always had to say "can I	R: and how did you try and make him eat them [meals]? P1: well we'd just leave him there for as long as possible [laughs] and eventually he'd eat.

	get down now Mummy?" or " can I get down now Daddy?" and we've tried saying "no - you're not getting down until you've had a spoonful" P6:30:1175	P1:4:192
Making the child go hungry (in the absence of accepted foods)	P4: and it's not, you know, th... when we went through a few months of like, “this is what’s for tea, take it or leave it…” R: yeah? P4: and she leaves it. It's not a nice feeling to think... R: no? P4: ...she's hungry really, she's gone to bed P4:27:1061	P5: …..She does often um, [sigh] rightly or wrongly, she does often go to bed hungry because she will point blank refuse to eat anything R: and is that when you've served foods that are on her accepted list or when you've served foods that are maybe not things she reliably eats? P5: yeah... when I've served foods that she doesn't always reliably eat P5:22:877
Re-presenting rejected food (as the only available option)	R: so do you make him stay 'til he's eaten? P11: yeah. I don't, well, I don't make him stay, I'll leave it, I'll leave it, I'll gi' him a good 40 minutes and if he still 'an't ate it, I'll, I usually leave it on the table. P11:11:462	P4: …..Um, tried re-presenting her with the lunch, saving it. But generally, she's very strong willed P4:15:607
Enforced food-trying	R: and do you expect him to try foods? P2: yes. I still... if we're having something we're pretty sure he won't like, we still put some on his plate, um... unless it's something like a spaghetti Bolognese type thing, where I just know he won't eat…..	P11: yeah, yeah, and you know, especially when we go out to restaurants and things like that, and you just, you can buy him like a £7 meal and he'll just sit and you'll not, he'll not eat any of it. And then everyone else is going to play, 'cos there's like a play area there, and

	But if we're trying something new or it's something that isn't easily separated, I would normally give him - or offer - a range of things, or offer a range of things that he would like, and then I'll ask him... to have a taste P2:17:875	everyone else's gone to play and they're sitting there eating their dinner and I'm making him sit there until he's actually tried something, and he won't try it. P11:30:1290
	Contingent strategies	
Food bribe or reward	P9 describes using chocolate as an incentive to eat P9: ….."Have some chocolate buttons" or something, just if we can get him to eat something else, then he can have a button afterwards and it's like, he might associate it with 'get something good after he eats this food' P9:2:63	P2: …..I do regret putting that higher status on sweet, and not terribly healthy foods now, because actually, we want him to enjoy eating healthy food for the reward of that. But I think we've fallen into the trap that a lot of people do, of... you know... bribing him to eat things that he doesn't like, with other food... which isn't really very healthy. P2:5:237
Non-food bribe or reward	P5:…..I have tried um doing stickers for trying something new but it's so rare that she will taste something she's not had before that it just wasn't working because she was never getting anything and then I sort of feel that you're actually making things worse because she's never being rewarded P5:25:980	P6: it did not work. Then I've tried um, not even food... like with sweets, I've tried saying, 'cos his favourite place to go is XYZ Farm Park, so I've tried saying, "you eat this, we'll go to XYZ Farm tomorrow". That doesn't work. P6:29:1155
Making desserts or preferred foods	P8: …..so now he's old enough, we bri... so he watches his sister finish her Sunday dinner and then she gets	P9: …..if they know they're gonna get dessert, something that they really, really like, then they're never

conditional	an ice cream and he has to eat, you know, we negotiate what he's got to have and it might be a piece of broccoli and three kernels of sweetcorn and then he can have an i...have his ice cream. R: and what do you base that on - the quantity? What do you base, like, the number of kernels... is it... P8: um, the number,the, the amount he can eat without vomiting f... from doing it. P8:9:352	gonna want to eat the dinner that they don't really want to eat because they might as well just wait for pudding, but if they know they've got to eat the healthy stuff first it will become a habit. P9:25:1005
	Reasoning	
Health based or nutritional arguments	P11: …..I always say to him like, um, you know, "if you eat this, you know, it'll make, it'll make your body really happy, it'll make your tummy really happy, it's really healthy for you, um, same as with your teeth, and...um, but, it depends on how he feels. R: It doesn't work? P11: yeah. Even though you do talk to him about it. 42:1786	P4: say," 'cos you're not getting all the vitamins and, you know, like, all the good things that you need to help you grow... big and strong... and help you at school, you need to eat other things as well...” 26:1040
Appealing to rational arguments	P11: and, even when I've took it off the cob, I've showed him "it's the same thing, look, it's the same thing, apart from you hold this one and then they take it all of the cob and they put it in a tin, or, you know, they freeze it, and that's what it is". But	P4: I say "look, I've only given you like, a little bit, literally two little pieces, can you, can you...you know, you can eat those, you used to eat them... " 29:1148

	apparently, it's not the same thing and he won't eat it. So he will eat it off the cob. 24:1001	
	Negotiation	
	P8: …..it's never enough just to be able to give him a plate with four different things on it. Immediately, he says "I don't like carrot" as soon as you put his dinner down, you know,s... "I don't like that". "Just ea..." R: ...and how do you respond to that? P8: "just eat the bits you want to and we'll talk about it at the end" so then he might... R: ... what happens at the end? P8: um, it depends on the scenario, how bothered I can be to have an, yet another argument with him about if he's gonna eat three peas or not [laughs] 14:528	P11: so he'll say to me straight away: "um, how many have I got to eat?" and I'll, and I'll say "all of it" [laughs] you know what I mean? "I'm not giving you a number! Eat as much as you can." Eat a... eat as, I mean it's s... I don't, I don't understand if he knows what I mean, but I'll say, "eat er... eat 'til you're full. If you're full, but then, W's full is that he's have one bite of sausage and "I'm full". You know what I mean? So I'll say "y' need to eat your sausage and you need to eat your Yorkshire pudding" and he'll say straight away, "I don't want to eat my potatoes" and I'll be like, "well, try and try them for me" 25:1042
	Begging	
	R: did you try anything else apart from offering alternatives to get him to eat? P10: begging, crying [laughs] R: oh, really? Tell me about that... P10: um, I used to... sometimes I'd sit there and I'd just burst into tears and beg him to eat. 14:549	

	Physically feeding the child	
	P10: …..Sometimes now, we still spoon feed him some yoghurt because he won't do it himself, so we haven't stopped spoon feeding as such R: ok, so it's something you still do, but you, you do it in response to him not doing it when you feel he needs the food? P10: yeah, yeah, yeah, yeah, he can feed himself, he often chooses not to [laughs] 12:490	R:….. maybe first tell me about what you used to do before? P12: well, try, try to feed her, try to encourage her to get some, to eat. 9:336
	Distraction	
	P11: um, we tried to occupy him, um, I found if he was focused on something, he would start to eat and he didn't even know it, so I used to give him a tablet 5:175	

11.16 Appendix P: Subtheme: Losing the Battle - it Doesn't Work

P1: yeah, yeah, um, trying to sit him down and have a meal, which, or just letting him sit there with it in front of him, **nothing seems to work.** 16:830 P1: 'cos I have cut his portion sizes down, thinking I was giving him too much, and that's why... R: oh really? P1: he wasn't eating it, and **then it didn't really work**, so... 'e's still not eaten it. 27:1436 P1: …..He never really, he didn't really... if he didn't want it, he just wouldn't eat it. So, and he's... and he's.. the plate of food in front of him, he'll only pick at what he wants and leave the rest. R: yeah? P1: and **even if you try and force him to eat, he'll just not do it.** 17:902	P2: …..I think there must have been a turning point where **we realised for R, my eldest, that us standing over him sort of dictating what he was gonna eat and being quite 'you haven't eaten your dinner, you can't get down'** **R: yeah... yeah** **P2: wasn't working.** We became more laid back with him and he started to eat more. Um.. and he has start.. slowly... slowly he is starting to eat a wider variety of food and I think that's because our attitude has changed. 4:184 P2: well, I mean, often the puddings he will have... we often let him choose what he has for pudding and it will often be a chocolate biscuit or...[something that's in] R: [right...right] P2: .. the snack... we have a snack cupboard. R: so you treat main course food and pudding foods really differently= P2: =we have done in the past, and we've REALLY tried in... probably since we've had our second child, **we've really tried to**	P4: …..You're sort of, **trying a little bit in vain** to widen the repertoire what she'll eat 34:1355 P4: she'd say: "I don't want that, I don't like that". I'd say: "well, you do, because you... but you used to eat this." "No. I don't like it" "w... you know, you'd, you have ate it, can you just try it?" "No." And then you'll sort of try and reason with her, like "just eat two pieces of it, like two little bits of fish finger". "No". R: so you go from, you try and give her that rational view, which is your take on it [that] P4: **[doesn't work, yeah...]** R: actually, there's no logical reason for you not to eat this, and then you explain that it's your expectation that she has a certain amount, or...? P4: yeah. **And that doesn't generally work.** 7:267 *Re: hope that school dinners would help:* P4: …..So I wanted her to have a school dinner and like, be offered all this food, um, and some of the things she wouldn't get at	P5: so, we've tried bribery**, that hasn't worked**, so basically, if you eat that you can have a chocolate bar P5: in the past I've got really cross. I've got really cross before, um, I've said to her, I've put things on her plate and said "no, you need to eat that, you're not leaving the table" and that is, and when I look back, even an hour later, I think, "Oh god, you know, why do you let it get to you?" **because I know that that won't work. It doesn't work.** 22:864 P5: …..Yeah, and now I'm sort of trying to be more chilled about it because I've realised that actually, **being like that wasn't getting anywhere. Wasn't making a difference**. 26:1053 P5:... uh, she's recently started, September she started pre-school and I put her in full days on the basis that she'll be going for dinner and she'll be sat with other children who'll all be eating their dinner and **that to me would be**	P6: yeah. because it's kind of, N (partner) will say, so his dad, N will say "when I was his age, I was given my tea and if I didn't eat it I went to bed with nothing. And that, so his mum (my mother in law) that's got them now, that's her opinion, she doesn't understand: "well, just give him it! If he doesn't eat it then he won't starve himself, he'll eat it if he's hungry. **But he doesn't, 'cos I've tried that!** 13:497 P6: …..So I thought oh, he really likes sweets and he doesn't have them very often so I tried to bribe him with a meal and then I used to put like three chocolate buttons on the table and say "you can eat those if you eat this" R: and did that work? P6: **no. Not at all. He wouldn't even have a mouthful. he wouldn't have anything** 29:1142 P6**: it did not work.** Then I've tried um, not even food... like with sweets, I've tried saying, 'cos his favourite place to go is X Farm, so I've

	change that because we had reached a point where S wasn't really eating anything. **5:249**	home, like, so... **and she didn't eat a lot,** but then that was the same at nursery 16:634 P4: yeah, I'm kind of trying to be a bit more... relaxed about it R: are you? P4: because I just think, **well, it hasn't really got us anywhere, the last three years**. 17:681 P4: but then, in the past, we've sort of 'made' her eat it, **and that doesn't really work**, 'cos that's when... R: and how have you made her eat it? P4: oh, promise her things, like, "you eat this and you'll get a marble", or "you can have some haribos" or... and **that doesn't really work** 29:1163 P4: …..Or like, she loves tomato ketchup, I don't know how, at some point, she decided that she liked this, but she does, so we'll like, literally coat the food in like, a load of ketchup and uh... try and persuade her to eat it that way [pause] but... **a lot of the time it doesn't really work** [pause] it just... it makes mealtimes very stressful. Like, she gets really upset and I get... frustrated and	**hopefully where she would start then trying new things but she doesn't.** [Laughs] she just apparently just sits there and looks at everybody else and looks at her food and then just sits there. And they say to me "she doesn't eat a lot" and I'm like "yeah, I know" 31:1247 R: and it sounds like you've got clear strategies that you are consistent with...d'you, d'you f... P5: yeahhh [questioningly]? R: [laughingly] you're not totally agreeing with that? P5: er, yes, **yes I have but they don't really work** 45:1798	tried saying, "you eat this, we'll go to X Farm tomorrow". **That doesn't work**. 29:1155 P6: but we've tried that, we've tried sitting him at the table and saying "just have a spoonful" um, and I've always... he's always had to ask if he can leave the table. He's always had to say "can I get down now Mummy?" or " can I get down now Daddy?" and we've tried saying "no - you're not getting down until you've had a spoonful" R: and how did that go? P6: **doesn't work.** 30:1175 *Describing husband in relation to sending child to bed when he rejected (nonaccepted) foods* P6: I think because we try... he said "right, let's just try it for a period of time, so I accepted and **'cos it didn't change anything...** R: so he was happy 'cos you'd given it a go? P6: yeah 32:1250 R: so you're not sitting there just going "have another bite! Eat some!" P6: no, because I've tried that before R: you have? P6: yeah, I've tried

		upset 30:1172 P4: ...like, and it's irrational, isn't it. It's like, “I’ve ma... I've spent a lot of time making this, will you not even just try it?" R: so d'you...do you actually share that with her then? P4: yeah R: yeah P4**: but then... it doesn’t really get anywhere** [laughs] 32:1266 And that *[reasoning with her]* doesn't generally work. R: how does she react to that? P4: um, sometimes she'll just refuse, and then you know, we'll say, we'll give you a marble for your jar, or... R: so you'll do some sort of incentive? P4: yeah, and that... she's not bothered 7:284 P4: …..Like my, my daughter ate on Christmas Day, a sandwich. And it's not 'cos we didn't try 31:1213 P4: …..But we have tried. We've tried the approach of "if you don't eat this there's nothing else, you go to bed hungry". R: and how did that go? P4: she's not bothered. 11:426		the "mmmm, this is so yummy! Ah, Daddy's so good, he's eating his tea! Oh look at your sister!" and I've tried all that and it's just... n..n**... there's nothing there, there's no point.** 33:1324 P6: …..But I've also, I've tried being really chilled out and just leaving things around for him **and just, he's just got no interest in eating... at all.** 35:1383

P8	P9	P10	P11	P12
P8: …..we eat very healthily at home I would say... but for some reason, **we're not capable of, of enforcing that on him**, when we enforce other things really well 7:278 P8:…..I could e... I enforced breast feeding exclusively for six months, I breast fed him for a year, it was really hard but I did it because I wanted to do it [and that's my choice]and it's really well supported, **whereas this, this realm…** 8:307 *Re: Online advice not making a difference to eating* P8: I d... I definitely do remember googling it [A*E*] when he was wea... when he was past weaning and he was getting more fussy, and I think the things that came back were like, fun ways to make your t... you know, it was all about packaging it up differently but still giving them the f... same... involving them in the cooking, taking, you know, he LOVES going to the supermarket, that's his favourite activity, and putting things in the basket and h... you know, he loves all of that stuff, and preparing, but... he, **it just doesn't transfer for us into sitting and enjoying the**	R: um... you also sound like you're quite clear in the strategies you're using, so... i... would you say that's fair? That you, you're kind of confident in how you're approaching it to a degree? P9: yes I am. **I'm not sure how well they're working...** because I think, if you go for a week and there's been no progress whatsoever, you start to get a little bit despondent, but I know that I'm using the right strategies, I'm using everything that I was taught to do, so it gives me a little bit more confidence there... 46:1868	P10: …..Um, and I've tried sitting there and begging him with the spoon and "please, please, please, please, please" and **that doesn't work**, so I try not to do that so much, but sometimes you do just feel like I, I, I don't know what to do. He's got to eat, and that is what I sort of resort to. 16:657	P11: …..So then, and then I've thought, well, maybe it's overwhelming him, you know, with being in front of him. So I've tried to put less on his plate**, and even that don't help** 10:389 P11: …sometimes, sometimes I've refused [request for bread & butter] and said "no, you're not having it, you need to eat your dinner" **even though I know he's not going to eat his dinner**. 2:58 P11: …um, I've tried taking him out, you know with saying that we can go out on days out, um, I've tried money, you know, pocket money, you know if we, "you eat, every time you eat a new food, um, I will give you a penny and you can save it and then at the weekend we can go out and buy something". **But if it's anything to do with new foods, he just will not try it, just not even try it** 8:327 P11: …Um, she [professional] said to try um, like a post it box where I print the pictures out of what he's ate and every time he's ate one of these foods, to post it in the box, **so we've tried that, and that**	R: Maybe start, maybe first tell me about what you used to do before? P12: well, try, try to feed her, try to encourage her to get some, to eat. **So she will have couple of spoons, that was it. She wasn't interested.** 9:343 P12: …..Now we have a reward chart and she hate it because she knows that's for food [laughs]. R: ah really? so tell me about the reward chart? P12: The Health Visitor suggest it so we got it, and then the first day she want, she ask for some chocolate actually. And "you can have some chocolate if you have your food" and she had the food and we give her some chocolate. And I said "look, here I said, if you have your choc... your food you can have your chocolate, and she was like, very pleased. The day after, something similar happened. She want a toy or something and we say, "you need to eat your food, it says here, if you eat your food you will get your toy". **"No mummy!" And she went and smashed this chart.** 14:554 P12: …..Over the weekend, we try to,

dinner, so... 41:1635			**don't work** because some of the foods, he won't even try. 9:344 P11: yeah [laughs] but it's, it is, it's, it drives you mad because**... there's... you just can't, you know, no matter how much you try**…and I've tried reminding him "come on, you need to eat a little bit more, you need to eat a little bit more" 16:689 P11: …..I've tried putting them in something, taking them out of it, and then going: "these are Mini Cheddars but they're out this packet" an', **he can tell the difference.** So... even then, I can't work round it. P11: yeah, yeah, "you can have an ice cream" or, you know, "if you eat that, er, we've got something really special, we've got something really special you can have after", um... "what is it?" you know, he's like, "what is it? What is it? Can you tell me? Can you tell me?" mm, "you can't, you can't, you, you, you can't know until you've ate your dinner" **but that sort of didn't make him want to eat it.** 35:1479 P11: …..I always say to him like, um, you know, "if you eat this, you know,	we try to introduce, well, introduce like, proper food or pasta Peppa Pig or I don't know, a stew, I don't know... R: and would you serve that by itself or with things she likes? P12: no R: just by itself? P12: the same we eat. we try to give her the same. R: how do you... how does that work, then at the meal, what happens? **P12: she will probably not even touch it.** R: and then how do you respond to that, if you know she hasn't eaten it? Do you give her something different or do you just leave it, or... P12: no, not any more. Before, we tried to offer something else. 17:684 P12: yeah, yeah. But because she will not have anything with sauce on it, it's complicated! [laughs]. We've tried, we've tried to present things like, as they I, the brocol... the veg. Play with them and I, I've even try, not a lot of times, but I've seen some photos of preparation of like, rice, in, with a shape of a panda bear, things like that. Or yeah, try to do um, rainbow with fruits or try to, I don't know, stupid

			it'll make, it'll make your body really happy, it'll make your tummy really happy, it's really healthy for you, um, same as with your teeth, and..".um, but, it depends on how he feels. **R: It doesn't work?** **P11: yeah. Even though you do talk to him about it.** 42:1786 <u>Worked temporarily</u> P11: yeah. I don't, well, I don't make him stay, I'll leave it, I'll leave it, I'll gi' him a good 40 minutes and if he still 'an't ate it, I'll, I usually leave it on the table. And then, you know, **earlier on, you could... you had to leave the dinner there where it was, because he would come back with it**, but it could be two hours later and he would eat it cold 11:463 P11: …..if you, if, you know, "if you can just try and eat this bit" or, playing games, for instance... I used to play games with him, um, and then obviously I had to do it with E [sister} because she wanted me to do it with her. And I'd be like, I'd stab something and I'd go "don't you eat that, don't you eat that" [playfully] and then, and then I'll pretend to do something "that's	things like, she will see a picture on there**, she will touch it, she will play, but she won't eat it.** 23:950

			mine, don't eat it!" and he would eat it, he would. And y'know, he'd get really, he'd laugh about it and it were getting him to eat it, he'd eat it. **But it didn't last.** 22:930 P11: …..So I'll say "y' need to eat your sausage and you need to eat your Yorkshire pudding" and he'll say straight away, "I don't want to eat my potatoes" and I'll be like, "well, try and try them for me" and, and, and at first it worked. I could chop them up into really small pieces and he, and if he seen like it were only a small piece, he would try it, he will eat it. And if I could only get two tiny pieces down him, it's something. **But he won't even do that now.** 25:1051 P11: I'd say I were [worried], yeah, I'd say I were. Yeah, because, um, it's not a thing where I can, I can't, whereas before, like you say, you can like think, well if you, if, you know, if you eat that one piece, or if you do this, or if you, if you be really good and you eat all your dinner, we'll do this, an', an' the, the... **nothing's working anymore.** 25:1074	

11.17 Appendix Q - Incidence Table of Attributions of Avoidant Eating

Explanation	**P1**	**P2**	**P4**	**P5**	**P6**	**P8**	**P9**	**P10**	**P11**	**P12**
Sensory		**X**				**X**			X	
Interoception	**X**	**X**	**X**	**X**				**X**	**X**	
Low food interest		**X**					**X**	**X**		**X**
Arrival of sibling	X				X					
Temperament/personality		**X**		**X**				**X**	**X**	
Part of a wider profile		**X**		**X**					**X**	
A developmentally normal phase		**X**			X					
Need to control				**X**		**X**			X	
Genetic (parent is AE)		**X**	**X**	**X**						X
'Something wrong' with child	**X**								X	
Concludes they do not know	**X**				**X**			**X**	**X**	**X**

A distinction is made between a maintained view and a rejected view, the former being denoted with bold type.

12 References

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