

**Children's restricted eating: analysis of parental and
mealtime discourses**

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Submitted in accordance with the requirements for the degree of
Doctor of Clinical Psychology (D. Clin. Psychol.)

The University of Leeds

School of Medicine

Academic Unit of Psychiatry and Behavioural Sciences

October 2017

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Acknowledgements

Firstly, I extend thanks to the families and parents who gave up their time and energy to take part in this research project. I have felt hugely privileged to hear what you said, and meet you and your families in your hectic and busy lives. Your stories have been moving and important, and I hope I have done you justice in representing them.

I also thank the staff of four services who helped me to identify families for study 1. I would not have been able to conduct this research without your help. I very much appreciate your efforts and enthusiasm in supporting my recruitment process. I also thank the research and development staff at the trusts involved, and at IRAS, who supported the ethics process.

Particularly huge thanks go to my supervisors Dr Carol Martin, and Dr Tracey Smith, whose support and guidance has been invaluable, alongside encouraging messages and cat pictures to spur me on in. I also thank Dr Helen Edmunds, who has supported this process as field supervisor, and Dr Sylvie Collins who was involved in the early stages of this project.

In a more personal way, I must thank a lot of people for being there for me through this long process. Matty, I cannot express how much your love and support has meant through this thesis, the DClin and my MSc before it. I hope I can return the care now, and that we can do some more fun things with our time! Thanks also to my parents and siblings and friends, you have all listened to me and put up with me cancelling plans and talking about this thesis! And last but not least, thank you to my coursemates and colleagues in particular my office and car-mates.

Abstract

Introduction:

Many children restrict their food intake, some to the extent that they receive clinical intervention. Much of the literature on feeding difficulties implicates parents' actions in the mealtimes as relevant for outcomes around eating behaviour in the child. However, there is little consideration of the discourses and constructions made by parents in the understanding of their children's eating and mealtimes. A discourse analytic project was therefore undertaken with the aims of finding how parents talked (or used language) about their child's eating and mealtimes both within a mealtime and when reflecting about mealtimes.

Method:

Two studies were devised to meet these aims.

Study 1: A video recording was made of mealtimes in a clinical sample of three families accessing NHS services in relation to their child's restricted eating. Parents were subsequently interviewed, providing talk about their child's eating and reflections about their child's mealtimes.

Study 2: A non-clinical sample of parents using mumsnet and netmums internet forums, who identified themselves as having a child who restricted their food intake, were invited to take part in a qualitative online study about their child's eating and mealtimes.

Data from both studies was analysed using discourse analytic methods.

Results and discussion:

Study 1 found discourses about the children having been unwell and needing special care; acceptance and loss; blame and responsibility for the problem and implications of parental identity. These could be used to understand the goals of the mealtimes and the actions completed by parents at mealtimes.

Study 2 found discourses about the constructions about the child's eating; parents' emotional reactions, and blame and responsibility.

Taken together, the construction of the problem, whether parents accept or feel loss around it; and ideas around parental responsibility and blame contextualise different approaches to mealtimes. This gives clinicians and others ways to consider mealtimes, and how these may vary in individual families, in order to best offer support.

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Chapter 1: Introduction

Eating is a part of everyday life. Feeding a child may be considered as a primary role of a parent, particularly in the early years: without sustenance the child would not survive. As a child grows older, the role of parents in their child's eating changes and the child has more of a role to play in their own eating. For some children this is a relatively straightforward process, and for others difficulties develop. Mealtimes (or the times when children eat) can be a key part of family life also, and there may often be societal expectations about what should happen, relating to how they are set up, the food, and behaviours that are seen as good or appropriate. The starting point for this study was considering what mealtimes are like in families where a problem or difficulty has developed in the child's eating. This progressed to the development of two related foci: on what is said during a mealtime between parent(s) and child, *and* parental accounts of their child's eating. The study utilised Discourse Analysis, with a discursive psychology slant, to consider how the talk created by parents and children in a video-recorded mealtime is used to make constructions about the child's eating and what functions the talk had. Talk is the base of the data: the words used. Discourse is the stories and narratives: uses and functions this language creates or serves.

The introductory chapter firstly introduces eating and feeding development, before moving onto considering definitions of when problems develop and what could be considered an eating or feeding problem, and their prevalence. Factors associated with problems eating, including parental factors and feeding practices, are discussed next. The research in this area has largely been made up of quantitative studies where broad patterns, for example links between parent feeding practices and child eating behaviour have been made by multiple studies. These links are important and interesting, but do not tell us about what happens within mealtimes. There has been relatively little qualitative research on these interactions which would enable a more detailed understanding of what happens within individual mealtimes. Additionally, although parental self-report is a widely used methodological technique, this has often been through the use of questionnaires, or then been coded according to pre-existing schema. Two areas of interest are therefore developed: what parents and children say to each other during their mealtime interactions, and what parents have to say about

these mealtimes, or about their children's eating more generally.

Given that talk is identified as important, ideas around talk and discourse are introduced, with reference to studies about discourses around parenting, eating, and mealtimes. Qualitative studies investigating or utilising talk in mealtimes are discussed. The aims of the current study are then presented as a focus on the talk produced both within a mealtime and by parents about mealtimes and their child's eating.

The Development of Feeding and Eating

Feeding (usually in earlier infancy, and involving the giving of food by a parent or other) and eating (the consumption of food) involves an interplay between a complex range of skills and behaviours which progress through multiple phases in healthy development. The transition of a bolus of food is the basis of eating, but in order for this to happen, the child must possess the physical ability to do this effectively, involving their mouth, their throat, digestive system. This is also reliant on the availability of food appropriate for the child to eat, and therefore on the provision of food by parents. As well as food being merely available, infants need to be physically fed via breast or bottle. A relationship where a child's needs are recognised and met in terms of food provision occurs here. Wickenden (2011) points out a conversational element to feeding as the child becomes more proficient at communicating when they are hungry, full or uncomfortable, necessitating further skills on behalf of child and parent.

In addition to the ability to understand signals from their body and communicate them, the child's physical ability to feed themselves develops, therefore facilitating the child to meet their own needs. From around six months of age, babies may be more active in their feeding, for example holding food or grabbing a spoon (Carruth, Ziegler, Gordon & Hendricks, 2004). In a study of the timing of the development of physical skills infants need to feed themselves, Carruth and Skinner (2002) used parental interviews when children were aged between 2-24 months of age to assess the onset of gross motor abilities e.g. sitting and crawling, fine motor skills, such as raking food with the fingers; and oral motor skills progressing from opening the mouth when food approached, onto chewing and swallowing foods without choking. The focus was on the ages these abilities developed, and it was noted that there was a considerable range reported by parents. Although there are some methodological weaknesses associated with parental interview, this study

demonstrates the range of physical abilities needed for eating. The varying timings of the development of these skills indicate some of the individual differences that may be present for different children. Problems or delays in these purely physical areas can lead to difficulties with eating.

In addition to the development of physical skills in feeding, these must also be utilised in eating behaviours, such as taking food from plate to mouth, and gradually increasing food repertoire. During weaning, the child's repertoire of food usually expands, progressing from softer foods such as purees, to a gradually increasing range of textures and tastes.

Wickenden (2011) also reports that alongside these food intake behaviours, there can also be eating behaviours that do not involve the child consuming food, such as spitting food out. Behaviours where a child is not taking in food can also be considered to be a part of healthy and normal development. Dovey and Martin (2011) report that children may push food away or eat slowly when they are full, using their physical skill to monitor satiety and enact this behaviourally. Douglas (2011) describes 'faddy' eating as common and suggests that food preferences in children vary repeatedly and frequently over time. Harris (2009) suggests that up to the age of 2 years, all children are likely to be 'faddy' or experience neophobia (rejecting new foods and some previously accepted foods), but that beyond 2 years of age this tends to stop. Behaviour around eating and mealtimes, have been categorised as 'appropriate' or 'disruptive' by Sanders, Patel, Le Grice and Shepherd (1993). A combination of both of these 'appropriate' behaviours such as requesting food, preparing food, biting and chewing, as well as the 'disruptive' behaviours such as food refusal and noncompliance (presumably with parental requests), spitting or playing with food, were found to be commonplace when parents rated the occurrence or non-occurrence of a list of behaviours. This study separated 'feeding disordered' and 'non-problem eaters' and found that while these behaviours were much more commonplace in children categorised as having a feeding disorder, they were also present in the 'non-problem eaters'. Faltering growth (previously known as 'failure to thrive'), weight loss, or deficiency in certain nutrients may be seen as demonstrative of behaviours being a problem. Further consideration is given to the definition of problems.

Eating problems

This section considers what could constitute a feeding problem in general terms, as well as a focus on some of the terminology used. Terms used alongside the varying definition of feeding problems in the literature are considered first, followed by studies prevalence of feeding and eating problems involving the restriction of food.

Parental report has been widely used to gather data on feeding behaviours, and while some of these have been specified by researchers, such as “not always hungry at mealtimes... trying to end the meal after a few bites... strong food preferences” (Reau, Senturia, Lebailly & Christoffel, 1996, p 149), whether or not this is problematic may be relative to the individual. Transient issues described by Douglas (2011) may be experienced as highly problematic by some but not by others. Terms implying acceptability and judgement such as ‘disruptive’ or ‘inappropriate’ are applied to specified behaviours by Sanders, Patel, Le Grice, and Shepherd (1993) in the development of their Mealtime Observation Schedule. It is difficult to ascertain whether ‘disruptive’ behaviours would tend to be considered ‘problematic’. It is perhaps children whose feeding appears to be impacting on their weight that are more likely to be referred to services. Faltering growth may lead to more concern from medical professionals (Dovey, Farrow, et al., 2009).

ARFID- Avoidant/Restrictive Food Intake Disorder

The classification of problems versus what could be considered as a part of normal eating behaviours is not always clear. One of the most significant developments in this in recent years is the development of the ‘Avoidant/Restrictive Food Intake Disorder’ ARFID diagnosis, produced by the Diagnostic and Statistical Manual of Mental Disorders or DSM-5 (American Psychiatric Association, 2013). The manual requires both a disturbance in eating resulting in consumption of insufficient nutritional and /or energy intake. It is indicated that this would be observed through manifestation of faltering growth and/or weight loss. Behaviours described as problematic include “apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating” (APA, 2013, p334). ARFID is differentiated from other eating disorders in the manual, and is defined as not related to changes in perception of body shape. This issue is therefore categorised as a mental disorder, rather than purely explained by a ‘concurrent medical condition’. The inclusion of avoidance based on the sensory characteristics of food, and concern about aversive consequences of eating indicate

possible aetiologies, possibly explained by sensory sensitivities, or fear of a negative effect of eating food.

Fisher, Rosen, Ornstein, Mammel and Katzen et al. (2013) completed a retrospective case-control study to evaluate the diagnosis. The cases examined had been referred to seven adolescent eating disorder clinics in 2010 in Canada and the USA. Charts from all new referrals within a time frame were included and reviewed. The clinics providing the sample were for adolescents which limited the possibility for assessing whether children as opposed to adolescents would meet criteria for a diagnosis. The limited clinical information available from records could also be considered a limitation in that when collected, the dimensions related to the diagnosis may not have been considered, meaning the data quality is not certain. The study's findings were important in thinking about the different possible aetiologies of a feeding problem, however. The study found that young people with ARFID were unwell for longer and were younger than those with Anorexia- or Bulimia- Nervosa (prevalence rates in child clinics would be interesting to consider). Of the ARFID cases analysed 28.7% experienced 'selective (picky) eating from early childhood', 19.4% had gastrointestinal symptoms, 13.2% had a history of choking or vomiting. More than half had comorbid medical conditions. This was significantly higher than the 10% of patients with anorexia. Anxiety was also more prevalent in those meeting ARFID criteria. These findings suggest that for a group of young people who limit their food intake to the extent that they lose weight, but who are not pursuing weight loss, that a history of medical problems may be important in the development of the problems, and could be related to aversive experiences around food.

Other descriptors have also been used historically to describe difficulties eating. Feeding and early childhood eating disorders have been categorised in a variety of ways, such as organic (i.e. related to a specific physical problem such as cerebral palsy) and nonorganic (i.e. poor environment or parenting) (Budd, McGraw, Farbisz, Murphy, Hawkins et al, 1992). Children with disabilities or physical problems, such as oesophageal reflux, are more likely to experience feeding problems than typically developing children (Chatoor & Ganiban, 2003; Field, Garland & Williams, 2003). Children may also refuse or avoid food behaviourally rather than in relation to a physical problem specifically, perhaps following negative experiences, or based in fear of food for example (Dovey, Farrow, Martin, Isherwood, and Halford,

2009).

Food refusal

Food refusal is a commonly used term, and on the surface is a behavioural description, a child refusing food. However the degree to which the child refuses food is not always agreed upon. In a review, Williams, Field and Seiverling (2010) define this as ‘a severe feeding problem in which children can refuse to eat all or most foods’(p625). Chatoor and Ganiban (2003), however delineate three main types of food refusal. They categorise these along two lines: aetiology and the way in which the refusal presents. The first of these is inconsistent or unpredictable food refusal, which occurs at some times but not at others. They made less comment on the aetiology of this type of feeding problem, but this became a more important part of the categorisation. Fear-based food refusal is described as following a traumatic eating event, or series of unpleasant or aversive experiences of food, for example, vomiting. Selective food refusal is related as consistent refusal of specific foods across all settings. This was related to sensory sensitivities. Unpredictable food refusal was broader and included inconsistent and/or inadequate food intake. The latter two focus on how the food refusal presents, while the former is defined by what precipitated the problem.

Picky or fussy eating

Taylor, Wernimont, Northstone and Emmett (2015) in a review of definitions, assessment, prevalence and dietary intakes, indicate that there is no universally accepted definition for picky or fussy eating, and recognise that there are also many words that could be used to describe it. From the definitions included in their review, it is apparent that restrictions in the types of food eaten, and often amount of food eaten are common ways of defining these issues. However, the problematic aspect of this seemed to vary, with some (Mascola et al., 2010 cited in Taylor, Wernimont, Northstone & Emmett, 2015) referring to the need for adapted meals from parents alongside limited food intake (Dovey et al., cited in Taylor et al., 2015), and others to inadequate variety, although it is not clear what constitutes adequacy. The variety represented in their relatively small review demonstrates the range of ways these difficulties may be conceptualised. The aspect considered problematic varied: while limitations in types of foods consumed was important, Dovey, Staples, Gibson, and Halford (2008) differentiate food neophobia from ‘picky/fussy’ eating, describing the latter as being a more wide-ranging rejection of foods whether they are familiar or

not, and the former as unwillingness to try new foods, which could be seen as a more problematic behaviour. The impact or perception of these 'problem' feeding behaviours is important to consider here, or as suggested by Essex and Wooliscroft (2011), perhaps it is persistence rather than transience of these behaviours that is problematic and may therefore lead to access to services to intervene or support with these problems.

Prevalence

An estimated 25% of parents report food refusal in their children (Chatoor & Ganiban, 2003), but there is a marked range between studies, from 8 to around 40%. Jacobi, Agras, Bryson, and Hammer (2003) found that in a longitudinal study following 12 children from 2-11 years, that over the course of this time, 39% of children were reported to be picky eaters by their parents, with incidence decreasing with age (fewer new cases per age group). However, point prevalence increased (the prevalence at the beginning of time added to new incidences), which suggested that although there were fewer new cases of picky eating as children got older, the total proportion of children who were described as picky eaters did not, suggesting that the problem was chronic in nature. Later, Jacobi, Schmitz and Agras (2008) completed a cohort study of 426 older children aged 8-12 years and found that 18-19% of children were classified as 'picky eaters'. Parental reports were used to answer the question 'Is your child a picky eater?' with responses being given on a Likert scale from 'never' to 'always', with 'never' and 'rarely' categorised into a non-picky eater category and 'sometimes' 'always' and 'a lot' into a picky eater category. Little consideration was given to how parents answering this question defined 'picky eating' meaning that it is not clear what this was measuring, which was justified by the reported high level of agreement between behavioural measures and parental reports of picky eating in the study by Jacobi et al. (2003).

A prevalence study by Equit, Palmke, Becker, Moritz, Becker, and von Gontard (2012), indicated that 34% of 1090 children aged between 4 and 7 years could be classed as 'selective or restrictive' eaters, however more than half of parents (53%) reported that their child avoided some foods, suggesting that some avoidance of food is 'normal'. Sixty-one percent of this sample were classified as 'normal eaters'. The probability (p) of responding positively to the question 'my child avoids certain foods' was 0.33 for 'normal eaters', compared to 0.9 for 'selective eaters'. There was a considerably greater probability of parents of 'selective eaters' reporting that their

child ate a 'limited range of foods' compared to 'normal eaters'. The findings from this class analysis suggest that the degree to which restriction or avoidance occurs differentiates 'normal' from abnormal or problematic eating.

Wright, Parkinson, Shipton and Drewett (2007) found that 8% of 455 parents of children aged 30 months responded in a questionnaire that their child was 'definitely faddy' and scored lower for foods liked, and gained less weight over the first 2 years. Twenty percent of parents reported that they felt their child's eating was problematic. This finding is interesting as it suggests that 'faddiness' in this study had a higher threshold for parents in terms of notability, than problematic eating. This could reflect other problems with eating such as overeating, but could also highlight the difficulty surrounding the use of language to make assumptions about what is meant. There is clearly a problem here as there was no effort made to ensure that parents shared an understanding of what this question meant.

Discrepancy in definitions may be part of the reason for the differences in prevalence rates, resulting in a mismatch between studies in terms of what was being studied. The ages of the children also could be a factor, as the longitudinal study by Jacobi et al. (2003) suggested. Having recognised that there is a high rate of feeding difficulties in this further research, some of the ways eating difficulties have been classified are discussed. This issue also highlights questions about how parents may talk about their child's eating, and whether or not it is a problem. These prevalence rates do not indicate much about what constitutes feeding difficulties and where they may come from.

While it has been established that some food refusal or avoidance of certain foods may occur in many children and be considered in some cases a part of normal development, it can clearly also be defined as problematic. As discussed earlier, many physical, relational, and other systems are implicated for eating to develop and progress. This highlights some of the ways in which eating development can be disrupted, and problems may develop. For example, oral-motor problems and other physical difficulties or medical problems such as dysphagia may cause problems with feeding, and unsafe swallowing (e.g. when food goes into the lungs rather than oesophagus) may impact on feeding in some children. Harris (2010) also suggests past aversive experiences such as allergy or pain with food as providing a more psychological barrier. This finding fits with interview data collected by Douglas and Bryon (1996) where aversive experiences such as feeding distress during the first six

months, and high levels of vomiting were commonly reported by parents of children with severe feeding and eating problems. This could perhaps be seen more like a phobia. Parental feeding practices have also been implicated in the development or maintenance of feeding problems. These could also link to parental concerns following on from physical difficulties. It may not always be possible to tell what the cause of a feeding problem is, or several potential causes may occur simultaneously. The nature of the feeding problem may vary between individuals.

Terms in the current study

Having considered the literature, that while there were many terms used to describe eating difficulties 'eating difficulties' is used alongside 'restricted food intake' to represent a broad-reaching idea that children would be restricting either the amount of types of food they ate, or the amount that they ate. Terms such as food refusal and picky/fussy eating can be used to refer to both restrictions in amount and type of food. The ARFID diagnosis can include restriction of types and/or amount of food. Restricted food intake itself is rarely defined specifically. This study is concerned with children who limit or restrict their food intake in either type or amount and it is recognised that there are many ways that this could be defined. As is discussed later, this study offered a range of terms to participants to reflect the apparent range of terms utilised in the literature and likely by parents also, however, the food intake of the child had to be considered to be restricted or limited in type or amount by the parent participants or by clinicians involved in participant identification.

The role of parents in feeding

As mentioned in relation to normal eating development, parents are important in the feeding of their child and are influential on their child's feeding behaviours and habits, acting as 'providers, models and regulators' (Birch, Savage and Ventura, 2007, p3). Black and Aboud (2011) apply theoretical principles of responsive parenting to a feeding context, saying that the context should be comfortable, with clearly communicated expectations, the child should be responded to encouraged and responded to appropriately for their level of hunger/fullness, and level of development; promptly; and contingently (that is in relation to their own behaviour). Black and Aboud suggest that this provides the basis of the normal development of feeding. Examples they provide include: signals of hunger/satiety from the young child, with starting or stopping feeding and the child learns their needs will be met; the provision of routines and environment to support feeding allows the infant to

explore new foods and to try to self-feed and that mealtimes are positive experiences where the caregiver will be responsive to requests or signals. This section discusses feeding practices in relation to typical feeding. Parental feeding practices and problem behaviours are discussed later.

Feeding practices can take a variety of forms, but could largely be described as behaviours conducted by parents in order to impact the food intake of their child. Parental feeding practices associated with child feeding problems seem to have been largely categorised between coercive (e.g. force-feeding as an extreme) and restrictive feeding practices. Musher-Eizenmann and Holub (2007) point out that there are also other feeding practices, such as modelling of healthy eating, that are less studied, but which fall along a spectrum of feeding behaviours.

Carnell, Cooke, Cheng, Robbins and Wardle (2011) conducted a qualitative study using parental reports and diaries that investigated parental feeding practices and motivations for these in parents of pre-school children without particular feeding problems identified. Feeding practices described by parents included involving their child in the choice or preparation of foods, playing games with the food, verbal discouragement, and instrumental feeding (using one food to encourage the child to eat another). This study begins to identify the sorts of behaviours that parents feel they enact within mealtimes. The latter strategy however (instrumental feeding), has been found to decrease the preference for the target food in other studies (Birch, Marlin & Rotter, 1984). Carnell et al. (2011) also sought to gain parents' perspectives on their motivations for their feeding tactics and behaviour. This is discussed within the section on parental factors.

Several studies have investigated links between parental feeding strategies and practices to child feeding behaviour, tending to see parental behaviours as influential on child behaviours. Associations have repeatedly been found between more demanding, coercive parental behaviours and feeding problems in children. In an observational study of 45 pre-school children, Sanders, Patel, Le Grice and Shepherd (1993) found significant associations between coercive and aversive parental behaviours and food refusal with noncompliance in their children. They also found that parents of children with feeding disorders engaged in more aversive feeding behaviours than did parents of children without feeding problems. Similarly, Powell, Farrow and Meyer (2011) found that maternal self-reported pressure on children aged 3-6 to eat was predictive of food avoidance in their children. It is interesting that in a

study of older children, aged 7-11 in Australia, that children reported slightly but statistically significantly lower parental responsiveness and demandingness than their parents.

It is possible that parental coercive feeding is more common as a reactive strategy rather than a precipitant. Haycraft and Blissett (2011) report that controlling parental feeding practices are predicted by child feeding behaviour (as well as child temperament and parental mental health). It seems likely that there is a bidirectional relationship and that parents and children impact on each other. After the completion of the current study's data collection, and initial literature review Walton, Kuczynski, Haycraft, Breen and Haines (2017) published a paper which proposed a relational model of understanding parent-child interactions around eating, and that this relationship should be considered as bidirectional with parental behaviour or feeding practices being influenced by the child's behaviour and vice-versa rather than the relationship only working one way. Importantly, they also propose that mixed methods involving observational data and qualitative data should be used in order to understand childrens' mealtimes better. Over the course of the completion of the current study, the need for more detailed understanding of what occurs during mealtimes was identified, which support the aims of the present study.

What is interesting about the research in this area is that parental strategies such as pressure to eat do not seem successful on a broad level. It could be hypothesised that this mismatch between parent and child behaviour is important in the interaction and the relationship, although the quantitative data does not tell us how. The literature reviewed up to this point has demonstrated the importance of the relationship between parent and child in feeding interactions. While parental behaviours have been identified as important in relation to a child's feeding behaviours, there is considerable room for understanding in detail what issues and processes may account for problems and for understanding what parents and children say to each other in these interactions. Talk between parents here may be a useful source of data on the processes within mealtimes.

Parental Factors

Parents have been found to utilise a range of different feeding behaviours. Carnell, Robbins and Wardle's (2011) qualitative study, mentioned in relation to the role of parents in feelings divided motivations into categories of: practical,

(health/balance/variety), and weight related motivations, and were related to feeding practices designed to gain particular outcomes (e.g. promote food intake or to restrict it). There were also other more relational reasons cited, such as offering food for the child to calm down, or to be 'nice' in case the child felt left out. Reasons cited for promoting the food intake of children included time pressures, wanting children to have eaten enough to not need food again too soon, or to ensure their children had the right amount of food for good health and development. The data gathered suggest that in families with a variety of backgrounds and characteristics, parents seek to impact their children's behaviour for a variety of reasons. Pre-existing literature was used to guide some of the themes, as well as bottom-up methods. The use of top-down analysis could have led to falsely divided themes. The use of parental report alone reduces the validity of the findings: their reports could be influenced by demand characteristics. Additionally, it is possible that societal or researcher discourses could have influenced the findings, however this was not fully explored.

Blissett, Meyer and Haycraft (2007) link maternal mental health with difficult child feeding interactions and child eating behaviour. This is having also referenced the 'ambiguous' causality of the relationships between factors investigated in other studies, particularly in the presence of mental health problems in parents. This suggests that parent factors may also play a role. The authors worked with a community sample of 106 mothers (56 of male children and 40 of female children, mean age 32 months). A selection of measures tapping into mental health difficulties including anxiety and depression, and eating disorders were completed. The mothers of male children who scored higher on measures of anxiety and depression but not on eating psychopathology scored higher for more difficult eating interactions. In contrast, mothers of female children who reported higher eating disorder symptoms in themselves but not anxiety, reported higher food refusal. The differences between the reports of male and female children are interesting here. As the study utilised self-report measures it is not possible to tell whether these differences are due to differences in mothers' perceptions of their child's behaviour or a manifestation of different types of interactions. It is possible, for example, that female children mimicked their mother's (who reported symptoms of eating disorders) behaviour in a way that boys did not. This study raises questions about *how* maternal psychological well-being might have a role to play in eating interactions and child eating behaviour, and questions about what it is like for parents in this situation to feed their children.

Collins (2003) conducted qualitative interviews with mothers who themselves had problems with their own eating, about their experiences of feeding their children, in the context of their own difficulties around eating. In order to address this, mothers were interviewed twice: once individually, and for a second time while watching a video of their child's mealtime in an Interpersonal Process Recall (IPR) approach, whereby a video is used to prompt recall of the interaction. The interview data was analysed using Interpretative Phenomenological Analysis (IPA) in order to understand parental experiences of what it was like to feed their child. The mealtimes themselves were coded using the Mealtime Observation Scale (Sanders, LeGrice et al., 1993). Ten mothers and their children participated. Although limited by the small sample, Collins found that there were higher levels of 'stress, control and disorganisation' in mealtimes of women with higher scores on the eating disorder measures, although the small sample means this is not statistically significant. In qualitative analysis, the women who took part made reference to their own childhood experiences, and their current relationship with food as influential on their relationship with feeding their child. Mothers made comments about healthy eating, with views about whether certain foods should be restricted or not ('good' and 'bad' foods) varying between participants. Mothers expressed worry and concern about their children's eating and links were made between their hopes for their child in terms of their relationship with food and their physical health (wanting this to be better than their own), and their desire not to have a negative impact on their child's eating. One mother commented on the emotions brought about by the advice given by experts and the mealtimes, that there is a rulebook that professionals believe should be followed, but which cannot be met. Another parent made links between her own patterns of eating and her child's. Rather than making linear links between maternal and child behaviours, Collins' study helps in understanding how parents who have had their own difficulties around eating might experience their child's eating, and how this may translate into actions in their child's mealtimes. The data from the interviews contextualised the quantitative findings raised in other studies. From the data excerpts included in the thesis, it was apparent that the language used by mothers could also be of interest here. While the mealtimes were utilised to an extent, more focus could have been given to what happened between mothers and their children during the feeding interaction.

Parental romantic relationships and child feeding/eating behaviours

Very little research has been done in this area. Haycraft and Blissett (2010) received data from 156 mothers, all married or co-habiting with a partner and recruited from British nursery and pre-schools. Participants reported on the quality of their current romantic relationship in terms of warmth and hostility shown to them by their partner. Data was collected via questionnaire on parental feeding behaviour and child eating behaviour. Children were aged between 1.5 and 6 years. Mothers reporting greater warmth in their relationships reported that their children enjoyed food more, and were less likely to emotionally undereat, as well as to be less responsive to feelings of satiety. Conversely, the mothers who reported hostile relationship quality reported greater restriction in their children's food intake. Mothers reporting moderately hostile relationships reported their children were slower to eat, and more likely to emotionally undereat. More hostility in the maternal spousal relationship was also related to reduced likelihood to monitor their child's eating. The correlation coefficients were low, indicating relatively small relationships, although significant. It seems possible that hostility could be present at mealtimes, which seemed to alter the way food was offered at mealtimes, which intuitively would make sense, in addition to a warmer atmosphere being likely to engender a more pleasant eating environment for the child. Clearly this is an area that would benefit from further research as this could be an avenue for potential intervention. It is also possible that parents perceive themselves to be more restrictive if they perceive a more hostile relationship also.

Fathers and feeding practices

While not always excluded from studies, the literature investigating fathers and feeding is relatively minimal, with most studies including fathers as part of a sample rather than reporting on them separately. Khandpur, Blaine, Orlet Fisher and Davison (2014) also completed a review of twenty studies into fathers' feeding practices, sixteen of which were quantitative. Given the small number of studies investigating paternal feeding practices alone (three of the twenty reviewed), the majority of studies were those that had investigated parental feeding practices more broadly but had separated mothers' and fathers' data within them (e.g. Blissett & Haycraft, 2008). The authors noted that the definition of who was considered to be a father had been neglected, and that in the context of many different types of paternal relationships and the amount and type of involvement these figures can have in children's lives, there is a limit to which the understandings generated can be

generalised. Additionally, many of the measures used were developed with mothers, and it is unclear whether these were appropriate for use with fathers.

Following on from this review, Khandpur, Charles, Blaine, Blake and Davison (2016) sought to address the lack of father-focussed research on feeding practices through the completion of a study using a qualitative interview methodology to explore what feeding practices fathers reported using. Forty fathers were interviewed and asked about their own behaviours in relation to feeding their child. The data was categorised and the prevalence rates between fathers divided by different attributes, such as whether they were resident or non-resident with the child, or whether they had a college education, were analysed. The feeding practices identified were divided into responsive practices, made up of practices relating to autonomy and structure, and unresponsive practices relating to coercive control and permissiveness. While the themes were clearly delineated using a chart, and illustrated with examples and quotes, the use of overarching categories of 'responsive' and 'unresponsive' feeding practices were not clearly described or justified. The unresponsive practices in some instances, such as 'pressuring the child to eat' and 'using distraction to feed' could perhaps better be described as non-contingent: they could be seen in a way of responding to the child not eating, but not necessarily in a way that was supportive or contingent in the way that behaviours grouped into the 'responsive' practices group were. Despite this difficulty with the category definition, twenty feeding practices reported by fathers were identified. More than one type of feeding practice was often used by the same father, indicating that there can be considerable variation. The authors concluded that fathers demonstrated similar feeding practices to mothers.

A study by Fielding-Singh (2017) also began with the same premise: that there had been little investigation of fathers' feeding practices, and again adopted a qualitative approach, interviewing mothers, adolescents and fathers. There was minimal description of the content of the interview schedule. This article was strongly framed and stated that 'many fathers are seen at best, detached, and at worst, a threat to mothers' dietary aspirations' (p98). Fielding-Singh reports that while mothers wish the fathers to be involved, they seek to exclude fathers from mealtimes. While there are a small number of quotes used to demonstrate that *some* of the 109 families interviewed did make statements about fathers making limited contributions compared to mothers, there was not sufficient evidence to support the assertion that the conclusions were the only ones that could have been drawn. There was little

evidence of reflexivity or consideration of the author's own position, or consideration given to the philosophical stance of the approach taken, raising questions about the way in which this was done and the reasoning behind this.

A study by Tannen, Peterson and Fraser (2014) examined discourses produced by mothers about fathers with a premise that fathers are 'silent' in the research, but also recognising that much research and public discourse has positioned women as largely holding the responsibility for children's eating. They found that gender was relationally produced. Rather than the strong wording of Fielding-Singh (2017), the authors reported that mothers tended to frame their partners as 'supportive' but less skilled than they were in producing food or taking this responsibility.

It is notable that while there has been less research with a focus on fathers, the role of fathers has been considered in more exploratory and curious terms in recent times through qualitative studies. There is very limited research looking at the talk of either mothers or fathers and their own experiences or understandings of their children's mealtimes.

Self-report, observational measures and limitations of quantitative studies

Many of the studies cited around feeding behaviours rely on self-report measures completed by parents. While this is a helpful and appropriate method for understanding parental internal measures, and for understanding parental perceptions of their child's eating, or what happens within mealtimes, there are problems with assuming an absolute truth is reflected within these. Some studies (Blissett & Haycraft, 2008) have managed this difficulty through triangulation of self-report through the use of observational measures. Some of the time, this has shown a disparity between what is observed, and at other times, agreement. It may be that the concepts portrayed by the words in questionnaires are not shared between participants and researchers: the language may not mean the same things to each person who reads it. Taylor, Wilson, Slater and Mohr (2011) and Walton, Kuczynski, Haycraft, Breen, and Haines (2017) commented on the differences between reports from children versus their parents. Taylor et al. (2017) reported associations between child-reported parenting style and food attitudes, whereas no association was found with parent reports of parenting style and the same outcomes, indicating that self-report may reflect a version of events or the 'truth'. There may be many possible reasons behind this, such as difficulties in recall of mealtimes in general or specific events, or a lack of awareness or reflective capability to be able to accurately reflect events, which for

some parents seem to be emotive. Additionally, there may be demand characteristics, or caution from parents in terms of what they want to portray about their child's mealtimes. That is not to say that participants' own representations are not of interest as they may not be 'accurate' but instead it raises questions about how we may understand what they say. These limitations of questionnaire measures used to measure particular behaviours can somewhat be ameliorated by the use of observation methods such as those used by Blissett and Haycraft above. This means that the researchers can be surer that what they intend to measure is being measured, although this strategy uses a lot more resources and may lead to smaller sample sizes. Demand characteristics may play a part here also, and only the specific event observed can be used. While demand characteristics and the difficulty of only having a snapshot from any research cannot be extinguished, a move in philosophical stance can remove the need for the language of participant and researcher to match and a truth to be found. Instead, if importance is placed on what is said, how, and with what purpose, this can shed light on not only mealtime interactions between parents and children, but also what parents have to say about their child's eating more generally. The available literature highlighted a lack of focus on talk in either of these contexts. Talk as a source of data, and discourses produced through this and other sources are considered next, with reference to the ontological and epistemological stance discourse analytic approaches entail.

Talk and discourse

Social constructionists such as Burr (1995) argue that "the person is socially constructed" (p32). That is we come to see and understand ourselves and others in a way that is built or constructed by society: that the language we as society use is what leads to these constructions of self and person. The way we talk about and are talked about influence our view of ourselves and the world. Burr also points out that studies of discourse can relate to these ideas of self but also to the way people use language: the purposes behind their words. More is said on this in Chapter 2 in relation to methods of discourse analysis: Foucauldian discourse analysis and discursive psychology. However, both the approaches Burr describes may be important to consider in relation to parents and children and their feeding interactions. If talk is important to personhood, and societal ideas are influential, both parents and children could be affected by this. If talk is used purposefully by parents and children, then this is also of significant interest in understanding the processes occurring or developed

through this talk. Discourses around issues of food and eating, feeding and parenting, are considered here as part of a broader landscape and context.

Discourses, food, eating, and culture

There are many rules, norms and discourses around food, eating and mealtimes in society, which vary between contexts, and which link into other discourses around issues and ideas such as health, values, social identities, class, gender, parenting, culture. It seems that there is a cultural value attached to food, and that this varies between cultures and societies, but also within them. Rozin, Remick and Fischler (2011) found in questionnaires that French people value quality and moderation in food, compared to people from the USA, where more value is placed on abundance and convenience. Discourses around healthy eating have been found to vary between cultures and result in eating behaviours to achieve a goal of healthy eating (Ristovski-Slijepcevic, Chapman & Beagan, 2008).

It seems that multiple complex societal discourses and ideas around food and eating exist. There may be discourses about the meaning of mealtimes and food. Larson, Branscomb and Wiley (2006) suggest that mealtimes are symbolic of unity within a family, but also that there are discourses that also exist suggesting this sharing and togetherness is being eroded. Governments may create or attempt to create discourses through the use of public health messages. Schemes such as the 'Change 4 Life' (Department of Health, 2015) or '5-a-day' campaigns that issue guidance about what people *should* eat. Foods may portrayed as 'healthy' or 'unhealthy'; 'virtuous' or 'naughty'. This may alter people's conceptions of their own diets. In talking to shoppers about health, O'Brien, McConnon, Hollywood, Cuskelly, Barnett et al. (2013) identified discourses around the need for control to make health choices. The meaning for someone presenting these discourses could vary depending on their own eating behaviours. It seems that discourses and behaviours interlink in a complex fashion and influence each other and themselves.

Discourses Around Parenting, Health and Responsibility

When children are born, they cannot feed themselves, making their parents therefore responsible for their food intake. Lupton (2008) discusses the presupposition of schemes such as those developed by governments aimed at health promotion that parents will act to promote the optimal development of their children. Lupton also comments on the idea that mothers (rather than fathers) are often more heavily implicated in these health related messages, starting with pregnancy and

progressing through breastfeeding and later onto other health related behaviours such as immunisation, taking environmental safety precautions and likely behaviours around feeding a child, or ensuring they are active.

Murphy (2000) interviewed 36 mothers individually at six time points: during pregnancy and at specified times until the child was two years old. Reference was not made to a specific established analytical approach used and codes were formed into an operational framework discussed between researchers. The data presented is from a subset of 12 women who initially took the advice of professionals to start breastfeeding, but then stopped. Murphy considered how mothers dealt with this as a threat to the identity as a 'good mother'. She discusses the idea that neoliberal societies invoke discourses about a 'good mother' being "one who maximises physical and psychological outcomes for her child, regardless of personal cost" (p292).

Murphy discusses perceptions of infant feeding as a 'social problem', making people accountable to society for their actions, and she says 'hold mothers responsible for the way their children turn out', (p295). Participants reportedly saw feeding decisions as moral and needing to be justified in the face of challenges by others in order to retain a 'good mother' identity. This is in the context of an interview that could have been seen socially by mothers as a setting in which they might be judged by the researcher. This may have influenced the justifying nature of some of the talk represented. However, the paper highlights some important ways in which feeding a child is important for parents in terms of the way they present themselves to others, and the way in which they may be seen or treated by others in society (such as healthcare professionals).

Whilst the current study is not concerned directly with breastfeeding, it is concerned with discourses and talk around feeding, and what might influence feeding interactions. It is clear that discourses may be experienced in different ways but that they may be important in a parent's thinking and decision-making about feeding, as well as their reported experience. Wall (2001) suggests that while breastfeeding can be seen as empowering and as demedicalising child-care, there may also be 'restrictive subject positions' shaped too. It was not known which discourses may be present with parents feeding children with a feeding problem.

Mealtimes will vary between households and can be characterised in different ways. In a qualitative analysis of multiple videos of family meals in four families, Grieshaber (1997) points out differences between hers and other studies, where she

understood children as ‘active participants’ in the family mealtime in comparison to others that see the job of ‘feeding the family’ being located with parents. Greishaber draws on ideas about resistance and power within these discourses and also talks about the use of mealtime rule-setting as a means by which parents may seek to ‘configure’ their child as one who behaved in a certain way at a mealtime (i.e. conformed to social rules and norms about eating a meal). However, she acknowledges the different positions of children and parents and makes observations about the social and power discourses occurring between parents and their children. Greishaber does tend to focus on gender roles and issues, which may have guided the way in which she viewed and constructed power in her representation of these discourses. Consideration of power relations in mealtime interactions may be important in thinking about social purposes of the talk occurring.

In a qualitative study, O’Connell and Brannen (2013) interviewed 47 sets of parents and children (aged 2-11) about mealtimes. Traffic light stickers were used to assess how much ‘say’ children thought they had about food. It is possible that this may have been a difficult concept for some (especially young) children to grasp, as well as being asked about what they thought was happening in pictures of a child refusing food. Some children took photographs of meals. It was somewhat unclear how this data was combined: it is stated that a flexible approach was taken, however this leaves the reader with some questions about how this was done, and therefore the extent to which researchers’ pre-existing ideas informed conclusions, or how fully the data was used. Using both parent and child data allowed useful comparison, however.

Four types of power relationships were identified: hierarchical, where parents either overtly or covertly controlled their child’s eating; resistance, where both parent and child attempted to control the food the child ate; child control, where the child has more say in the food they eat; and negotiated order, where there is some compromise, e.g. parents preparing food that they know their children will eat. They suggested that younger children, or those conceptualised by parents as less competent in making decisions about food were more likely to have less control in the feeding relationship. Poverty in both time and money were suggested as possible further influences on the goals of parents in feeding, and also cited parental feelings of inadequacy around the foods their children ate. Cultural values or socio-economic status were suggested as possible influences. In mealtime interactions in families where a problem is identified with the child’s feeding, there may be room to consider

Discourses in other aspects of parenting and child difficulties

Discourse analysis has been completed in a surprisingly small number of studies with parents themselves in relation to child difficulties. Instead, discourse analytic studies have tended to focus on the language used in other places. In relation to child obesity, Friedman (2015) examined scholarly articles and media in print around obesity and its intersections with child protection. She argues that the literature ‘reifies myths of poor parenting’ (p14) by drawing on discourses holding parents and bodies responsible for the development of child obesity and reproducing them, thus strengthening these ideas. Mainland, Shaw, and Prier (2015) found that in 70 mainstream media articles that a ‘fear of fat’ discourse was instilled alongside the idea of parental choice. These studies show that among popular discourses available to the general public, including parents, discourses of parental responsibility for their children’s weight and eating are prevalent. These are the sorts of discourses that parents may also draw on in relation to their own children, or are discourses others could use towards them. Parents themselves do not seem to have been a focus for research.

Parental discourses around problem representations were considered in the context of assessment for Autism Spectrum Disorder (Avdi, Griffin, & Brough, 2000). This study utilised interviews and observations of appointments with clinicians. Parents used discourses around normal development, and the medical model to discursively navigate this. Manago, Davis and Goar (2016) found in interviews with parents of children with disabilities, that these parents used both the medical model (situating the problem in the child) and the social model (situation the problem of society failing to accommodate an individual) of disability to ‘challenge’ and ‘deflect’ stigmatisation and devaluation of their children. It is interesting that these parents do not only use one type of discourse (i.e. medical or social models of disability) but are purposeful in their use of language, discursively acting to reduce the stigmatisation. This final study in particular suggests that despite availability of multiple discourses, it is the action with which the talk is used that is significant: different discourses can be used to perform different actions.

Talk in or Around Mealtimes as a Source of Data

Analysis of the talk and discourse within mealtime interactions could tell us more about how feeding interactions -that may or may not involve the use of ‘practices’ or ‘strategies’ by parents- play out. Mealtimes can be characterised as

environments important for learning, the development of language skills and socialisation occur (Harding, Wade & Harrison, 2013). In a cross-cultural study of mealtime talk, Aukhurst and Snow (1998) found that narratives provided by parents varied between Norwegian families where social norms were a greater focus, and American families where a greater focus on explanations of behaviours or physical events was observed. This fits with the idea represented in the previously discussed study by Carnell et al. (2011) that there may be a variety of complex reasons behind parents actions at mealtimes (although this was not considered through mealtime talk).

Harding, Wade and Harrison (2013) conducted a statistical analysis of communications made within video-recorded, naturalistic mealtimes of a small sample of six children aged 8 months to three years. The study was not conducted by psychologists, but rather, was conducted by linguists. Three children were categorised into a 'Typical Early Feeding' group from parent questionnaires, and three into an 'Early Feeding Difficulties' group. The data were coded and counted according to a pre-existing scheme including directive (e.g. instructions from parents) and social communications from both parents and children, such as comments about enjoyment or initiation of interaction from the child. Use of the coding scheme allowed comparisons to be made between groups, although statistical analysis could not be relied upon due to the small sample size. Additionally, the analysis was relatively simple, and how the communications of parents and children worked together could not be commented on. They suggest that there may be differences between the talk in parent and child communications where the child had early feeding difficulties compared to where feeding had typically developed. More language was used by parents of children with difficulties eating, to manage and guide their behaviours. Caregivers made relatively more comments about appropriate behaviour, and children initiated communication with their parents more where children had had early problems feeding. While Harding's et.al (2013) study is limited in the conclusions it drew by both sample size, and the use of a pre-existing scheme, the use of the language used by parents as providing insight into the interaction is relevant for the current study.

Kahari (2013), again from a linguistic perspective, analysed discourses at family mealtimes in Zimbabwe, making ten observations lasting approximately twelve minutes, and subsequently interviewing mothers for approximately 7 minutes. This was a very short time for either aspect. The use of 'persuasive communication'

aimed at changing the child's eating behaviour or encouraging them to eat was the target of the study. Kahari described the analysis as discourse analysis, but this was very limited and made reference to only two of the conversations in the paper. Nine types of persuasive communications were identified, e.g. rewarding eating, and positivity and negativity. However, this labelling of communications largely seemed to constitute the descriptive identification of feeding practices, rather than considering either the use of societal discourses or the way they were utilised in the context of the mealtime interaction. Some attempt was made to analyse the social purpose of these interactions as persuasive communications, although the apparent decision from the outset to identify persuasive communications could have blinded the researcher to other social actions occurring. Despite the weaknesses in Kahari's study (including lack of clarity over whether recordings were made, how the material for analysis was therefore gathered, and the limited reference to the first hand data within the paper) the methodology of observation followed by parental interview has the potential to yield useful data with families of children with feeding problems. Additionally, the structure and technique of the interviews were not made clear.

Wiggins, Potter and Wildsmith (2001) took a more detailed approach to analysing the talk within families at mealtimes, using a discursive psychology approach to discourse analysis. They analysed mealtimes recorded by families with teenagers with eating disorders over a seven-day period to understand the social purpose of the talk used and understand what functions the talk was performing. The discursive analysis focused on the constructions of a) objects, b) the individual and the c) the behaviour. They found that constructions about the nature of food as an object in the analysis (good and bad properties) was variable: it could be constructed as unpleasant to serve a purpose to the person who does not want to eat it, but be redefined or refuted by another family member for the opposite reason: to make a statement that the food is appealing and encourage the other person to eat it. The children or young people (individuals) in the families used their physiological states as persuasive devices, for example saying that they were full and did not have a big appetite to block parental attempts to encourage the young person to eat. Eating behaviour (e.g. a report of eating a particular set of foods) was constructed as normal or restrained, and also portrayed ideas around accountability. Due to the age of the participants, there may be a different kind of talk between families with older children, but, the focus Wiggins et al. (2001) place on the interactive context demonstrates the utility of a focus on talk and the possibility for using this to support understanding of

the links between parent and child. The social action of the talk has the potential to provide insight into not only how parents use talk to enact goals around feeding in the mealtime, but. The use of audio-recordings made by the families themselves are likely to have made this data a good representation of naturalistic interactions, compared to self-report measures, however while audio recordings may be less intrusive than video-recordings, it did not allow non-verbal information to be considered, or more contextual information understood. The use of recordings at several mealtimes will also make these more likely to be representative of mealtimes more generally. It would also be interesting to understand more about how parents or the young people reflected on or talked about the findings or the mealtimes.

While not a discourse analysis, the thesis by Collins (2003), which is discussed earlier in the introduction in relation to parent factors and mealtime behaviours, asked parents to reflect on a mealtime. She found that mothers who had had difficulties with their own eating reflected on the way they acted at mealtimes as well as their hopes and fears. Collins focused on the experiences of the mothers, but the way in which the mothers used language and talked about their child's mealtime also could be analysed around the different possible understandings of what happens in mealtimes, what is ideal, and what might impact on them. These stories or discourses could be very important in understanding the range of understandings available, and the ones parents discuss in relation to their own children.

Summary and the current study

There is a lack of clarity over the terms that may be used to describe children's difficulties eating and it appears that even within the academic literature there is overlap between terms, and a lack of agreement over what constitutes an eating difficulty. While ARFID has been developed as a more clearly operational definition, at the outset of this study this was not in common usage. The restriction of food intake in quantity or amount were the key aspects of interest, although there were many terms which could be used to describe this.

Interactions between parents and children have consistently been shown to be important in understanding child feeding behaviours. The studies which have made these links have tended to be quantitative, meaning that while generalisable patterns have been identified, these do not provide a full explanation of what occurs between *individual* sets of parents and children who are restricting their food in type or amount, in the interactions that have been identified as so important. This highlights the need

for research examining these mealtime interactions in depth, using qualitative rather than quantitative methods, as is also encouraged by Walton et al. (2017). The talk and words used by parents and children is a good source of data, which has largely been unexplored. The studies by Wiggins, Potter and Wildsmith (2001), and Kahari (2007) go some way to demonstrating the utility of discourse analytic methods for analysing mealtimes, however there have been no studies that have analysed the mealtimes of children who have eating difficulties using discourse analysis, or which have specifically looked at the talk occurring between parents and children at these mealtimes. This is clearly an area of importance as it allows better understanding of how the interactions happen, rather than simply labelling behaviours and practices.

The second unexplored area is parental talk and the discourses they use and create about feeding their children and their child's eating. This is true more generally, and in terms of their consideration of what happens within specific mealtimes. There has been remarkably little focus on what parents have to say about their child's mealtimes, rather a more common focus is a positivist philosophical stance attempting to find the impact of one factor on another within mealtimes. Collins' (2003) thesis, while not analysing discourse, gave a focus to parental experiences and made use of mealtime videos as a prompt for recalling what happened in the mealtime (in Interpersonal Process Recall). The combination of analysis of discourse within a mealtime, and the analysis of discourse of parental talk about a mealtime therefore had the potential to not only yield information on a mealtime and parental talk separately, but also for links to be made between them.

For this study, a clinical sample where the restricted eating (in amount or type) was sufficient to warrant intervention was initially identified as a focus and services working with such families identified as sources were liaised with. However, due to the difficulty in defining the terms and the commonness of difficulties eating, the discourses of parents of children not receiving specialist services' input were also identified as a potential source of data. The following aims were developed.

Aims:

1. The key aim was to understand discourses developed by parents of children who restricted their food intake (in amount or type of food), about their child's eating and mealtimes. This is addressed in both Study 1 and Study 2 below.
2. To understand discourses developed through talk within mealtimes, between parents and their children. This is addressed in Study 1.

The purpose and function of the talk and discourses are a focus for each aim.

The following research questions were developed:

Study 1

In a clinical sample of families accessing services in relation to their child's eating:

1. What discourses are constructed or drawn on by parents about their child's mealtimes or eating, either within an observed mealtime, or more generally?
2. How do these discourses contextualise and provide understanding of the observed mealtime?

Study 2

What discourses are produced by a non-clinical population of parents who identify their child as being a 'fussy', 'picky', or 'restrictive eater' or 'refusing food'? How does this compare with the data collected in Study 1?

Chapter 2: Methodology for Study 1

This chapter contains the methodology for Study 1, involving direct study of mealtimes in families with a child who is receiving specialist input around their eating, as well as following interviews. Study 2 is contained wholly within chapter 4 and relates only to online survey data collected from users of parenting forums who considered themselves to have a child who restricted their food intake in type or amount. As is discussed in the introduction at several points, there are several possible sets of terminology that could be used to describe this. Materials made use of multiple terms, referring to ‘restrictive’, ‘picky’ or ‘fussy’ eating, and ‘refusing food’ in order to allow parents to identify a descriptor that made sense to them. Study 1 included a clinical sample of parents whereby the nature of their access to services in relation to their child’s eating implicitly indicated that there was felt to be a problem present, rather than the avoidance of particular foods which can be considered as ‘normal’.

In this chapter, a fuller description of discourse analysis is given alongside a justification for the use of this in the current study. This leads into a discussion of the methods chosen for data collection, and a method section detailing the data collection process. The chapter concludes with the analytical process and framework for analysis with a narrative and reflective description of how this developed. The results for Study 1 are presented in Chapter 3, Results for Study 1.

Rationale

The choice of discourse analysis over other qualitative approaches

The introduction has recognised that, while there has been a large amount of research conducted on mealtimes and consideration of relationships between parental and child actions, this has largely sought to find patterns amongst groups, and links between identified variables, often around the interaction between parents and children at mealtimes. This is useful for making generalisations, but leaves gaps in terms of understanding how these interactions happen, or what additional insights parents can provide into understanding what happens in their own children’s mealtimes. This study’s aims were therefore developed towards investigating a more detailed and particular understanding of what can occur within the mealtimes of individual families. This therefore involved the use of qualitative methods in order to

gain detailed and deeper understandings of mealtimes.

The largely quantitative research in the area of picky, restrictive, or fussy eating in children, has given insight into some practices that occur within mealtimes, but researchers have been the ones to construct labels to describe these such as 'coercion' or 'restriction'. There has been little room for the development of understanding about whether, or how, these labelled realities are constructed within feeding interactions, or how or whether parents use these or other discourses to understand their child's eating and mealtimes. The language used within the research is interesting in and of itself, but has tended to label behaviours in a top-down organisation, with language used coming from researchers, rather than families. While self-report has often been used, this has been through the use of pre-constructed questionnaire measures, or been used to amalgamate and generalise findings, leading to the generation of broad links. Much less consideration has been given to whether observed and labelled behaviours are constructed in this way by parents or whether these constructions are borne out in the interactions between parents and children themselves. Discourse analysis is an approach that can be used on a range of data, and although often pre-existing talk or text data is used, it is also possible to use in-vivo data or interview data (Willig, 2008). It can be used to consider what functions talk serves and what discourses and constructions about issues, individuals, behaviours, are developed.

Other analytical approaches were considered. For example, Interpretative Phenomenological Analysis (IPA) could have been used to consider experiences reported by parents. IPA tends to consider how people make meaning, rather than how talk is used or the role it plays, as in discourse analysis (Biggerstaff & Thompson, 2008). It postulates that rather than constructing reality, an individual's meaning can be reached through interpretative processes. While this certainly could be a useful approach to take, it would not allow analysis of naturalistic mealtime data, but would be more suited to understanding lived experiences of parents. Grounded Theory (Strauss & Corbin, 1994), also offers an approach for qualitative analysis, which arguably gives more flexibility, but is more commonplace in areas where little research has already been done. As there is a significant amount of research already, although much of it utilising other approaches, grounded theory is not an appropriate methodologist.

Philosophical position

It is important to consider the ontological position of the researcher and epistemological position of discourse analysis overtly as it is quite distinct from other approaches, viewing talk as action being used to achieve social aims, rather than necessarily being revealing of internal processes or cognitions. This is quite different from those scientific research paradigms that tend to take a realist perspective to discover objective truths. Psychological research often uses experimental paradigms to research phenomena through the manipulation of variables in controlled settings. Behaviour may be seen as representative of psychological processes, and talk as representative of people's internal cognitions or states, and may be measured, e.g. through questionnaires. Discourse analysts reject that there is a straightforward relationship between subjective state and self-report measures, and posit that these observables occur firstly within their own context of dynamics; and secondly through language (Harré, 2001). Parker (2005) describes four key ideas in the analysis of discourse: multi-voicedness, the idea that the contradictions in the discourses people create are important; semiotics, both how we put words together to form discourses, and that we necessarily use words that are part of a discourse, the meaning of which we cannot fully control; resistance, that language is not merely descriptive but can have an action, for example language can be used persuasively, or to anticipate the reaction of the listener and agree with, or counter them; and the idea of separate discourses that may include or exclude certain people and the potentially oppressive nature of this through the formation of social bonds.

Discourse analysis has a variety of uses. In psychology, two main approaches to discourse analysis tend to be taken. Discursive Psychology and Foucauldian Discourse Analysis (Willig, 2009; Willig 2003). Other approaches such as Narrative Analysis can also be incorporated (Edwards, 2014).

Foucauldian discourse analysis

This approach takes a broader stance than discursive psychological approaches which are discussed next. Foucauldian Discourse Analysis concerns itself with how language and discourse impacts on 'social and psychological life' (Willig, 2003, p171), and how availability of particular cultural discourses may impact 'subject positions' (the stance or role a person may take, e.g. a patient as a passive recipient of care (Willig, 2003), or being of a particular social group). Participation in this group may then link to strengthening or altering of discourses that led to a

person's identification with a particular subject position. Foucauldian discourse analysis is also interested in power and availability of particular discourses to certain people, and the impact these may have on someone's experience of themselves (Willig, 2003). Whilst this approach is informed by ideas of power, it also places the power outside individuals, which could be interpreted as imposition of power, an assumption that society's discourses, e.g. those around feeding, may be more important than other ways discourses may develop e.g. through interactions between individuals. However, it does take account of how these discourses are experienced.

Discursive psychology

Discursive psychologists understand language to not only represent internal realities for a person or external processes unambiguously, but to produce social realities, and "achieve social objectives" (Willig, 2003, p160). They are concerned with what people *do* with their language, particularly in social terms or oriented to particular actions e.g. disclaiming an idea. Discursive psychology is particularly concerned with rejection of the cognitivist stance taken by more realist psychological research: that cognitions are based on perceptions and social bias can be removed by external conditions. Instead, it takes the stance that language itself constructs ideas and objects, and that 'things' or 'objects' people talk about may not be consensual: attitudes and attributions about topics of talk are discursively constructed and negotiated through conversation (Willig, 2009). Interaction is therefore seen as important in discourse analysis, including the contribution of the researcher, and context of the research. Naturalistic interactions are often used, as this allows the examination of something happening without the involvement of external agents or researchers. However, there may element of artificiality through the research process, compared to the use of pre-existing talk or text, as is often used in studies using Foucauldian Discourse Analysis.

What relevance do these ideas have for the current study?

The emphasis discursive psychology places on naturally occurring interactions fits well with the research aims of examining a naturally occurring mealtime in detail. Whilst the child may be too young to have the same input verbally as the parent in the interaction, it seems likely that the parent's input (even if this is minimal) is likely to reveal a considerable amount about the way eating and feeding, or feeding problem is constructed by that parent. Given that dynamics will exist between the parent and the child, it is likely that the parent's (if not the child's) talk will construct and form a

discourse around that particular mealtime or feeding interaction. However, these interactions may also be revealing of cultural discourses that have influenced the parent's experience.

The likely availability of interactional discourses and the potential for the representation of external cultural discourses in both the feeding interaction, and the interview with the researcher indicates a mixed analytic approach incorporating aspects of discursive psychology and Foucauldian ideas would be beneficial.

Georgaca and Avdi (2012) draw less distinction between discursive psychology and Foucauldian approaches than other researchers, and incorporate them, by taking an overall Foucauldian approach (using steps similar to those described in Willig, 2003 and Willig 2008). However, they state that micro-analysis drew on more discursive ideas described in the above Willig research as focussing on the "context, variability and function" of discourses present (Willig, 2008, p100; Willig 2003, p165). Wetherell (1998) proposes synthesis of approaches to allow consideration of both the 'fine grain' analysis of action orientation in interactions, as well as the broader discourses brought into the analysis. Subject positioning in Foucauldian discourse analysis may be one focus. While the construction of objects and subjects in discursive psychology is considered, it may be important to consider the positioning of both parent and child in the mealtime interaction.

Study 1 Design and Procedure

Overall design

Study 1 of this research project is a discourse analysis of data from two sources. The first of these is naturalistic recordings of mealtimes in families who have been identified as receiving specialist support from NHS services around their child's restricted or limited eating. The second of these is parental commentary on the mealtime recording from an interview in which the mealtime recording is watched with the researcher. These are combined to give an understanding of the way talk is built about and within the mealtime.

Phase 1: Naturalistic data, a video of a mealtime

It was important to consider how data should be collected in order to meet the research aims of understanding text from parents about mealtimes and within mealtimes themselves. Potter and Edwards (2001) advocate the use of naturally occurring talk or text. This fitted the first aim of the study: to examine what talk occurs

within mealtimes and therefore indicated the use of a direct observation of a mealtime. This would allow the data to be situated, constructions and social actions and processes to be witnessed as they happened. However, there remained many possible methodological implications for how this was done and the possible repercussions for the data generated.

The main requirement was that the data should be from as naturalistic as possible a mealtime, in order that this was as true a representation as possible of a normal mealtime for that particular family. This is important when drawing on a discursive psychological approach to discourse analysis, which requires that data is understood within the situation of interest. The situation within which the data is gathered therefore provides the specific context for understanding that interaction.

A video recording of a naturally occurring mealtime was the most appropriate method for this. Potter (2012) indicates that discursive psychological research should be conducted through the use of video or audio recordings. Data can then be transcribed and analysed.

In order to make this as natural as possible, participants were asked to identify a time when a typical mealtime could be video-recorded. A mealtime was defined as any time when the child would be provided with food, which is supported by the dictionary definition which states that it is 'a time at which a meal is eaten' (oxforddictionaries.com, accessed February 2015). This was in order that variability between families' different styles and patterns of mealtimes could be accommodated, and to allow families to choose a time that was convenient and comfortable for them. Whilst naturalistic, the video recorded mealtime could not realistically be described as totally natural, as there is likely to have been some self-consciousness. Families did comment that they had bought specific items of food and had done things slightly differently for the observed mealtime, suggesting there was a level of self-consciousness that impacted the way the family behaved.

Phase 2: Interview about mealtimes

This part of the study elicited parental talk and reflections about what happened within the mealtime and about mealtimes in general. There were several options for this part of the study, for example conducting an interview directly with parents straight after the mealtime, asking for their reflections. Kahari (2013) used a similar method to this to gather parental views, however this was only on average 7 minutes of data, and therefore was not likely to provide sufficient information to gain

a deeper understanding of what happened in the mealtime nor allow parents time and space to process or reflect on what happened. Additionally, there would be a potential considerable burden on the participants, both in terms of interrupting family life by asking after a meal to talk about it, but also practical limitations around children being present and needing care and attention. This would also have been likely to produce only a small amount of data.

Interpersonal Process Recall (IPR) (Kagan, Schauble, Resnikoff, Danish & Krathwohl, 1969) is an approach developed for use with counsellors in order to support their reflections and was used for both clinical and research purposes. Jones, Latchford and Tober (2016) used this approach to ask clients about what happened during sessions of motivational interviewing. Collins (2003) utilised this approach with parents to reflect on their child's mealtimes. The researcher was concerned with supporting parents to broadly reflect on interactions between parents and children, and about the way in which they talked about mealtimes. It was evident from Collins' research that parents could be supported to reflect on feeding their child.

Macaskie, Lees and Freshwater (2015) used IPR to consider dialogue and the dominant discourses in research between researcher and research participant. Brown (2013) used the IPR methodology to examine interactions between people with learning disabilities and the staff who supported them, using discourse analysis to analyse the talk between them and reflections made by participants by watching the video back, thus demonstrating the use of IPR in a discourse analysis. These studies demonstrated that it would be possible to utilise discourse analysis to analyse both sections of data. While it is recommended that discursive psychological approaches are used with naturally occurring data, the talk generated within interviews can also be analysed using discourse analytic techniques (Willig, 2008). The data does need to be seen as situated within the research context and the potential social actions between interviewee and interviewer need to be taken into account as part of this data. In this study, the benefits of using an interview to support reflections clearly outweighed the limitations of this approach, as the consideration of the research process as part of the data gives an interesting social light, which could support clinical implications of the data

It was important to consider how interviews should be constructed. The set-up needed to be able to facilitate reflections from parents, but also needed to be flexible and vary between participants, rather than ask the same of each of them. A crib sheet

was developed (Appendix 1), drawing on similar prompts used by Brown (2011) but adapted to the ideas around mealtimes. This was to allow prompts between parents to be similar to each other, but not guide or lead them to make particular reflections. Power within the researcher-participant relationship was also considered in order to support parent participants to feel comfortable in making reflections and entering into the research process. The protocol for interviews was developed with this in mind, to allow both parent and researcher to highlight things to reflect on, and it was clearly stated that either could stop the video at any time. A disc was created of each mealtime, so that either the participant's own equipment or my laptop could be used, in order that families felt comfortable to stop or start the video. In the event, the first family did not have a DVD player, so I used my laptop. Parents were asked open questions about what they thought was happening, or what they or their child was doing or thinking. At other times, follow-ups were related to what the participants had mentioned, so if they had commented on what their child had done, this would be followed up with a related question. It was important to maintain awareness of the potential impact of questions in contributing to construction of ideas both in the interview, and in analysis, and it was intended for questions to be open and follow-ups to be about comments already made by participants, in words as close to their own as possible..

The combination of these two approaches allowed both research questions to be answered, with mealtime data being anticipated as being primary and interview data as supporting its analysis. As is discussed in the analysis section and in the results chapter, this was not the case and the analysis therefore needed to be adapted to accommodate the great deal of talk provided by parents in the interviews in comparison to the data gained during the mealtime itself.

Procedure

Sampling and Recruitment

Clinicians from two teams, in particular a field supervisor (Dr Helen Edmunds) were consulted in the design phase of the study. It was planned that between 4 and 5 families from a clinical sample in these teams and two others would take part in Study 1 due to the extensive analysis planned for the data from both stages of data collection. The key characteristic of interest is the identification of a difficulty with feeding or eating, and a referral to a specialist service. It was intended that families should ideally be near the beginning of any specific interventions around

eating or feeding with that service, in order that limited intervention had been carried out already.

Services

Four services were identified to support with participant identification. Two of these were Child Development Centres. A further one was a specialist service for children with difficulties with eating or feeding, and the fourth was a community team who had a sub-section related to eating and feeding difficulties, meeting regularly to discuss these cases. The approval documents are in the Appendix 2a and 2b.

Recruitment protocol

Staff in these teams were not to directly recruit, but to offer information to families they saw in clinic who met the inclusion/exclusion criteria. Additionally, the researcher personally attended clinics and one group for parents affected by these issues in order to offer information to families while they waited. I did this on 6 occasions, between November 2015 and June 2016. It was an important point for the research and development team ethical approval that clinicians were not recruiting participants, only identifying and offering information to them. This process was participant identification and not recruitment. Once the information was handed to families, this was the end of the process for the professional involved.

Staff in the services were provided with an information sheet about the recruitment process as well as an overview of the study. I attended team meetings in all services to explain the study and to provide information packs that could easily be given to families.

Information packs for staff contained:

- An instruction/information sheet with inclusion criteria and a script for professionals to use if they chose to (Appendix 3).
- A log sheet to record how many families were given information as well as how many families were approached (Appendix 4).
- A précis of the study and its aims (Appendix 5).

Packs for families included:

- Poster/information sheet (these were altered to be more colourful and simpler after 3 months and only one response from the originals) (Appendices 6a and 6b). These also had a contact form at the bottom for parents to complete and return.

- Freepost envelope to allow parents to return the contact form.
- A fuller information sheet for parents to read (Appendix 7).

Inclusion/Exclusion Criteria

These are presented as they were to the healthcare professionals identifying potential recruits.

Inclusion criteria

1. Due to the focus on feeding problems, participants (children) must refuse food at times (not only have difficulties with eating in a physical sense).
2. Families may or may not be receiving a clinical intervention around feeding/eating. For families not receiving an intervention around feeding or eating, inclusion is on the basis that parents feel their child has a difficulty with eating such as picky, avoidant or restrictive eating. Initially it had been intended that families needed to be at the start of a clinical intervention, although, this was adapted when insufficient families met this criteria.
3. Younger children are most often referred to identifying services in relation to their feeding problems. By age 2, the child is likely to have been experiencing difficulties for considerable time, and is more likely to be taking an active role in mealtimes. Therefore, the child must be aged 2-7 years. Age 7 was the upper age limit as by this age children would be more independent in their eating but still likely to have some parental influence.
4. English must be the main spoken language within the home in order that the researcher can understand the nuances of what is said by parents and their children and the analysis is as full as possible.
5. Regardless of additional diagnoses or disabilities, as long as there is an issue around food refusal/restriction the child and family may be included.

Exclusion criteria

1. Families do not speak English as their main language at home.
2. If the child's eating difficulties are due to purely physical causes (and are not around refusing food, but a difficulty in consuming food in a physical sense).
3. Families are not accessing clinical services involved in the identification of potential participants.
4. Families must not have an open safeguarding referral.

This is to minimise stress to families who may already be struggling more than others, and to limit potential for concerns to be raised and confidentiality broken. As researcher I checked this through other routes for families expressing an interest.

Sample

Six families returned the forms given. Two of these families had direct contact with the researcher through the researcher's attendance at the clinic or group waiting room. Of these, one mother was very interested in taking part but her husband declined once a time had been arranged and this was therefore cancelled. Another mother decided not to make contact again after the study had been further explained as research not intervention, One other mother made contact after the study had been closed. This left three families who took part.

Improving recruitment

Around sixty parent packs were distributed to staff members to share with families. It was not clear how many were given to families. When recruitment was slower than anticipated, two requests for amendments were made. The first was to update the poster/contact sheet to look more colourful and appealing, with pictures as opposed to text only, and included the full information sheet, with less information on the poster itself. This made it stand out more and look more appealing. It is not clear if this was what increased recruitment, as there was a higher response rate following this (only one response was made before the introduction of new materials). Ultimately, the sample was smaller than planned. This led to the development of Study 2 (Chapter 4).

Data collection

Data collection from the families occurred in January, June and July 2016. The recruitment process began in November 2015. Families contacted the researcher via the form attached to the poster. The researcher then telephoned them to discuss the study, answer any questions and check they met the inclusion/exclusion criteria. If they were happy to go ahead, a time was arranged to complete the mealtime video.

At the mealtime video the researcher went through the information sheet with parents and asked them to sign the consent form (Appendix 8). Any non-parent adults were asked to complete the non-participant consent form (Appendix 9), this happened on one occasion and the additional family members absented themselves from the

mealtime and I agreed not to include any talk captured on the tape within my write-up. The children were shown the video camera and it was explained that the researcher would be filming. The ethical procedure was to gain assent rather than consent at this stage. The children in two of the families were not fully able to understand this, but were not distressed by the presence of the video camera. The camera was set up as unobtrusively as possible whilst being able to see as much of the room as possible. The researcher then left the room and sat in the hallway or another room. She was still able to hear what was happening, but was not visible to the family members. In one household, she needed to return to the room as the child wanted to sit where the video camera was located.

After the video had been completed a second visit was arranged to complete the interview.

Data was transferred as soon as possible (usually immediately after) to the university's online servers and copied onto two secure memory sticks, one for me and one for the transcriber.

Interview

The researcher returned to the family home within three weeks to complete the interview. She again went through the information sheet about the interview (Appendix 10) and asked if there were questions, though there were none. The video was set up so that it was visible to both participants and researcher. The option of using the family's own equipment was not used by any of the families. For two of the families the child was not present, but this was not the case for the third family. The video camera was set up to capture the screen where the mealtime video was being shown in order to ensure talk from the video and the interview could be matched up clearly and that talk from the interview was clearly distinguishable on the recording from talk coming from the mealtime recording.

The crib or prompt sheet (Appendix 1) was not as structured as a semi-structured interview schedule as the interview followed the events of the mealtime and the topics covered by the family rather than direct them totally. It therefore included open questions that could be asked in such a way that prompted parents to reflect on events of the mealtime, their and their child's responses and feelings to those events. The researcher also asked for some background information on the family and the child's eating. This provided the opportunity for parents to talk about

the history, and tell the story of their child's eating. Once a history had been gathered, the interview progressed to discussing the primary data from the mealtime.

Data gathered

The data was gathered from the three families, labelled Family A, B, and C. The makeup of these families and additional information about their background is included in more detail in pen pictures in the results section of Chapter 3. In brief:

- Family A- White British couple with one son age 2, professional jobs, joint care of son, nursery 2 days per week
- Family B- White British couple, son age 7 and two older daughters also living at home, father in a professional job, mother previously, but had own small business after caring for son, son at school full time. Child had previously had cancer, and ongoing effects of this. Tube fed some of the time.
- Family C- White British mother, father not living with the family, but present a lot, daughter age 3 with physical disabilities to do with her limbs, two older children, one also living in the home, one out of the home. Mother not working, father working in a non-professional job. Child had a physical disability.

Analysis

Watch Videos

The first stage of the analysis was to watch the videos through completely without transcribing. Notes were made and reflections were recorded in a reflective journal, which had also been added to after each visit to collect data.

Transcription

This was the second stage of the analysis. Data gathered was transcribed in part by me and in part by a transcriber employed through the University of Leeds. She signed a confidentiality agreement. The researcher checked all transcriptions carefully and made changes to ensure that the exact words were transcribed correctly as in places there were differences. It was ensured that dialect and accent were reflected accurately. Many people in discourse analysis use annotations to demonstrate emphasis used, and time annotations to illustrate how long different pauses and utterances were. In this case, it was decided not to do this, as it was felt that the timings did not add anything to the understanding of what happened. Instead it was decided that actions which were occurring simultaneously would be annotated,

in order to illustrate what else was happening in the mealtime at that moment. Vocalisations that were not words were also transcribed as far as possible, with approximations at the phonetic sounds made.

Watch again, making annotations

Once transcription had taken place, the videos were watched again and transcripts annotated with ideas around the analysis. One of the first ideas was about what discursive objects were being constructed, in a similar way to the analysis done by Wiggins, Potter and Wildsmith (2001). However, it became apparent that often there were multiple constructions being made by the text simultaneously. This process occurred on multiple occasions. These were labelled as far as possible, but the discourses were broader than this. The labelled types of constructions were later used when drawing out the fuller analysis, in the results.

Considering the mealtime data and interview data together

Each family's dataset was analysed in turn. Initially the mealtime was analysed, then the interview. The mealtime data was used to illustrate some of the constructions made, and how they related to some of the constructions and discourses made in the interview. The discourses often provided context within which to understand the mealtime data.

Identification of key ideas

Several key questions were borne in mind as the data was analysed. These were largely informed by discursive psychological approaches and a discursive action model (Edwards and Potter, 1993). The answers to these questions can be understood as a collection of actions, ideas, constructions that are utilised and drawn upon by participants, rather than one overarching discourse or narrative.

The questions asked of the data throughout were:

- a) What or who is being constructed?
- b) What social actions are being done?
- c) What positions are being taken or given?
- d) How are these discourses being created (what are the features of the talk that do this?)
- e) Do these discourses vary and how?
- f) What is the effect these discourses are having?
- g) Is there a narrative or story being developed?
- h) First person reflection: the researcher questioned: why she might be

understanding the data in a certain way (reflecting on the interview itself and reflecting on her own feelings, and on any conclusions drawn from the analysis itself).

In considering these questions throughout, it was clear that multiple actions were being completed within each section of the talk. It was important to recognise this complexity and represent this in the data fully rather than single out particular aspects and risk minimising the range of constructions covered in a particular section. Each section was labelled with an overarching sentence covering the main discourse constructed within that section. Within this, individual constructions were identified related to particular aspects or people. The social or discursive actions were identified, alongside the implications of these discourses. These summarised each section of text within the analysis and then were used to draw together the findings at the end of the results chapter. Identifying these areas was a key part of the analysis.

Situating the sample

A pen portrait was created about each of the families in order to provide contextual information. The exact ages of the participating parents were not disclosed nor their exact professions as this was felt to be too identifying given the small number of families. A general indication was given.

Quality checks

In relation to corroboration, it is usual to discuss ideas with others, but less usual for completely independent ratings to be made by separate researchers, as the analysis is partly constructed by the researcher, and therefore is not seeking to find a single truth, but rather recognises that the analysis is also constructed. Quality checks in the form of meaning checking in this case, were completed by readings and discussions with supervisors. Extracts of analysis were shared with supervisors alongside transcripts and some audio aspects of the videos. In discussions, potential meanings were discussed and challenged at times, or alternatives put forward. Ultimately the researcher decided what the most accurate and appropriate reading of the data was. Raw data was discussed with supervisors to cross-check understandings as they developed. Antaki, Billig, Edwards and Potter (2003) cite six possible shortcomings of discourse analytic research: under-analysis through summary; taking sides; over quotation or isolated quotation ; circularity; false survey or spotting. It was therefore important to hold all these ideas in mind and to think about whether any of these had occurred.. The analysis was checked with a focus on these ideas to ensure

that none of these things had occurred.

Elliott, Fischer and Rennie (1999) created some guidelines for the publication of qualitative research. These included: owning one's own perspective, which has been stated; situating the sample (see above); providing credibility checks (through discussion and sharing of data with research and field supervisors); coherence: a summary at the end of each family's data and the results chapters, and a formulated structure created within the discussion to draw together ideas from both studies 1 and 2. The researcher took care to describe the findings as representing only the families studied, but recognise that there are some generally applicable implications from the data.

Mealtime data

There was considerably less talk data than had been anticipated within Family B and C's mealtimes. This was in comparison to Family A's which had included a lot more talk. This is largely due to the way in which the mealtimes were set up, and the people present. Family A had both parents present and the child. This meant that there was a lot of opportunity for talk, both between each parent and the child, and between the parents. Once transcribed, this amounted to a lot of quite complex data. In comparison there was only a very small amount of talk within the mealtime for Family B, as the child chose to sit in the living room to eat his meal alone while the rest of the family ate in the kitchen. This meant there was some interaction but it was limited. There again was only a relatively small amount of talk with Family C. The child in this family had very little verbal speech, which reduced the amount of conversation. The child sat with a tablet and watched a cartoon while she ate and the mother sat on the sofa nearby. There was some engagement over a lengthy period of meal preparation, but again this was considerably less than Family A.

This was interesting in and of itself but substantially altered the focus for the analysis. This is because as well as there being less data from the mealtime itself to analyse, there were also fewer opportunities in the interview to reflect on this.

Ethical issues

Ethical approval was sought and gained from the Yorkshire and Humber IRAS NHS ethics board (15/YH/0431, Project ID: 181261 Appendix 11). Ethical issues are listed below:

Potential for Inducing Distress

The participants in the study had been referred for specialist help with eating. There was potential for the mealtime to be distressing for parents and children as this may be time when an eating problem manifests itself most clearly, or other issues may be present. Although the study did not seek to alter the recorded mealtime in any way, being observed or recorded may be distressing for parents, especially if there are difficulties during the mealtime, or the child is distressed. For Phase B of the study, it was anticipated that while observing the mealtime video, parents may have become distressed, perhaps seeing things they hadn't been aware of, or observing difficulties in the mealtime or distress in their child or themselves. Participants will be able to stop either phase at any point, and may withdraw from the study within a week of taking part, after which the transcription and analysis process will begin. All participating families were engaged with an NHS team in relation to their child's eating problems. They were directed to seek support from people within the relevant team in relation to any issues the study raises for them (whether or not they stated this was the case).

Confidentiality and Potential Safeguarding Issues

There was the possibility of witnessing practices around feeding that cause concern. In this case, the planned action was to return to the participating centre to discuss the most appropriate course of action, without sharing the name of the participant. The field supervisor had agreed to offer advice, as had my thesis supervisors. No safeguarding concerns were raised. The safeguarding procedure of the participating centre would have been followed had this issue arisen (the researcher had obtained copies of these).

Informed consent

It was important for participants to understand the purpose of the study and what would happen to their data. Given the clinical nature of the sample, it was also important that participants were aware that the research was not a clinical intervention and did not constitute advice. This did need clarification for some parents, but all parents who took part were very clear on this. This issue was managed with information sheets provided when participants received information packs, and by offering the opportunity to ask questions or withdraw at each stage of the study.

Presence of people other than the main participants at the mealtime observation.

It was intended that the meal be as representative of a typical mealtime as possible. This meant it was possible multiple family members or other people were present. Consent was sought from additional people to use their data. This was only an issue for one family, where the two family members decided to absent themselves from the room while the meal was taking place.

Security of information and Privacy

The study data needed to be kept confidential and anonymous. Families needed to be able to take part in the study without their clinical teams being aware. Details of those who had taken part was not shared with clinical teams unless the families chose to share their video with them. Data also needed to be kept secure.

To keep data secure, recordings were transferred to secure University servers as soon as possible (or onto a secure memory stick). In the meantime, the camera was kept in a locked box. Other data was also kept in locked storage at the university or again within the locked box until it could be placed there (e.g. between participants' houses, and the university).

What did participants get in exchange for taking part?

Participants were not offered anything in exchange for taking part, but were offered the opportunity for their video to be shared with the clinical team working with them. This may have prevented parents feeling coerced into taking part.

Dissemination

- A written thesis published online on a database of theses.
- Presentation to clinical teams (those involved or potentially other interested teams)
- A written summary for participants who provided their details as they wanted to know the findings.
- Publication within a peer-reviewed journal

Reflections:

I realised through the data collection and analysis stages that I held several assumptions and presuppositions that had guided the way I had asked the research questions. I have tried to tease out what I had and hadn't expected in an effort to acknowledge what I myself brought to the analysis. I did not assume that all meals

would be sitting down (either at a table or in another place). I thought there would be talk about the food and about what the child was eating with attempts to encourage this at least.

I spent some time pondering where this had come from, and using my reflexive diary to hypothesise about what had led to these. I think some of these are around my personal experiences of mealtimes in my own family (as a child, as I do not have children of my own), and in the families of people I know. Mealtimes were busy and talkative times in my household, and my mother was quite concerned with what we ate and that this was nutritious. We almost always sat around a table as a family. I don't remember coercive strategies, but I do remember clear rules about food and table manners, which my father also reminded us of, and of other strategies such as chopping fruit up into shapes to encourage us to eat it. There were no significant problems related to eating in our house, but I had anaemia as a small child and my parents had stopped being vegetarian because of this. I wonder if there was some anxiety about the nutritional value of our food because of this.

Although I think that my assumptions were partly due to my own experiences, I think that they were also built on considerably through my reading of the literature, prior to collecting data, especially the link between coercive feeding practices and restricted food intake.

Chapter 3: Study 1 Results

The results are structured with a separate section for each family (A, B and C). The primary data is the reflective interview. These are presented in a case series in order to fully explore each family's data in detail. For each family, there is a pen portrait which includes background information about the family, my perceptions and reflections from gathering the data, and a description of the observed mealtime and what happened within this. The data is divided into sections with one or more extracts analysed in each. A heading in bold summarises the main discourses, with bullet points covering the main constructions, narratives and actions contained, with more detail covered in the analyses that follows. The primary data discussed is from the reflective interview in all cases, however there are also extracts from the mealtimes discussed alongside this when appropriate. Each extract is numbered and labelled with whether it came from the interview or mealtime data. Reflexive comments about the analysis are included where appropriate and are boxed off for clarity. Each family has a summary section at the end, in relation to the research questions. At the end of the chapter is a summary of all three families together.

The data for each family is different to the others, and therefore a different emphasis is made for each. This is most noticeable in Family A whose dataset was larger and more complex due to the presence of both parents in both mealtime and interview, and the greater amount of talk occurring in their mealtime compared to the other two families. Analysis for families B and C focuses more on the interview data, as this formed the bulk of their datasets. The significance of this in relation to the families' different approaches to mealtimes is discussed individually and in the final section of this chapter.

Research Questions:

1. What discourses are constructed or drawn on by parents about their child's mealtimes or eating either in an observed mealtime or more generally?
2. How do these discourses contextualise and provide understanding of the observed mealtime?

Family A

Pen Picture/Background description

Family A consisted of Rob (who made the initial contact about the study) and Michelle, both in their thirties, and Louis, aged 2 years. Rob and Michelle both work in professional public sector roles on shifts and do not get a lot of time together with Louis, their only child. Louis spent 3 days in nursery per week. They lived in a very well kept, clean and tidy house (there were toys, but there were storage places for these). They presented as well organised and efficient, they had prepared for my visits, for example the meal was ready for very soon after the video camera had been set up. Rob, in conversation, said that he had wanted to take part as this would help the difficulties they and Louis were going through be understood better and would help other families. He seemed to find it surprising that other people may not want to. Rob and Michelle were friendly but quite careful.

The mealtime video was completed in an early evening, and the interview 2 weeks later. Parents chose to both take part together, although there was a short section of interview when Michelle was putting Louis down for a nap. It was in this part of the interview where the first section of analysis began, with Michelle then joining. Around 20 minutes were spent before the mealtime video was played back, with Rob and Michelle both having things to say about the history and background to the mealtime. During the video, the researcher was the one to stop the recordings, although it had been made explicit that Michelle and Rob were able to do this. At times Rob or Michelle would start talking, and the researcher would stop the video, or at others, they were not talking and the researcher would stop the video to ask them about what we had just watched.

Mealtime Setup

Rob and Michelle had food in the oven when the researcher arrived. They signed consent forms. The meal was eaten at the table in the kitchen. Rob and Michelle both prepared aspects of the meal. It was Michelle who sat next to Louis (there was one seat per side of the table) and Rob opposite Louis, on the next side on from Michelle.

Main discourses: The eating difficulty was originally caused by a medical problem with a medical solution, which had a psychological impact on Louis

- **Constructions:**

Problem- was originally medical (sickness) but can now be understood in psychological terms, is situated in Louis

Doctors were therefore responsible for solving or not solving the problem and parents now deal with the fall out

Parents- as limited in their capacity for solving the problem, but as having upheld their responsibility to seek professional help

Louis- a child who had been sick and who had more needs than other children

- **Discursive or social action:** *Parents demonstrate to the researcher that they are not responsible for the difficulty: they defend themselves as parents and position blame with doctors for not resolving the problem when it first occurred*

- **Implications** *are for parental identity and responsibility, for development, continuation and resolution of the eating problem*

The following extracts from the start of the interview illustrate the complexities of the discourses drawn on by Rob and Michelle to explain the problem. They start with framing Louis as not being fussy, and recognition of the impact of the mealtime on him psychologically of having experienced a lot of sickness when he was first born. Louis' restricted eating is situated as having a medical root, and subsequent psychological cause (all within Louis). The discourses quickly move onto who was responsible or to blame for Louis developing these problems, with medical professionals clearly framed as responsible for solving this medically rooted problem. Parents also situate themselves as having been unable to solve this problem. Ultimate responsibility is placed with doctors or healthcare professionals, and away from parents.

Extract 1

(From the very start of the interview, just Rob present, Michelle joins shortly after)

Interviewer: ... I wanted to hear a little bit more about how you'd sort of describe Louis' eating and mealtimes, like that type of thing.

Rob: Um, I wouldn't say, like, he's a child fu-, fussy eater because 'e will eat all sorts of food, but it's because he's been sick a lot when 'e were younger and I think that's why 'e's got an aversion to putting anything sort of moist, or that sort of texture in his mouth.

I: mmhmm

R: You can put something in front of him and if he doesn't like the look of it- I think it's the thing that he's been sick before- he won't even look at it, he'll push it away and won't even look at it. So, it's just difficult- it obviously stresses him out and creates a negative experience, you know it's a-...

Rob makes some complex constructions within extract 1. He begins by refuting a possible label that Louis could potentially have been given of 'fussy eater'. In starting by saying what he isn't, it gives the impression that this is how Louis could be seen by others: he is rebutting a potential claim before it can be made (this is called stake inoculation by Potter, 1996). Rob uses a statement apparently of fact about Louis eating "all sorts of food" to disprove the 'fussy eater' label and immediately goes onto describe a more complex relationship between Louis and food as an 'aversion' to specific textures (rather than specific foods themselves) due to past sickness. This gives an explanation and empathic understanding to the interviewer of Louis' reaction to food, which removes blame from Louis as a 'fussy eater' to provide an understandable reason why he "won't even look at it" (in an extreme case formulation) and food "stresses him out". The problem is constructed as Louis' behaviour in relation to food, but stemming from his previous sickness. The problem is constructed as an understandable response to an originally medical problem.

In Extracts 2a and 2b that follow, Michelle and Rob discussed how they began to seek and receive help, and their feeling, as parents, that something medical was wrong. From my question about the sickness, Rob's talk turns quickly to who should have been able to help with this. Through the telling of this story, parents build on the construction of the medical root of Louis' eating problem. Ideas about responsibility for solving the root problem are brought to the fore, with doctors positioned as ultimately holding this, in comparison to parents who were able only to seek this help.

Extract 2a (Interview)

I: When was it exactly, did the sickness sort of start?

R: It started from birth and then we went to the doctors a load of times and never really got any help with it, then, um, we thought it would stop when he was weaned, but it didn't, it just carried on.

I: Mmm

R: And we carried on with solids and it got worse, to the point where (Michelle

enters and takes a seat) he was sick every meal, and that's how it happened. That sort of- we've sorted it out now, and he's on medication for it, he's not being sick any more, but the knock on effect is the eating. So that's why mealtimes- we're much more relaxed than we were aren't we? Before we were just trying different options basically, if you're force feeding him or panicking that he's not got anything in him, but now he's a lot more relaxed now, but you put the food in front of 'im and if 'e dun't eat it, and that's the way it is- more relaxed now and he does seem to eat a bit more when you're more relaxed, I think. But yeah, it can be stressful I used to dread mealtimes, I used to hate them. It's not too bad now.

Extract 2b (Interview)

A short time later in the interview, following an explanation of having a specialist assessment:

Michelle: Yeah. I think it took us about, oh God, til he was about sixteen months really to get anything done and get referred and get people involved. As I said, I think Rob mentioned, it took us taking him to A&E to say "this ain't normal, you know, this child is constantly being sick".

I: Was that sixteen-

M: About a year I think. It was probably about twelve, thirteen months when we eventually just thought "this ain't normal".

R: Referred to the consultant and he gave 'im the medication to try and stop the sickness and that seemed to start working, so if the GP had referred us earlier at six months, we wouldn't have this problem now.

The original problem had already been put forward as Louis' sickness, which I used as the basis of the question. Rob's response that this began from birth situates the sickness as a naturally occurring physiological or medical problem within Louis himself. Rob then turning his talk immediately to having sought help from doctors clarifies to the researcher that this is a medical issue and one requiring medical help. This single sentence at the start of the interview sets the scene for how the underlying problem is constructed: as simply existing within Louis and for which nobody is to blame, but needs a medical solution from healthcare professionals (not parents). This begins to highlight a link between problem construction and responsibility. Rob's talk about his and Michelle's efforts to engage medical support, presents them as having taken responsibility to solve the problem. From the very start of the interview, parents' image and identity is constructed through their talk about the problem and

related responsibility for this and for acting to resolve it.

Rob's use of the term 'knock-on effect' maintains the construction of sickness as the primary problem, but draws a link between this and Louis' current difficulties with eating. Rob demonstrates consideration of what might have affected Louis' difficulties with eating. The development of the problem into Louis' eating behaviour in response to the medically constructed sickness, has much more complex potential implications in terms of the location of the problem and the responsibility for it. This is shown by Rob talking about his and Michelle's own behaviour and reactions to this: panic as their emotional response, and force-feeding as the way this impacted their behaviour towards Louis at mealtimes. Rob also tells of having continued with weaning Louis onto solids, at which point he was 'sick every meal'. Both of these references to his and Michelle's actions around Louis' feeding and eating are topped and tailed by statements that defend their actions, and arguably them as parents. Rob defends the progression onto solids despite the increased sickness first: they thought the problem would resolve. This defence of an anticipated criticism (in this case perhaps that they should have acted sooner) is sometimes known as stake inoculation (Potter, 1996). This hint or admission of the potential for Rob's and Michelle's actions of 'force-feeding' or 'panicking' to have affected Louis' eating can only be made here preceded by a defence, and followed by a statement that this was not a long-lasting effect: that the problem is now 'sorted'. This performs the action of distancing Rob and Michelle from responsibility for lack of improvement in Louis' eating. It is much harder to criticise something that the speaker has moved on or learned from: the practice is described as already having changed: meals used to be dreaded, but not now, as Rob and Michelle are more relaxed.

The construction of the original sickness problem as medical serves an important purpose within the narrative of the problem and how -and more significantly- who should have solved the problem. Both Rob and Michelle introduce the idea that they actively sought to respond to the problem: took him to the 'doctors a load of times', until Michelle describes how they eventually escalated their pleas or requests for help at A&E where they pushed their view that 'this (the sickness) ain't normal' giving the sense that they had gone along with the doctors, until they were desperate for help (the exclamation 'oh God' adds to this) and had built up their own conviction and confidence in their view that there was a problem that needed help. The way Michelle says 'this child', rather than naming Louis or saying 'my child'

creates a sense of objectivity and fact to her account. A lack of response from A&E staff and the GP places healthcare professionals in a position of power: they could have solved the problem sooner but did not. Parents here position themselves as holding considerably less power than the doctors (unable to perform the medical or professional actions such as referrals to experts). This introduces an idea that parents could not solve Louis' problem. This frame, created jointly by the construction of the problem as medical and the parents' actions, blames doctors. Rob evidences both these constructions in the last section of extract 2b by stating as fact that medication resulting from an expert referral made a difference, and that therefore if the GP had made the referral earlier, then the problem could have been solved earlier: through medical means, by medical experts. This could be seen as 'narrative warranting' (Potter, 1996), which is the use of narrative to support an argument: the story leads the listener to draw a particular conclusion. Here it is that the medication solved the problem. Rob's use of the narrative here is instrumental in supporting the idea that Louis' reflux was the problem. Michelle's use of 'detail' and her own 'active voice' (Potter, 1996) gives a sense of factuality to her account. These have both been considered as rhetorical devices.

The narrative that healthcare professionals are ultimately responsible for solving this medical problem begins to also construct Rob and Michelle's own capacity for solving the problem as limited. They could ask for help, and made overt efforts to demonstrate how much they pushed to receive medical support. The idea that Rob and Michelle had done all they could to get help inherently constructs Rob and Michelle's capability and resources for solving the eating problem as limited. This is apparent when Rob talks about the panicking and force-feeding. While this seems to be an honest and potentially exposing account of their approach, with the potential for leaving them open to criticism, it serves an important purpose. In not having sufficient skills to resolve the eating problem, Rob and Michelle remove responsibility for solving the problem from them, to the doctors, as it is the doctors who have the resources and skills to do this.

The following extract builds on the idea that Michelle and Rob felt out of their depth and alone with Louis' eating problems, and constructs Louis' needs as greater than those of other children, he is not just any baby.

Extract 3 (interview)

M: I just think with us being first time parents and you don't know, you don't get a booklet, you get sent home and we didn't have a clue what we were doing, so you've not only got like, this newborn baby and suddenly you've got this 'projectile vomit baby' and everyone keeps telling you "don't worry, he'll grow out of it, grow out of it", but it gets to a year and you're like "he's not growing out of it, I don't know what to do". No one – every time we talk to someone, like family or friends- no-one understood it or anything, so we'd be pretty much just lost with it all. And that's why I were just one day I just went to A&E and said: "Right, we're not leaving until someone refers us or does something" and at that point, that's when things started rolling on a bit didn't it?

Michelle begins this extract by drawing on the discourse of being a first time parent and not getting a 'booklet' explaining how to be one. She uses the device of 'categorisation' to do this: belonging to the category of 'first time parent' allows her to explain and excuse them not knowing what to do. Getting 'sent home', presumably from hospital, again positions some responsibility with doctors or outside systems and suggests it could have been these people/systems who should have provided the booklet. This gives a sense of the parents being left to cope without support.

Michelle also puts across indignation through use of the word 'right' as she describes her assertive approach in A&E to get support: she was doing all she could to get care from an unresponsive system. That they did respond and 'thing started rolling' serves to evidence that this discourse is correct: the healthcare professionals did act and there began to be some action or change.

The justification for parents not having the answers was extended by Michelle in her construction of Louis: he was not only a newborn baby who is difficult to care for, but also a sick, 'projectile vomit baby', a more complicated and difficult to manage version of a baby. Michelle provides evidence for this by saying other people did not understand the problem and her family's reactions to witnessing Louis' vomiting. This justifies and normalises their uncertainty as other people also didn't understand and wouldn't have known what to do. It invites the researcher to take on Michelle's construction: to be someone who did understand as not doing so would imply that the researcher was another person who did not understand how this was.

In combination, these discourses explain and excuse Rob and Michelle from knowing what to do, positioning responsibility for the problem away from them personally, and situating it with Louis and with professionals/the systems around

them. How could they be expected to solve this complex and difficult problem without the tools and support to do so?

The idea of nobody having instructions for parenthood is one that normalises not knowing how to do things or a feeling of incompetence. It serves the social purpose of building sympathy in the listener and removing blame from the parents.

Main discourses: Enjoyable mealtimes are normal, and this family have lost out on these experiences (comparison with ideals and expectations for mealtimes)

- **Constructions:**

The family's mealtimes as abnormal

Problem: situated with Louis, whose reactions are different to others

Parents: as having lost out on normal mealtimes

- **Discursive or Social Action: expression of loss, building of sympathy**

- **Implication: The idea is emphasised that the family have missed out on mealtimes like other families have, and a sense of loss is developed through comparison with others**

In the following extract, Rob and Michelle talk about the mealtimes of other families they know and make comparisons with what others can do and what they say they cannot do. In doing so, they make constructions about what they would like or expect mealtimes to be like in their family. Through these discourses, they express regret that things are not how they would like, and a sense of loss about what they see others having, but do not have themselves. Although there is recognition that there has been some change, there is still a feeling represented of loss and missing out on something that others have, because of Louis' sickness and lack of excitement (which could be expected of children). This hints at Louis' reactions as being responsible for this deprivation for parents of what they construct as normal family mealtimes that could reasonably be expected. Michelle could be said to be using 'abnormalisation' (Potter, 1996) to demonstrate the difference between Louis' mealtimes and those of their friends. She positions Louis as different to other children, their experiences as a family as not usual, or to be expected.

Extract 4 (interview)

R: Just sort of accept that he's not going to eat everything that we want him to eat, he'll what he wants to eat and that's just the way it is. It's all, it improves.

I: And is that how it's been for you Michelle?

M: Stressful? Yeah mealtimes and not being able like to go out for meals or anything. You know, like, we've got friends that have children the same age and you know they suggest "oh let's just go out for tea" but you just can't because one, we didn't know if he was going to be sick everywhere, and two, you'd be lucky if he ate anything. And you just- mealtimes are- I think better now- but mealtimes were never enjoyable for him- he were just never excited about them or anything was he?

M: It's hard because you see other families go out and the kids are just sat there, you know, happily eating meat and two veg, and yeah it might be messy or whatever, but-

R: I'd love to cook a meal and it will arrive, you know and he has it as well, we all have the same meal, it would be so much easier for us, but not just that, for him to sit and eat what we're eating, that would just be brilliant, just be nice, but it just doesn't happen.

In the piece of talk below, Rob seems to be expressing frustration that other families could have mealtimes similar to those he would like, but do not always appreciate it. There is a hint of resentment here. He is framing a family led value of having enjoyable family mealtimes. He talks about he and Michelle working shifts, actually highlighting another reason why their idealised mealtimes might be more difficult to attain. At the end of this, he says that he enjoys 'the opportunity to sit' at a mealtime, recognising the aspects of normality the family do experience.

Extract 5 (interview)

R: Yeah, and it should be enjoyable shouldn't it? And he dun't enjoy it

I: As you say, family wise-?

R: Yeah, it is yeah, I think it's quite important. You see families sitting in front of the TV eating and I don't like that. It's not that I don't think it's right but-

I: Would you not- is that how you normally have meals, all sat round a table?

R: Yeah, well as I said before, we work shifts don't we? (I: Yep) so when we do get the opportunity to sit, it's nice, it's really nice...

This section positions the family as having lost a normal family experience in the way they believe it could or should have happened. Louis is implicated and is positioned as at least partly to blame in this for not enjoying food or mealtimes, and for being sick, as this is what Michelle says prevent them from having these

experiences. While it is not stated that it is Louis' fault that he was sick, as this could be attributed to the medical problem he faced, the problem is situated in him, meaning the lack of ability to enjoy parent's ideas of normal family eating also is. However, Rob does also acknowledge their shift work as something else that takes away some of the opportunity for these experiences from the family. This is a discourse of sorrow and disappointment, and frustration for the loss of these expected family experiences. There is not acceptance of this, there is an expression of effort to change this.

These discourses demonstrated through the 5 extracts are about mealtimes more generally and provide contextual information about how Rob and Michelle have constructed the problem, as medical and situated in Louis, and therefore something medical professionals needed to help with. They also make constructions about Louis' eating difficulties, and actions (e.g. projectile vomiting) at mealtimes relating to their loss of a normal family mealtime experience. The following sections contain extracts of reflections about the video-recorded mealtime alongside extracts from the meal and descriptions of this.

Main discourses: Louis is in control of mealtimes, and dictates to Rob and Michelle, control needs to therefore be negotiated between family members

- **Constructions:**

Louis as being demanding, in control, and a dictator

Parents as 'pandering' to Louis' demanding

- **Discursive Action:** *Michelle and Rob place responsibility for the 'pandering' with each other (Michelle jointly and Rob placing responsibility with Michelle)*

- **Implications:** *There is a sense of unease about the setup of the family mealtimes and whether they fit with the family's ideals*

In this section, Rob and Michelle's reflections on Louis' behaviour in the mealtime are considered. This gives a sense of the relationship between Louis' and parents' actions in the mealtime. Parents bring their past experiences to bear in their talk, relating Louis' behaviour in the mealtime back to his behaviour as a baby, in order to make generalisations about him. Rob and Michelle move onto some judgements about the roles Louis and they took within the meal: him as dictator and they as 'pandering' to his orders. Their discourses relate to power and control, and how this is navigated. The next section also discusses ideas related to the actions parents take within the mealtime.

Extract 6a (interview)

I: What do you think he might be-

M: Well he wants something and he wants something now.

I: Okay.

M: Don't he (to Rob)

R: Yeah, that's what he's doing there, he wants something to eat.

M: He was always like that, even as a baby. If he wanted his bottle, he always wanted something now. Not like 'can you wait two minutes?'

R: He's shouting at us (laughs).

Extract 6b (shortly after 5a) (interview)

R: It looks like he's sitting there just (laughs) like he's in charge inne?

M: Yeah.

R: He's sitting there dictating.

I: What did- what made you reflect on that then?

R: It's really what- what we've always done.

M: Yeah. Pandering.

R: You pander to him yeah.

M: We pander to him.

R: Sitting there demanding that his food's cooled down. Can't do that 'imself can 'e really. Doesn't know what he's doing but it's what he's doing yeh.

Michelle's discourse is about Louis being demanding: he not only wants something, he wants it *now*. She seeks support from Rob in this statement, which he provides in a slightly softer manner, whilst agreeing that Louis does want something to eat. Michelle's next utterance strengthens her discourse of Louis being demanding. There is a sense of being put under pressure to deliver 'now'. Her link back to Louis doing this as a baby serves to position this as a character trait in Louis, but also as something that she has experienced from him for a long time. Rob laughs as he says 'he's shouting at us'. This has the social effect of minimising this, but the words on their own alongside Michelle's hint at victimisation. Slightly later on, Rob reflects that 'it looks like he's... in charge'. It is not clear whether this is how he thinks it might appear to me as a researcher, or whether this is how it appears to him, until he then says that Louis is 'sitting there dictating', overtly constructing Louis as being

completely in charge and powerful in the mealtime. The 'dictator versus panderers' constructions clearly present a power dynamic in that part of the interaction, with Louis as being powerful and parents as submitting to him. This constructs parents as unconfident in the face of Louis and of him as very much in control.

The ownership of the pandering behaviour is subtly negotiated between Rob and Michelle next. When asked more about the dictator term, Rob immediately becomes vague, which reduces the impact of the 'dictator' comment he made, perhaps in recognition that it was quite strongly worded. This has the effect of distancing himself from this. When Michelle picks up and shares in this narrative that Louis is in control of his parents, Rob repositions the 'pandering' as something Michelle rather than he does, positioning responsibility for Louis being allowed to have control with Michelle. As Michelle takes responsibility back, Rob then returns to the discourse of Louis as demanding, but in drawing on ideas of Louis' internal world, then removes responsibility from Louis, as he 'doesn't know what he's doing'. He could be using empathy as a discursive device here (Whittle, Mueller and Mangan, 2008): making the assertion that Louis was a dictator by showing empathy and understanding his underlying position. This simultaneously supports but softens the 'dictator' discourse. This last act of Rob's talk in this segment reframes Louis' responsibility for this dynamic, in the sense that the outcome lies with Louis, but that he cannot be accountable for this as he 'doesn't know what he's doing' as he is only a baby. This felt to me like an attempt to be caring, and regain some of the compassion for the sick baby.

Ambivalence and lack of stability in the discourses is clearly represented in this section. It highlights the difficulty in holding the discourse of Louis as a sick child, alongside the discourse that he is difficult to care for and responsible for the family's ideals around mealtimes (which they demonstrate that they value). There is a to-and-fro of parents' constructions of how they feel, with a censure that holds Louis as a baby or small child in mind, perhaps related to societal acceptability of making critical comments about your child, or of a child being in control of their parents. In the next section, Rob and Michelle describe their actions:

Main discourses: Parents need strategies to persuade Louis to eat

- **Constructions:** *Parents construct Louis as being cautious of food and therefore needing persuading to eat*
- **Responsibility:** *Louis makes decisions about what he eats but parents need to persuade him or use strategies to reassure*
Primary goal of the mealtime is for Louis to eat
- **Discursive actions:** *Parents persuading through demonstrating evidence that food is okay; Parents playing games in order to persuade Louis*
- **Implications:** *Parents place pressure on Louis to eat*

This section links to the previous one, where the power Louis has over mealtimes is played out and parents need to acquiesce in order for Louis to eat. At the start of the mealtime, when Louis' food is presented to him initially, Michelle and Rob encourage the excitement they described as missing for Louis, by saying 'wow!' to Louis as they give it to him. Michelle, also spends time encouraging Louis to blow on the food before he eats it as it might be hot and demonstrates this action to him. The food is simultaneously presented as something to be excited about and cautious about, and this pervades into other parts of the mealtimes. In the following extract from later in the mealtime Louis uses the word 'hot' and Michelle responds. In the interview, she explains this as reassurance. This builds up the idea that the food may be unsafe or that Louis may be afraid of it, and therefore needs action to support it.

Extract 7a (mealtime)

L: Hot!

M: Hot!(laughing, looking at R). That's a new word!

R: Hot! That's a new word!

L: (Crying, rubbing hands on face)

M: He's learnt a new word, that's a new word isn't it?

L: (Babbling) a dat!

M: (Put chip to mouth, giving it back to Louis). That's not hot.

L: (Babbling, sounding more cross, crying)

M: That's not hot is it? (Wipes Louis' mouth), that's not hot is it?

L: Crying (hands on face)

Extract 7b (a short time later in the mealtime)

M: (moves food on Louis' plate). Put that on there?

L: mmmhmmm ah (look at mum).

M: It's not hot.

L: Crying, bashing fork on plate.

M: Watch mummy touch it. Not hot, and that's not hot, and that's not hot! (Touching each item of food on Louis' plate in turn).

L: (Crying, holding cutlery to his head) Oh!

Extract 8 Reflections in the interview:

I: ...I just wondered because you were touching his food and things...?

M: I guess because he was saying "Oh, hot", I was trying to reassure him they weren't hot (pause) so he'd eat them

Parents comment positively on Louis' use of the word 'hot' initially as something new he has learnt (illustrating an idea that mealtimes may not only be for eating). When this is commented on and parents interact with each other about this (Michelle looks to Rob while noticing that this is a new word), Louis then starts to make high-pitched, crying type vocalisations and rubs his hands on his face/eyes, but this returns to babble quickly. Michelle, then physically checks Louis' chip by putting it to- or in- her mouth then puts it back on Louis' plate while saying to him 'that's not hot'. Michelle's response of checking the food and refuting that it is 'hot' is consistent with an understanding that Louis' use of the word 'hot' is him expressing caution or reluctance to eat the food. Michelle then refutes this to show Louis that the food is fine to eat: Michelle is the one who makes the decision about whether the food is edible.

Michelle in the interview explains that her action was intended to reassure Louis. Interestingly, however this demonstration of it's safety, does not then result in Louis eating, and he cries instead of eating. There seems to be a possible mismatch between what Louis was trying to communicate and what Michelle understood at this point. It seemed to me that Louis was using the mealtime interaction as a way of learning other skills. Michelle's talk was much more focussed on persuasion as a way to encourage Louis to eat. Parents talked about and enacted various strategies throughout the mealtime.

Strategies demonstrated within the mealtime itself

Rob and Michelle talk about deliberate strategies they had used in order to encourage Louis to eat. It is not possible to include all of these in detail, but they include the direct persuasion just described; limited boundaries over food with Louis requesting (through pointing) or being offered food from parents plates, but parents also eating food from Louis' plate; elaborate games where each family member fed each other; imitating Louis' actions; encouraging him to play with his food (e.g. splashing water, dipping fingers in yogurt).

While there are some norms for mealtime behaviour set up within the mealtime, such as the mealtime being bounded by the time spent sitting at the table, and there is encouragement of Louis to learn and use culturally acceptable mealtime behaviours such as using a fork or spoon, these boundaries seem to be applied differently at different times during the meal. Food sharing seems to be a usual practice within the family. Louis points at Rob's food as soon as it is brought to the table. In the interview, Parents describe this as Louis wanting what they have as long as it is something that he will eat, and that they "*just let him do it because it's more for him to eat*", possibly suggesting they'd rather he did not take food from their plates, but acknowledging this is not something they discourage (and do actually encourage at times). It seems that Louis eating is the primary goal over mealtime behaviour at most times, but this is something that later parents come to reflect on. Later on in the main meal, there is an interaction for around 3 minutes that involves the whole family feeding each other. An extract of this is here:

Extract 9 (mealtime)

R: (reaches and picks up food from Louis' plate). Look at that. That's good, that's the best bit!

M: Why don't you give that to daddy?

L: (looking under table) cries

M: Give that to dada (pointing to food on Louis' plate). You take that and give it to dada (pointing to Rob).

R: Give it to me please.

M: Feed it to dada! Watch, mummy will give it to daddy (puts food on fork, hands fork to Rob). There you go daddy.

R: Thank you! Mmm nom nom nom

M: You do it? (To Louis) Give it to daddy?

R: Mummy have some.

From an outside perspective, the goal and rules of this game are not immediately clear but it seems parents are demonstrating to Louis what to do. The instructions from each parent are not direct attempts to persuade Louis to eat. In fact parents seem to have different aims for specific parts of this game, as can be seen when Michelle encourages Louis to give the food to Rob and Rob then encourages Louis to give the food to Michelle. Later in the 'game', Rob tries to direct Louis back to eating the food himself, and he persists in trying to feed it to parents: as in the game. Rather than Louis learning how to eat from seeing his parents eat, it seems that he has taken on the action of feeding them. Parents reflect in the interview about their aims once their attention was drawn to it in by the interviewer:

Extract 10 (interview)

I: Is that you eating off his plate?

M: Yeah

R: Didn't work did it?

I: So was that an attempt to get him to eat something?

R: [Yeah, yeah]

M: [If daddy eats it.]

R: Just trying to encourage him to eat it, it never works to be honest.

I: You said 'oh another' and then didn't finish what you were saying...

M: Oh that's another attempt, another-

R: technique

M: -technique that was tried, yeah. "Oh mummy try, daddy try, even the dog try" (laughs) we get the dog involved don't we? It's like it it mum eats it, dad eats and the dog eats it, will Louis eat it?

R: And it did work for a little bit, haven't tried it for a while. We'd get his bears and tell him to feed them and it did work for a bit he used to pretend to feed the bear he would eat it.

M: Don't work anymore.

Rather than framing this as a ‘game’, parents describe the feeding each other interaction as a ‘technique’ and reflect that this is something they have tried in order to ‘encourage him to eat’. The use of the word ‘encourage’ is important, as this frames the ‘techniques’ used as a persuasive approach in order to promote an action that Louis is reluctant to do, however, it expresses this is supportive rather than coercive. There is a sense from this that parents have to act with caution around Louis and use technical skills and thought through procedures. This constructs responsibility again, as well as power. Ultimately Louis chooses, but if parents do the right thing then they might surreptitiously be able to get him to eat. Earlier on in the interview, Michelle refers to preparing ‘*four or five different options for him...at one point we were nearly sat at the table for over an hour while we tried all different tactics*’ with the effect of conveying desperation for Louis to eat, as does the reference to ‘even the dog try’. This idea of parents needing to use different approaches is interesting, as it conflicts with the problem construction as medical.

Main discourses: Parents change their view of what happens: Louis does not need as many prompts

Constructions: Louis doesn’t need to be prompted after all

Responsibility: Rob and Michelle may have a negative impact through their actions

Discursive actions: Showing their openness to reflection

Implications: Rob and Michelle’s actions impact on Louis’ eating and has implications for them to reflect on how they interact with Louis in future mealtimes

Rob and Michelle’s discourse changes over the course of the interview. Having made constructions about their need to use tactics to persuade Louis to eat, when watching the video back, Rob and Michelle make reflections at the end of the meal about their own actions within the mealtime in relation to Louis’ behaviour.

Extract 11 (interview)

I: So overall, how would you say that meal was compared to others?

R: Quite typical really.

M: It is

R: But watching that, if you just leave him to it, he seems happier don’t he? Without being –

M: Prompted

R: -Pestered, yeah, by us. If we're just talking to each other, he'll get on with it, he'll sit and just-

M: He's awake. (Louis has woken from his nap while the interview happened).

R: Is he? Yeah

M: (gets up to go to Louis)

R: So, yeah, he just seemed a lot more relaxed when we weren't focussing on him.

It is interesting that when asked closing questions of the interview, Rob's overall reflections seem quite open and it seems that he has come to a new understanding: that the active approaches and techniques have not been as effective as they thought, and that not directing their focus towards persuading Louis to eat was more effective. Michelle does join Rob's narrative so it seems like she may share this, but removes herself to tend to Louis at that point. It may be that this is a discourse she does not want to contribute to. The idea that their approach to mealtimes may have different effects on Louis eating than they had thought previously, may have important implications for their overall discourses. Louis had been consistently constructed through the meal as someone that they needed to convince to eat. Food needed to be made safe, and he had to be persuaded and reassured that it was okay to eat. This also has huge implications for their own responsibility for the maintenance of the problem. If the new discourse that parents inaction improves Louis' eating, then it could follow that their action could have decreased his eating, making them at least partially responsible. It is also notable that Rob relates Louis' emotional state to his eating- he is 'happier', 'more relaxed'. This newly formed discourse if held could also have important effects on parents approach to mealtimes.

Family A: Summary

This family produced a range of discourses that changed over the course of the interview and mealtime, from being focussed on Louis' illness at the start of the study, and the responsibility as being positioned with health professionals, through discourses being about Louis' character and behaviour being responsible. By the end of the mealtime, this had shifted to being much more related to Michelle and Rob's own actions. A lot of ambivalence and anxiety, perhaps about how they were portraying themselves as parents occurred in the data, and at times the function of their talk as often being about positioning responsibility served to help protect the view of them as having done what they could: as good parents.

Question 1: What discourses were used by parents?

Discourses related to the problem having medical roots but a psychological effect. Louis was constructed as having additional needs to other children, and parents as being limited in their skills and that they could not fairly be expected to be able to solve the problem without the medical help they fought for. The medical solution as being withheld by professionals was key here. In these discourses, blame and responsibility were key issues: parents placed blame for allowing the problem to develop with professionals, and in so doing, removed responsibility from themselves. Parents defended themselves through this talk at the start of the interview. As Abell and Stokoe (1999) discuss, the positioning of responsibility with others, removes responsibility from the speaker.

Michelle and Rob also related the loss of normal family experiences and linked this to Louis' presentation (of projectile vomiting) and behaviour (not being excited) at mealtimes. This idea drew on societal discourses about traditional family values and mealtimes and what could be considered 'normal' (this is covered more in the discussion chapter). They still pursue this ideal setup.

In reflections on the mealtime itself, Rob and Michelle talk of Louis as being in control and more strongly, as 'dictating' to their 'pandering', constructing a power dynamic where they needed to respond to his wishes to do whatever it took to persuade him to eat. The responsibility for the mealtime shifts a little here. While Louis had already been recognised as having additional needs, he is positioned as responsible for dictating here, however parents become responsible for responding totally to his needs. Rob and Michelle's talk of their 'tactics' and 'techniques' builds an idea of a somewhat adversarial relationship where one side wins. The main goal of Louis eating, through whatever means necessary is constructed here, as Rob and Michelle portray dissatisfaction with mealtimes happening in this way.

At the end of the mealtime, Rob's reflections on Louis' behaviour in relation to his and Michelle's use of tactics repositions responsibility for solving the difficulty again and moves it to them. Their behaviour is constructed as making a difference to Louis' eating and to his feelings, giving the support that is needed for the family.

Question 2: How do these discourses contextualise and help us to understand the mealtime?

Rob and Michelle's discourses about responsibility position them as lacking in power to make a difference in the mealtimes. It is interesting therefore that they

employ so many tactics. Perhaps their lack of confidence in their ability to make a difference means they need to apply as many approaches as possible. Their talk about the loss of the ideal normal family mealtime could explain their active approach to the mealtime, doing multiple things to try and make the mealtimes normal. Their talk does not accept mealtimes the way they are and instead position Louis' eating as something that needs to be changed, and that needs to be closer to the ideal. While discourse analysis does not purport to be able to draw conclusions about internal cognitive or emotional processes in speakers, parents' switching of ideas and efforts to justify their actions and position responsibility away from themselves suggests anxiety and worry about Louis' eating as it is, which perhaps is not surprising given that they are accessing clinical services. Lee and Kwon (2006) found that there were higher levels of stress in parents with lower levels of self-efficacy in a study into feeding practices. Ideas around confidence and self-efficacy are considered further in the discussion chapter, but this has some relevance here.

Overall the changing and unstable discourses seem to be reflected in parents' approach to mealtimes. Their caution around Louis' eating seems to be expressed through the discourses around making food okay and reassurance, but their wish for an ideal mealtime expressed through encouragements. They are not clear who is ultimately responsible for what happens, and therefore need to try lots of approaches from telling Louis that the food is not hot and evidencing this in quite a firm way, to playing games designed to reassure him about the food and surreptitiously persuade him to eat it.

Reflexivity

This was the first family I collected data from. I found that the way the mealtime was conducted fitted with my expectations: a family who used many approaches to try to get their child to eat. I had anticipated anxiety about the mealtime, and Rob and Michelle fitted with this expectation. I also realised the complexity of the data in comparison to the other families due to the presence of both parents. I questioned my own assumptions and spent time working out how to manage the complexity of the data, through emphasising the discourses and the multiple constructions made through these, rather than the approach I had envisaged, of separating the discourses out into different discursive objects. The sense I had from parents was about a lot of anxiety that they were trying hard to manage, and reduce through the use of strategies and games. It did seem like there was some confusion between the goals of parents, with Louis playing rather than eating. I did consider my interpretation of this compared with his parents, however and take this into account within the analysis.

Family B

Pen picture/background

Family B consisted of Karen and John, in their later thirties and early forties, with Charlie, aged 7 years as the child of focus. They also had two older children, Caitlyn and Sarah, who were present in the house when the data was collected but were not included in the data. Karen works part time running her own business, and John works in the public sector in a professional role. Charlie became seriously ill with cancer when he was 2 years old, and spent a lot of time in hospital and has on-going ill effects from his treatment, in terms of his eating but also effects on his development more generally. Karen gave up work in order to care for Charlie when he first became poorly. Karen also has some health difficulties of her own.

The household is warm and friendly, it felt welcoming, and there was the feeling that people come and go in a busy and lively fashion. My visits were fitted in amongst the family's activities. The house was clean and tidy with evidence of children around and about, and a lot of pictures of the children on the walls. Karen commented when watching the video that it looked messy as there were some toys poking out from under the sofa. The sense was of a busy, but friendly family environment, with occasional differences in opinions but a relaxed approach to this (disagreements between parents on what the children should be doing to get ready etc). Karen asked if the researcher would like to have some food with them, which

was declined, but the researcher felt at ease with this family, treated as one of them in a way, another family task to be fitted into what was clearly a busy schedule. The researcher sat on the stairs to wait, and needed to move out of the way at times. The television was on in the living room with cartoons on. Charlie sat in there to eat his meal (this was offered as an option) and the rest of the family ate their meal at the table in the kitchen. John encouraged Charlie to come through.

Reflexive statement: I felt that this family had some similarities to my own when I was growing up. It is also important to note that I became aware part way through the interview that a close family friend when I was a child had sadly not survived the same illness that Charlie had experienced (I had been aware previously that Charlie had been ill, but not exactly what the illness was). I note both these things in recognition that these may have had some influence on my thinking about this family.

The interview was conducted 2 weeks later, but had been arranged for prior to this, but cancelled by Karen due to a mix up on the day. The majority of this interview was conducted solely with Karen, although John joined for the final few minutes. For much of the interview, the video of the mealtime was running in the background, as there were large parts of the meal where Charlie was quietly eating. This meant that while there was some focus on that mealtime specifically, there was more talk on mealtimes more generally and Charlie's eating and the story behind this. This story of Charlie's illness and vulnerability and the ways in which the family have tried to accommodate him and meet his needs, describe and explain how mealtimes are done in the family. The *way* in which this is described also has the effect of constructing Karen, the family and their decisions about mealtimes as competent, caring and considered. Karen's reflections on her emotional responses to the situation, provide more potential ways of thinking about and understanding the way she constructs discourses throughout.

The setup of the meal:

Charlie chose to eat in the living room away from the other members of the family. I was told this was usual for him. This decision had been made with Karen, and is discussed later with some talk from Karen.

There is relatively less talk from the mealtime included to reflect the much smaller amount of talk that occurred in the mealtime, due to its setup.

Main discourses: Charlie's cancer as causing his sickness and difficulties with eating

Constructions:

Charlie: as a child without problems who then developed cancer and became an ill child needing special care

Karen: presents herself as knowledgeable and competent

- ***Problem: cancer as the cause of the problem***
- ***Discursive/Social Actions: builds sympathy for the family, demonstrates Karen's competence, reducing likelihood of criticism***
- ***Implications: sympathy and special care is needed in the mealtime (this discourse then has implications for mealtime setup)***

The following extract comes from the beginning of the interview and is a response to a broad question about Charlie's mealtime routine and a history of his eating, Karen begins the narrative with Charlie's cancer, and links it quickly to his difficulties with eating.

Extract 1 (interview)

Interviewer: So, I guess I just wanted to hear more about Charlie's mealtime routine and how you'd describe the, um- a bit of history of what you've had, how this eating sort of started.

K: Yeah, that's fine. So, um, it started with his cancer diagnosis, so basically he was very sick, he vomited a lot. Um, before his diagnosis and then all throughout his treatment, um, and fairly quickly from his diagnosis he had a gastrostomy PEG tube fitted, um, I guess because they knew his appetite wouldn't be good on chemo, and he wouldn't be able to taste food very well, um and he's never eaten properly since really.

I: Can you just remind me how old he was when...?

K: He was twenty-three months, yeah... so crucial really, quite a crucial age really, I think, for food.

I: How had his eating been before that?

K: No problem, completely normal. He weaned really well, he wasn't a fussy eater. Erm, yeah, just completely normal.

I: Obviously that's a big thing to go through isn't it?

K: Yeah, I think right before we went to hospital with 'im, he'd vomited about...I think it was about sixteen times in a twenty-four hour period because of the hydrocephalus...

I: mmm

K: and he's still very sick now. He's got a very strong gag reflex...

I: Okay

K: and he's generally quite nauseous in the morning which we have to medicate him for, so, um, it's continued-

I: Yeah.

K:-even after the illness has been treated.

The question invited an answer about causality, and cancer is marked out as ultimately responsible for Charlie's difficulties right from the start. Karen makes a direct link between Charlie's eating and the cancer, its symptoms and its treatment, with the symptoms of sickness/nausea and vomiting being presented as key, and as having featured over a prolonged period of time, from before the time of the cancer diagnosis until the time of the interview. In referring to the 'gastrostomy PEG tube' (a tube that delivers food directly into the stomach through the abdomen) and the many times Charlie vomited over a day, Karen demonstrates the severity of Charlie's illness in an indisputable way, through the matter-of-fact delivery. This is added to through the almost professional use of factual language. It seems there is no need for an emotional element, as the use of medical language positions the problem as serious enough.

Karen immediately demonstrates the severity of Charlie's illness, by saying he was 'very sick' and 'vomited a lot', and that 'fairly quickly' he had a tube to feed him as a result of chemotherapy. This is a lot of information given within the first response of the interview and very quickly gives the interviewer the impression of how many big events Charlie has been through, as well as Karen as a mother. This has the effect of building sympathy for Charlie and understanding, which may have the effect of protecting both Charlie and Karen from any potential judgement from the interviewer. The interviewer does respond to this by commenting that it is 'a big thing to go through', taking on the narrative that Charlie had been affected by his illness, and perhaps putting a more emotional slant on this. This question is an attempt to recognise the emotion attached to the event, perhaps in response to the lack of emotional language included by Karen and elicits a response from her that builds on the extent of the illness through demonstration of how many times he had vomited. This results in a jointly developed response about how much the changes had been

impacted.

Karen's use of medical or technical terms such as 'gastrostomy PEG' and 'hydrocephalus' and the use of the number of times Charlie was sick, adds a weight of evidence to her narrative. The 'crucial age' at which Charlie's illness is highlighted by Karen as explaining why the impact on his eating was so marked. This type of language is linking theoretical ideas with Charlie's experience, and suggests this is a considered and educated account. Through her technical language Karen begins to position herself as knowledgeable and able to provide a factual account. This could also be considered as the use of 'detail' as a discursive device (Potter, 1996) to add weight to what she said.

Karen strengthens this sympathy and protects them both further in response to a question about how Charlie's eating was before the illness. Karen uses four phrases to show that Charlie's eating had been 'completely normal' and that *he* wasn't a 'fussy eater' implicitly. This is a form of stake inoculation (Potter, 1996): Karen is preventing the possibility of the interviewer saying that Charlie may have been a fussy eater (possibly therefore *him* having the problem as a person). This has the effect of defending Charlie and showing that he was changed by his illness, and strengthens the discourse that the illness was what caused the difficulties with his eating and that he has been vulnerable.

This initial exchange sets up several of the important discourses and narratives in the interview, about Charlie himself, as well as a justification of the reasons why mealtimes and Charlie's eating are managed or dealt with the way they are by Karen and the family. The way in which the discursive objects of Charlie, his eating, and mealtimes are constructed also serve to present and construct Karen as a competent parent and narrator, and the narratives she shares as valid and true.

The action of the talk within the mealtime itself positioned Charlie as different and needing special and different care from others in his family. His own actions and talk physically positioned him as such as he ate separately from the rest of his family in another room. This was in part his own doing, but was allowed by Karen and John, although they had offered him the option of joining the family in the kitchen. The initial background Karen provided at the start of the interview serves to provide an explanation for this positioning of Charlie as special and needing extra or special care. The description of his vomiting and of his illness and treatment provide evidence that Charlie has needed considerable extra care because of the things that have happened

to him: his health has been more vulnerable than most other children's. To have started the interview in this way primes the researcher to have this background understanding of Charlie, and sets the tone for all later descriptions of what happens in the family and with Charlie's eating. This narrative is strong and emotive: as the researcher in this scenario it elicited empathy and a feeling of support for the family, which provides protection in advance from criticism of the way the family do things. Without the provision of this context, the family's mealtimes and treatment of Charlie may be more open to criticism: it provides justification for their actions.

Main discourses: Charlie's eating has improved but is still problematic, approaches that might normally be used wouldn't work with Charlie due to his special needs

- **Constructions:**

Karen: as appropriately concerned about the future, and not having all the answers, but coping now

Charlie: as a child with significant difficulties who will continue to need complicated extra care

- **Discursive action:** *Demonstrating care as a good parent, demonstrating Charlie's special needs therefore building sympathy*

- **Implications:** *This moved away slightly from the discourse of Karen as competent and knowledgeable to being more about acknowledging the difficulty and Charlie's additional needs*

Two extracts follow, extract 2 is about the trajectory of Charlie's eating over the preceding years, and more specifically, the progress he has shown. Extract 3 relates more to the concerns Karen has about the future

Extract 2 (interview)

This relates to Charlie's eating specifically and changes seen over time.

I: How would you describe Charlie's eating?

K: Erm...

I: I know that's a bit of a broad question.

K: Yeah, it's (pause) difficult because where he's come from to now is actually a really vast improvement over the last three years, erm, but I still think it leaves

a lot to be desired really. It's very very limited.

I: mmhhmm

K:- uh, and that's it really, he doesn't eat much at all and what he does eat has no nutritional value so it's quite frustrating, erm, but he's come to this point from eating maybe three coco pops in a day.

In this segment of transcript, Karen presents a somewhat divided account of Charlie's eating: on one hand she describes the 'vast improvement', but on the other, how 'very very limited' his diet is. The example of Charlie eating three coco pops in a day all serves to demonstrate how severely Charlie's eating has been and is affected and gives a specific context for the researcher to consider Charlie's current 'very limited' eating within. Karen shows that although it might not seem that way to an outsider, or the interviewer ('actually a really vast improvement'), Charlie's eating was much more limited in the past. This gives the interviewer the impression of the enormity of the task of eating for Charlie and therefore his family. It shows the effort they may have needed to go to, and explains why there might need to be allowances made for Charlie (and parents/family) in the way mealtimes are done. Karen presents the changes that have happened as positive and explicitly ensures these developments are not obscured for the interviewer by Charlie's current 'limited' diet by stating how momentous they have been.

Although Karen constructs Charlie's progress as substantial and significant, she also represents them as insufficient insofar as more change is needed: his eating 'leaves a lot to be desired' and is 'quite frustrating'. She seems to move to and fro between this and remembering the progress. This seems to be a conflict for Karen. This mixed construction of Charlie's eating as having improved but not enough, presents Karen as a caring parent who can praise and recognise Charlie's achievements, but not blindly as she talks about her own concerns and frustrations about the reality of Charlie's lack of nutritional intake. This does show some of the difficulty for Karen in the role of parent: there are expectations of how Charlie should eat, but she is bound by the reality of how Charlie does eat, which she acknowledges can impact on her own feelings. This may embody some societal discourses and expectations of parents: caring and competent, as well as concerned and attending to the child's needs and future. Karen's discourse moves between the two, and it seems the function may be partly to portray herself as a parent, and possibly to reassure that there is some effectiveness to what she has been doing. She immediately flits back

after talking about the reality of Charlie's eating and her feelings of frustration about it, to a reminder of how much worse it was: taking the discourse back to the beginning of being about Charlie's progress. Karen follows this by telling the interviewer about what Charlie now eats, also referring to Charlie's previous time being fed through a tube. In a later part of the transcript, Karen talks about the 'journey' with Charlie's eating more and her attitude to this.

Extract 3 (interview)

K: ... he knows about food and I try to explain about... how he needs it to help him grow big and strong and how he needs to try different foods and stuff (...). I don't know his reaction to food is so strong in a negative way, I don't know how to turn that around for him. If he feels physically sick at the sight and smell of it, how, how do you change that, you know? I don't know I feel like I've come against a brick wall slightly and there have been were we deviate slightly, where we try different biscuits and things like that, but I just don't know how to make him move forward, I don't know how I'd ever convince him to eat a banana or an apple, or anything with a different flavour or texture.

I: Is it... What could happen if he eats something different?

K: He'd be horrified. He'd be (makes gagging sound) straight away and he'd be – it's just like (shakes head)

I: What's that like for you?

K: Well, like I say, I think I've come to the point where this (gestures to screen where Charlie is eating) is real progress...

I: mmhmm

K: But it's a little bit frustrating in the sense that I don't know how well I'll ever convince him or be able to have him not have that reaction to any different kind of food, you know, anything with a slightly wetter texture or- you know, it has to be crisp and tasteless (laughs) for him to eat it. So I think we've got a really, really long journey ahead and if I'm stressed about that journey all the time it's not healthy, it's going to be a long time that I feel like that, so I'm okay with it, you know, I'm okay with this.

I: It is good to hear that, so-

K: Yeah. And I'm sure he would pick up on my stress about the situation and that's not going to be good for him either. So we're all quite- we're good with it, we're okay (laughs). I do worry about the future and I worry about when he's an eighteen year old man is he still going to be eating party rings and melba toasts, you know? But that's a long, long way off and if we keep chipping away at it we might eventually be able to get him to be eating something like a normal diet one day.

In this later part of the interview, Karen describes her efforts to get Charlie to eat. The hypothesising Karen does about what Charlie ‘would’ do in various scenarios could be seen as ‘generalisation’ (Freesmith, 2007), making her interpretations span a large number of potential incidences, rather than only one. Again, she moves between talking about the enormity of the difficulties he has with eating (being physically sick in relation to certain textures etc), to talking about concerns about Charlie’s future eating, but then back again to reassurances that although progress will be slow, it can be made (‘if we keep chipping away’). She talks about being concerned about whether the task of Charlie having a ‘normal diet’ is one that can be achieved and if they will be able to impact his eating into the longer term (‘when he is an eighteen year old man’).

One particularly interesting part of this section of transcript is where Karen uses the enormous task and the length of time it may take to achieve to explain or possibly justify her less pressured and more relaxed approach. She frames this as deliberate in order to make the task approachable as well as to benefit Charlie (picking up on her ‘stress about the situation’ wouldn’t ‘be good for him’). This pattern frames her both as a concerned parent, but one who can manage this concern and the task for the benefit of Charlie and for her. This also constructs her approach as a coping strategy: one which makes the task manageable. It is considered and necessary in order to galvanise her and her talk indicates that her relaxed approach is a form of self-preservation also and management of emotional resources. Karen almost reassures with her repetition of ‘I’m okay with it’. It is interesting that I responded with ‘it’s good to hear that’ as this reassures Karen that I have heard her message that they are okay and managing. I took the message that they were ‘okay’ and managing.

It is interesting how the responsibility for the task of getting Charlie to eat is constructed through this part of the interview transcript. Karen takes responsibility for being the one to know how to ‘convince him to eat...’: for Charlie making the choices, but Charlie is ultimately responsible for choosing what he eats.

Main discourses: Mealtimes as normal for the family, and about happiness and avoiding stress rather than necessarily about Charlie

Constructions: Charlie needs different mealtimes due to his vulnerability and susceptibility to upset from food

Goal of mealtimes: about happiness and stress reduction not only eating

Parents: as having thought mealtimes through and are happy with them being different for Charlie

Control in the mealtime: Charlie has control and this is accepted

Discursive actions: Justification of the way the family do mealtimes, protection from criticism through this

Implications: emotions are an important part of the mealtime and need to be managed

Karen talks about hers and the family's attitude to mealtimes and the way mealtimes are conducted within the family home:

Extract 4: (interview)

I: ...I was just wondering if you could say about how mealtimes are for you?

K: Well, I suppose in some respects, um, it's quite normal. It's what's normal for us. So we will sit around the table and eat together, and Charlie will just eat his meal in the living room. And we've got to the stage at school where they're giving him a space to eat because we were having a lot of problems around the dining hall and his behaviour and it making him feel sick. So, our mealtimes are completely normal, just minus Charlie who'll just eat his food in the other room.

I: How do you feel about that?

K: Uh, um (...) I'm okay with it now, it bothered me before, but it's how- it's taken the drama out of it, erm you know? He's happier, we can sit and have our meal happily (laughs). So it's quite normal really for us.

I: Um, okay, right. I wondered if we should perhaps put the video on. Or is there anything you want to say about his mealtimes more generally?

K: Um, the only thing is obviously, the, the smells and the sight of food can make him start to gag and be sick, so, um, we've got to be mindful of that for him as well...you know.

I: How do you think he feels sitting there?

K: Uh, pretty happy I think, yeah. I think it helps him, like I say, to put the TV on, or he has the iPad which I wouldn't normally do, wouldn't let the girls do, but um, I don't know if it helps him, not really thinking about the actions, what he's doing, you know? Like, I mean, if he was really just focussed on the food I'm not sure for him that would be beneficial. Just because of how he is with food generally, you know? Um, like I say, we all sit at the dinner table, but I suppose he is different. I do have to treat him differently so if that means him not focusing too much on what's going on, it's more reflex (makes eating gestures) than (mimes focusing intently on the food). Oh yeah, I'm really... I don't know, I don't know what I'm trying to say.

Karen says that the mealtimes are ‘quite normal’ although straight away qualifies this with ‘normal for us’. It seems that the ‘normal’ she is referring to here is ‘sit[ting] around the table and eat[ing] together’ with Charlie eating separately from the rest of the family in the living room (which isn’t seen as ‘normal’ in a broader sense). It seems that Karen here is tapping into a societal discourse about what mealtimes are like ideally: whole families sitting around a table. Although this could be a more historical or class specific ideal of what mealtimes should be like, as in many families this is not the case. There may be some assumption of what the interviewer may expect a ‘normal’ family mealtime to be like. Although Charlie is not described as being part of the ‘normal mealtime’ here, this is not constructed as problematic, however it is justified through the use of the description about Charlie’s mealtimes at school and that they have had to take a similar approach of Charlie having a separate mealtime. This constructs the way Charlie has meals as something to do with him rather (‘his behaviour and it making him feel sick’) rather than something to do with the family and the way that they specifically treat him and his eating.

Again here, there is a joint construction of the problem being manageable, as well as being something that could be seen as problematic. Karen initially says in relation to how she felt about the mealtimes that ‘it bothered’ her in the past but not now. It seems possible that the interviewer’s question about how she felt could imply that the interviewer expected Karen to be bothered by it, however it was an open question that Karen could have responded to in many ways. Again the way she answers it constructs her as a caring parent with ideals about how family life should be, but one who is also in control and managing. Karen also again justifies Charlie eating away from the rest of the family as making him ‘happier’ and ‘tak[ing] the drama out of’ meals. This does fit in with the discourse constructed earlier about pressure being unsustainable and stressful, and mealtimes being about avoiding stress for her and Charlie. Again this presents the family’s strategies also as considered and thought through and Karen as someone who has done this considering and thinking: making decisions that leads to the well-being of the whole family.

Although the way mealtimes are done is explained here, it does locate the problem within Charlie and locates him as different and needing something different from others in the family. This links to earlier discourses about Charlie being different to other children and again at the end of this extract, Charlie as delicate and needing

to be looked after differently, rather than the 'drama' and keeping him separate from the rest of the family. The construction of Charlie as delicate is interestingly also subtly constructed within one of the few pieces of talk within the mealtime:

The key feature of this part of the transcript is that Charlie is overtly constructed as different to his siblings and in needing different care from them. Karen describes how she allows him to have things that her other children would not have, for his benefit and the benefit of his food intake. He needs to eat differently: needs a special environment, and favourable treatment compared to his siblings in order to get him to eat. Karen also talks about these adjustments and special measures allowing Charlie to be distracted and not to concentrate on the eating he finds stressful. This ties into the discourse Karen developed earlier about the way mealtimes are done, and the way she deliberately takes a less pressured and more relaxed approach being about avoiding stress. Charlie is avoiding the stress of eating, and the family are avoiding this too, by him having special care that keeps his eating separate from the family (in the living room) but also separate from him: outside of his conscious awareness and behind a screen provided by distraction.

The narrative provided by Karen is mixed in that concern for the future and worry does enter her story of Charlie's eating and meals. However, a key theme of the narrative is about how she and the family have carefully built a mealtime environment and a way of viewing Charlie that blocks out this stress and allows them to function at mealtimes. This allows the dominant discourse to be about coping rather than struggling with this difficulty.

In the mealtime itself (extract 7), Charlie is asked by Karen how he wants to have his meal (on the sofa). She also checks he is comfortable and asks him what he wants, rather than instructing, persuading. Karen then leaves the room and shortly after John then calls through and asks whether Charlie wants to go into the kitchen. Interestingly, Karen answers for Charlie and says 'no'. Charlie's original choice is defended by Karen. It is possible this is as the camera had already been setup in the living room, and this was not a representation of what would usually happen. Karen is Charlie's ally in this. She is confident in his decision to eat his food in the living room.

Extract 7a

K: Yeah? Do you want to sit in the middle?... Boh... Do you need a wee or

anything before you have your dinner?

Extract 7b

J: (from kitchen) Charlie are you going to come here and geddit?

K: No he's not

Extract 7c

K: (brings food in) There you go mister. (Places food on Charlie's lap). Are you happy now?

These extracts in combination with the previous extract demonstrates how Charlie does generally have control over the mealtimes, but this is encouraged and that Karen's focus is on his happiness and comfort, rather than the conventions of mealtimes or what and where he eats. This demonstrates how some of the previous discourses of Charlie needing special treatment may play out within the mealtime setup.

Main discourses: Professionals as having little to offer, as parents are aware of what they need to do, parents therefore as being the ones with expertise and responsibility

- **Constructions:**

Professionals: as holding little role or responsibility for making changes to Charlie's mealtimes

- ***Parents: as competent and able to make the decisions needed to manage Louis' care***

- ***Discursive actions: prevents questioning as Karen aligns herself with professionals***

- ***Implications: the parents do not need specialist advice due to their expertise built through their experiences***

The interviewer next asks about the service that the family access and Karen says:

Extract 8 (interview)

K: Yeah, just kind of to be fair I think we've, we've done a lot of the things that they would suggest us to do, um and just to continue doing those things so I don't necessarily at the moment, need them as a resource.

This feeds back into the idea that Karen is competent, and understands Charlie's

needs. That the family or parents (we) had already done a lot of the things professionals *would* suggest implies that some of these are conclusions that Karen has already reached herself. This adds further to this discourse around competence in that it positions Karen as being as expert as professionals in knowing what would be advised. Karen and her husband John use medical and professional terminology which adds to a sense of them being capable of providing what Charlie needs. This again protects them from being questioned or criticised: they have responsibly sought professional advice, but position themselves (Karen and John, it seems), as holding the same level of expertise. This construction of equal levels of expertise removes responsibility from healthcare professionals: there is no need for them to be involved.

Overview of Family B

Karen's discourses in general were relatively stable across the interview and could be seen to form a more coherent narrative than family A. Multiple extracts could have been used to illustrate the same discourses. Main constructions were that cancer had caused Charlie's eating difficulties, and these difficulties and the hard things he had been through made Charlie different and special. Karen talked of different approaches they had tried, but her discourse largely was about having found an approach to mealtimes that worked for them, as it enabled Charlie to feel happy and not stressed. The family discourses of the problem being related to cancer were important.

Question 1. What discourses are constructed or drawn on by parents about their child's mealtimes or eating (in the observed mealtime or more generally)?

The discourses constructed by Karen centred around Charlie and his illness, making him an ill child with special needs, who needed extra care. The cancer was ultimately responsible for the problem, so Karen did not need to spend time removing responsibility from herself. Instead her narratives focussed on Charlie's special needs, and her own ability to cope. She placed the focus of mealtimes on Charlie and whether he was happy or not in the mealtime, rather than on eating a certain amount or type of food, or eating it in a particular way. The cancer was responsible overall for the problem, and parents had found a way of coping that worked for them. This prevented criticism of the mealtime.

Question 2. How do these discourses contextualise and provide understanding of the observed mealtime?

These discourses link clearly to the control Charlie was given within the

mealtime, alongside the care and checks that he was okay and happy. Charlie's constructed difference from others in the family, justify and explain the different way he eats his meals. The food he eats was constructed as less important than whether he was content and free of stress in the meal. Karen linked her own stress levels to his. The long term nature of Charlie's difficulty with eating meant that the family had to find a way to reduce the stress of the meals: they could not 'afford' for every meal to be stressful as their internal resources would be depleted. Again, ideas around confidence and self-efficacy are relevant here and discussed further in Chapter 5.

Reflexivity

When I came to analyse Family B's data, I found that I had in my head the idea that they were coping. I had taken on Karen's discourses about them managing. I recruited Karen through attending a clinic, and as I introduced it, she told me that they did not have problems with mealtimes, they were not stressful. I said that this did not prevent them from being able to take part. The image Karen portrayed was one of confidence and competence, and I did need to reflect on this as a construction developed through her talk, rather than accepting the impression she had left on me. I felt for the family on a personal level, and also had to consider the potential impact this had on the way I heard their story. I did this by using this as information on the social actions of Karen's talk, rather than trying to ignore it.

Family C

Pen picture/background

Family C consisted of Maria, early forties and Sophie, 3. Maria had two older children, one of whom lived with her and one of whom did not. Maria was not working at the time and described some past difficulties with alcohol (she told me this when I first spoke to her on the phone in relation to my question about social care involvement, which there had been in the past due to this, and talked again about this in the interview). Sophie's dad had a lot of contact and was present for part of the mealtime video but did not want to participate in the study. He and Maria were not in a relationship, but had been previously. Sophie has some considerable physical health needs, as well as disabilities, and had needed multiple operations and continued painful procedures in between. There may also have been some other more general

developmental difficulties (Sophie had relatively little speech and was still in nappies). Maria did not express concern about these things.

Maria's house had large sofas and other things in the room. It was clean. She commented that she wanted to get new furniture, but it did not look worn out. There were items collected near sofas including things like Sophie's toys and nappies, but these were not in the way. There were quite a few large toys in the front garden set up, and Sophie pointed at these wanting to go out at one point. There was no table and chairs to eat at, which there had been in the kitchen of the other two families' houses. Maria was welcoming, she had been preparing food in the living room at the sofa. Sophie was dressed in a top and a nappy and shoes on each visit. She brought her mum a dress on the second visit, and Maria said she could put it on after her bath. Sophie was present in the room for the interview, playing or spending time using a tablet device.

Mealtime setup

Maria was chopping potatoes into chips on a chopping board on her lap on the sofa when I arrived. Sophie was playing round and about, the TV was on in the background. Maria explained that although this was the agreed time, this was not the usual time Sophie ate. She gave Sophie a wafer marshmallow which she called a 'jammy' while she finished preparing the food and waiting for it to cook. I did record all of this, which took almost one hour, but the mealtime itself (as in the time when they ate) took around 10-15 minutes. Sophie took her food to the place where the camera had originally been setup to eat her food, which Maria explained was not usual, but was where she might have a bottle of milk. Sophie reclined on cushions to eat, and had the tablet set up in front of her. She ate the food mostly with her fingers (Sophie had some physical difficulties in her hands), and when she had eaten the bits she wanted (small pieces of chicken Kiev, chips and coleslaw) she took her plate to where Maria was eating on the sofa, where Maria shared some of her food with Sophie.

Main discourses: The problem is serious but resolvable

- Narrative: Sophie's eating problem in the context of other health problems was serious, but not noticed immediately. When it was, Maria took action and now the problem has resolved

- Constructions:

Eating problem: terrible, but not seen that way at the time (doing well)

Maria: aware and responsive when she realised there was a problem, able to rectify Sophie's eating

At the start of the recorded interview, Maria is asked to describe Sophie's eating. Maria very quickly creates a summary of the story of Sophie's eating difficulties: from the experience of the problem for Maria and Sophie as 'terrible', through the identification that Sophie's eating patterns were impacting on her health in hospital but by Maria, through to a resolution where Sophie's eating has improved. Maria introduced as context, Sophie's illness and the way this impacted. This also presents a narrative that could be seen as a journey or process for Maria as a parent: from naïve or unaware mother with a poorly child whose needs she thought she was meeting, to her own recognition there was a problem and a new understanding which she then used to address it with a reparative effect. There is some conflict in Maria's descriptions, which is interesting to consider.

Extract 1

Interviewer: ... I wanted to hear a little bit more about Sophie's eating now first if that's alright, erm, ... I don't know you, you started telling me a little bit about it didn't you last time, you know about Sophie's eating in general...

Maria: Well it used to be really terrible, I mean she used to just (puke or drink-unintelligible) 'er milk. She wun't eat for da-ays on end, you know what I mean?... But I thought I were doing well... with her being... um... drinking milk... But then when she had 'er opperation, with 'er operations, she wan't well for weeks.

I: Mm

M: She'd wake, she'd jus', she just she'd get up, she'd wak... be err 'ov'ring round for fi'- about five, five or ten minutes, and then she'd be asleep on the floor again. So when I told them int' 'ospital: 'can you just do a blood count', she were downt'a forty six. They told me it were because she wan't eatin' and she was just drinkin't' milk all t' time. And she said to cut the milk down, which I water it down now, I do water it down, I do water it down, and her appetite has soon, you know, it's come together now (turns attention to Sophie).

Maria is initially invited to and forms constructions of Sophie's eating. She immediately refers to how it 'used to' be, positioning the difficulties in the past from the start. The description of it being 'really terrible' and Sophie not eating for 'days on end' emphasises the severity of the problem, and Maria draws the researcher in to really hear this, when she addresses her with 'you know what I mean?'. This builds in the listening researcher a sense of empathy and understanding. However, when Maria then says that despite Sophie's lack of eating, she thought she (Maria) was

doing 'well' as Sophie was having milk. It is Maria rather than Sophie or her eating is described as doing 'well'. This does two things: firstly it makes a link between Maria's sense of herself and whether she was doing a good job ('doing well') and Sophie's eating. There is the connotation that the severity of Sophie's eating difficulties had meant that her consumption of milk was a big achievement for Maria. Secondly, Maria is talking about what she thought in the past, thus showing that she had given some consideration to what she was doing in relation to Sophie's eating. In relation to the realisation of the health problems Sophie's diet was contributing to, that Maria describes next, she appears to be disclaiming her lack of action as she thought she had made the right decision.

Sophie's eating as one of many problems

Although clearly a considerable issue, Sophie's eating is clearly positioned by Maria as one of many health related concerns. This builds on the idea that on spite of all Sophie's needs, she was drinking milk, a positive in this light. Maria's descriptions of Sophie's sleepiness, and how ill she was after her operations serve to demonstrate to the high level of health problems Sophie was experiencing. This could be an additional explanation of the apparent conflict between Sophie's 'terrible' eating, but Maria 'doing well', her eating was one of many issues demanding Maria's focus and attention as a parent. Sophie was so unwell, standards of what could be considered 'well' did not apply in the same way. The circumstantial frame of Sophie's poor health puts Maria's actions or success in meeting those needs (or not) in a different light.

There are several possible functions of this collection of narratives. In constructing Sophie and her needs as so severe and extensive empathy and concern is built for Sophie, but also for Maria as a parent who had many challenges to cope with. The link to Sophie's operations give context for why Maria may not have paid attention to the eating problems, and her apparent dismissal of concerns because Sophie was still drinking milk. This could be seen to amplify the narrative of the severity of Sophie's needs: they were so extensive that despite her not eating 'for days on end', Maria did not think this was problematic.

In saying that she 'thought' she was 'doing well' with Sophie, by giving her milk, Maria constructs herself as naïve to Sophie's needs, rather than ignoring them. This is important because she goes on to say that not addressing these issues had led to Sophie being more unwell. Maria constructs the hospital staff as telling her why

they problem happened. This results in the construction of joint responsibility for recognising there was a problem between her and the hospital: Maria told them that they needed to do a test, she was proven right, and they were then able to tell Maria why the problem had occurred. Maria's citing of the number 'forty-six' as the result of the blood test puts out the idea that she now understood the problem. This could have been an assumed shared understanding of what 'forty-six' meant, Maria demonstrating some technical knowledge, or she may not have known exactly what it referred to. It could also be seen as an example of the use of 'detail' (Freesmith, 2007) to describe what has happened, and lend weight therefore to the description.

I felt it was important to retain the whole of this quote, as by the end of it Maria has moved on to show that the eating issue has resolved: that she was able to respond to advice, saying twice that she waters Sophie's milk down now, and that this had meant her appetite had 'come together now'. In saying this, Maria positions herself as adaptable in accordance with Sophie's needs, and able to learn. That she quickly reaches the conclusion of the story of Sophie's eating problems having resolved, reduces the potential for concern from the listener/researcher that Maria is now not doing a good job as a parent. This resolution of the issues has the effect of negating the admission of not knowing, or mistake in thinking that she was 'doing well' in that once she had sought and followed guidance, things were repaired. This also relates again to responsibility: she took the responsibility when she needed to.

Overall, although only a relatively small section of text, that took only around a minute within the interview, this first section tells a complete story, with the beginning where problems were happening but could not be addressed; a middle where Maria and medical professionals identified the problem, and the end where Maria resolved the issues by following advice. Sophie is introduced as a child with many needs, and Maria is introduced as a parent initially struggling to respond, but later taking on a more responsive role, exonerating her from the naïve (albeit well intentioned) position she had constructed for herself earlier.

Main discourses: Sophie is poorly and different to siblings

- ***Narrative: Sophie is different to her siblings, a 'sicky' baby and therefore parents could not have been expected to know she would have different needs***
- ***Constructions: Parents as naïve to what Sophie needed, but understandably so due to Sophie's additional needs***

Sophie: as different and unwell

Problem: situated within Sophie

- *Action: to remove blame from Maria and promote understanding of her lack of awareness of the action she needed to take*

Two extracts are discussed in this section. Maria's constructions of herself as a parent from the beginning are entwined with Sophie's specific set of needs meaning that different standards of what 'doing well' meant applied. The interviewer asks about Sophie's eating from being a baby. In the next extract, Maria builds on the narrative around Sophie's needs but also relates these to Sophie's older siblings, and thus again contributes to a construction of Maria as a parent in relation to Sophie's additional needs.

Extract 2

I: ... So with regards to Sophie's eating, was that something that you- I guess starting from when she was a baby, what was her feeding like when she was small?

M: She were always a bit finicky but they've all been like that though and I thought: it will come, like it did with the other two.

I: I mean like when she was little, like a new born?

M: Yeah, oh no, she was alright with her milk and everything else but she were a very sick baby. Very sick and me and her dad had never had a sick baby before, but she really was sick. When she started on solids she was a bit finicky. She was always good with her milk though, she was always good with her milk. (To Sophie who is holding something up to Maria: No, we'll do it after your bath). Then um, as soon as she was on solids and that, she was always a bit funny.

I: So how did that feel? I know you said she were always a bit finicky-

M: As I say, well as I say, I were giving her milk all't' time- I didn't think I were doing owt wrong. There'd be times when she'd have summat to eat but it wan't often (...) and I were always quite glad when she'd had summat to eat but it wan't often... (talks to Sophie)

Initially Maria conveys Sophie's 'finicky' eating as something she could understand and was not concerned about: her other two children had been the same and had recovered and Maria had assumed that Sophie would too. Maria's talk suggests that had it not been for her other children, she may have been concerned, but had dismissed any worries and had been reassured by her previous experiences as a

parent, thus adding to the idea that Maria has some level of expertise as a parent, and refuting the idea of naivety, but instead creates an idea that her incorrect interpretation of the action she needed to take was based on other children. This begins to further build the idea that Sophie is different from her other children.

Maria moves overtly onto describing how Sophie was/is different to her siblings. She makes a clear and repeated construction of Sophie as 'sicky' and therefore difficult to care: they had 'never had a sicky baby before'. The use of 'never had' one before almost suggests Sophie is something to deal with, and is somewhat strange or over-facing to her parents. At this point, Maria refers to Sophie's father in a way she doesn't do consistently throughout the interview. This gives the effect that it was not only Maria who didn't know what to do, and shares responsibility between her and her partner. This is an interesting way to manage accountability: it is shared when Maria is struggling to understand her child and her needs, but when Maria describes the progress and resolution of the issues, it is her that does this. That neither Maria nor Sophie's father knew what to do with a 'sicky baby', but later Maria was able to make amends. The construction of a shared lack of experience of a baby like Sophie leads to the conclusion that it is Sophie who is different herself. Maria consolidates this difference in Sophie further as the extract goes on. The use of the word 'sicky' has the effect of placing the 'sicky'-ness as an inherent characteristic within Sophie, rather than something making her sick or an illness. This sicky-ness can be linked back to the early comment Maria made in response to the first question of the interview about vomiting her milk up, however is another example that does not quite fit with the statement about Sophie being 'alright with her milk'.

Maria's statement that Sophie was a 'bit finicky' when being weaned seems to be a relatively mild term to describe fussiness, however the description of Sophie not eating often, combined with the earlier statement about Sophie not eating 'for days' would suggest this was more severe. This is certainly not overt, but Sophie not eating, was subtly positioned as coming from Sophie herself. She is not quite constructed as choosing this behaviour, but this being something that was naturally occurring. This may have been a way for Maria to describe how she viewed Sophie's eating at the time: as something that was a passing phase and that would develop naturally, as with her other children, without specific action from her.

The following section moves onto talking about mealtimes now at the direction of the interviewer but then when Maria begins to talk about her daughter (likely other

daughter-not referred to by name), Maria moves back to comparison of Sophie with her siblings and Maria's develops the discourse about her understanding of Sophie's difficulties eating at the time, and in relation to her experiences of parenting her other children. It also continues the narrative about Sophie's difference from her siblings because of her physical disabilities and therefore this being an additional demand for Maria to cope with as a parent.

Extract 3 (interview)

I: mmm, and how do you feel about her mealtimes in general, you were saying things have changed recently?

M: Yeah, she, as I say, she does eat off her own plate but, like I say, she does eat off my plate as well, which I'm not too bothered about as long as she's eating, because my daughter eats terrible. You know, they get themselves into such a state...

I: Is that what happened with Sophie?

M: ... I mean all 't' kids have been quite finicky, I mean our (son), he were near enough vegetarian at one point, woun't eat meat, but now he does. I think it's just phases they go through.

I: Yeah. Was that the sense you got with Sophie? Or-?

M: I thought it wa' yeah. I thought with the milk that we were doing alright wi't, wit' milk and everything. Obviously we were doing wrong, so it's a new one on me though is that, I've never-

I: How do you feel looking back on that then?

M: Shoudda known. You know, I shouldda known you know, because I've had three of them but for me I think it's that I've never had a physically disabled child before and it's a new one is that. And erm, I think what it is, with her I thought: 'Well milk, it strengthens their bones'. I honestly didn't think I was doing anything wrong.

Maria talks about how all of her children have been 'finicky' and that their eating had improved. The way she says 'I mean' before describing her son's eating gives the impression that she saw this as relatively severe at the time, but quickly comments that he 'does now' (eat meat). This follows a similar pattern to how Maria describes Sophie's eating at the very start of the interview: saying how bad the eating was, but almost reassuring the listener or herself that things got better, so were not anything to dwell on. When I asked if Maria thought that Sophie's eating was a phase, this provides an explanation for Maria to use, and she reintroduces the narrative that

her intentions were good: that she had thought the milk was enough. She does concede that this was ‘obviously’ not the right thing to do: that they: implicating both herself and Sophie’s father had made a mistake with feeding Sophie.

When asked how she felt about her statement that they had not done the right thing, Maria begins with quite a self-critical idea that she should have known, referring to herself only, thus taking on responsibility on her own this time for the decisions that were made around Sophie’s eating as an experienced mother. However, she quickly provides a reason that her previous experience had not meant she knew what to do: Sophie is different from the other children as she is ‘physically disabled’. The term ‘physically disabled’ could be seen as quite technical, almost diagnostic. This is evidence that she is different, presented as a fact making it difficult for the listener to dispute and has the effect of suggesting that there should be allowances for Maria in her parenting as parenting this child is a difficult and new task for her. As well as positioning Maria as challenged, but understandably so, this does position Sophie as different from her siblings.

Maria goes onto explain her reasoning that she thought milk ‘strengthens their bones’ to show that she had considered her actions around Sophie’s feeding and weaning. This consideration and thought through decision-making indicates that her intention was to look after Sophie’s needs carefully: she positions herself as naïve or unaware rather than neglectful. This is interesting as it raises the question of what makes a good parent: someone who tries to make the right decisions or someone who does make the right decisions. Maria seems to move between these ideas through saying she should have known, but that she could be excused for not knowing due to Sophie’s additional needs. It would be interesting to know whether she would have given herself any allowances had Sophie not had additional needs or been physically different from her other children.

Having some difficulty or being ‘finicky’ around eating is normalised by the statements Maria makes about her son and other daughter (who it seems she is referring to in the first part of the last section). Eating something is what Maria portrays as important to her through explaining that she is happy for Sophie to eat from Maria’s plate as well as her own. In talking about milk strengthening bones, she shows some consideration of the nutritional value of food, although consuming *something* is consistently put across by Maria as more important: than what she eats: the milk was acceptable as it was something, and Maria’s own food from her plate, as

this is something. This suggests the goal of the meal is to eat some food, what is eaten and the way it is eaten are not portrayed as the important aspects of the meal. This idea in relation to the other families is discussed further in the discussion.

Main discourses: The problem as resolved

- **Narrative: *The problem with mealtimes has almost been rectified***
- **Main constructions:**
 - Sophie: has returned to being like her siblings*
 - Maria: has been able to repair the problem, and therefore maintains the idea she is a good parent*
- **Problem: *temporary and reversible, any difficulties are not part of a normal pattern***

A narrative about the natural progression of mealtimes for children is developed further later on in the interview:

Extract 4 (interview)

I: So how are you feeling about her mealtimes now?

M: I feel a lot more positive. I mean, it's coming along slowly, but it's coming along. You know, that's the best thing really, she is eating on her own plate. It's not- she eats the best bit and then she comes over and has mine, but I'm not fussed about that at all because all't' kids have done that, it's just the progression for them to eat on their own plate. So, no, I'm not overly fussed about that, it's not a worry or owt like that for myself you know?

Extract 5 (mealtime, Sophie has come over to Maria who is sitting on the sofa eating):

M: Do you want some more?(putting some of her own food on Sophie's plate)

M: Do you want some more?

Extract 6 (later in the interview):

M: Yeah, like I say, what she normally does, she might sit with her plate then she'll come over to mine and nick off mine, but that day she started eating off her own plate and then come over and instead of taking it all off my plate, she started eating what I put on her plate. She quite enjoyed that, you know. It's not been as good since, but she does- you know, she finishes off what's her's and then I put some more on her's and then in about say five minutes, she'll go "no, no" and she moves it away and then she's on my plate.

I: What do you think is happening there then for her?

M: I don't know. I think it's a bit of comfort really, eating off my plate.

(Interaction with Sophie). As I say, it's more comfort than owt else when it comes down to her eating.

...

I: What do you think they're like for her? (mealtimes in relation to previous question).

M: I don't now, I think- I think she want is to have a little bit of independence with her own fork and plate and that, she does try- you know, she wants me to get her fork out and that. Um, but also I think, also, it's just like, I think it's routine for her to come over and have my plate as well. I think it's a lot of routine-y. She does like to have her little routines does our Sophie but our (son) wa't same.

Maria initially suggests here that Sophie eating from her plate is a natural progression and that this is something that all children do. This puts across the idea that children develop habits around mealtimes naturally, and by them with rather than the result of input from others, or encouragement by parents. Sophie and her siblings are therefore constructed as independent and in control of their own meals and eating. In this part of the text, Maria still presents as her own the view that children progress naturally, and that this is in their grasp rather than parents, and says that she is not worried about the progression to eating from her own plate. In other parts of the interview, Maria had recognised that Sophie continuing to consume milk rather than moving onto other foods, had been detrimental to her health, and that Maria had through at the time that this was okay, but also drew on a similar narrative that this was part of a process that children go through, being 'finicky' then growing out of it eventually without intervention.

The way mealtimes are done or conducted by the family is perhaps a slightly different issue. Maria describes not being 'fussed' or worried by Sophie eating food from her mother's plate as she describes this being something that is both part of a routine and that provides comfort to Sophie. She does relate this back to her son, again, drawing on the idea that children just do some things, and that phases are gone through and that this is therefore nothing to worry about. Although the type of food (milk versus solids) and the way in which they consumed (mealtime practices) are different issues, it seems that Maria has drawn on similar 'natural phase' narratives related back to her other children for both. The difference however, is that Maria was in a way forced to recognise that this had not been the case around Sophie's weaning and food choices as this had led to negative impacts on Sophie's health. Maria says several times throughout the interview that she 'should' have known, because she is an

experienced mother. In continuing to reference things that her other children did, she is continuing that narrative, but also providing reasons why there is no need to be concerned about Sophie's mealtimes now: they have improved. The discourse Maria develops around Sophie's eating now is that it is much better as a result of the changes she has made and action she has taken, and that she has seen a positive effect.

Maria: I make sure now that I don't even give her a full bottle of milk, I just water it down, and her appetite has really built up now, especially since she's had iron and that, she's been up and jiving and everything. It's great, it really is, it's lovely to see. You know what I mean?

Here Maria talks positively about the things she now does differently in relation to Sophie's eating. She simultaneously seems to describe this change as considerable as not 'even... a full bottle of milk' implies that a bottle of milk would have been seen as a small thing or usual, but now is not provided to Sophie as a matter of course: this is a big change. Maria immediately following this uses the word 'just' to describe her actions, which minimise them in a way. In this Maria seems to recognise the extent of the changes, but that her own actions are negligible in some way. Maria does also link the iron supplements as having contributed to Sophie now being 'up and jiving'. Maria's last sentences commenting on her own reaction to seeing Sophie's improvements in her demeanour and energy (for jiving) put across to the interviewer a sense of Maria's care for Sophie and emphasise how pleased Maria is to see the changes in her child. This combines to construct Maria as relaxed and able to make changes that have really made a difference. She is constructing Sophie as changed, well and full of life, very different to the 'horrendous' time described beforehand in the interview. This puts Sophie's illness and the problems around her eating in the past, something that a lot of Maria's talk has done throughout the interview. She recognises the difficulties and her failings in the past, but makes a clear distinction between then and the present where Sophie is doing well and there is now nothing to worry about. It is interesting that Maria talks of her lack of worry about Sophie's eating in the past too, that she thought things would be okay and that they were not for a while does not seem to have impacted this attitude.

Overview of Family C

Maria constructs Sophie's eating problem as serious, but hidden amongst her other health problems. Sophie's physical disabilities are talked about by Maria to explain why she did not realise straight away that there was a problem with her eating. Much of Maria's discourses focus on talking about the improvements shown and the

resolution of the problem. It seems this has a possible social purpose: to divert attention from the idea that Maria missed a serious problem, but also to allow Maria to preserve her own identity as a good and experienced parent.

Question 1: What discourses are constructed or drawn on by parents about their child's mealtimes or eating either in an observed mealtime or more generally?

The main discourses are that Sophie's eating was a serious difficulty. Responsibility for recognising and acting on the problem after this was shared between professionals and Maria, however without blame for the problem being key here. Maria acknowledges she 'should have known' as she constructs herself as an experienced, but vulnerable parent, but focuses on the difficulty now having resolved.

Question 2. How do these discourses contextualise and provide understanding of the observed mealtime?

Maria allows Sophie control over the mealtimes. In the interview and in the mealtime talk, Maria talks mostly about this issue rather than what she ate, or the amount she ate. It is interesting that Sophie comes to get more food from Maria's plate. It seems that there is something special for Maria about sharing her food with Sophie in this way. She is putting Sophie's needs before her own which could be seen as a reparative action related to the previous discourses of

Reflexivity

I thought a lot about how much information to include about Maria's past difficulties with alcohol. She did talk about some of this in the mealtime, but I worried that this was too identifying so have left it out. I did include some information about it, as Maria was open about it, and I felt perhaps it was my own discomfort, and desire to protect Maria from possible judgement which may have encouraged me to avoid including this as well. Maria talked of other difficulties which positioned her as having improved, as Sophie did.

Joining up the three families

While the way the discourses are developed is different between the families, once examined together there were some interesting commonalities and differences between them. The discourses provided through the interview support the

understanding of the mealtimes themselves. Ideas about responsibility and agency within the mealtimes, and acceptance are particularly important here to provide a backdrop for not only the talk occurring in the mealtimes, but also the setup and organisation of the mealtimes.

Acknowledging situational differences between the three families

The situation of each family differed significantly as could be expected. Family B had dealt with this issue for longer than the other two had, largely due to Charlie's age. He also had been tube-fed for some time, adding a further dimension to the problem, as if he failed to eat, then there was an alternative method by which to give him food.

All children had experienced some kind of physical health problems that were linked in some way to their eating difficulties by parents, either as the cause in Louis and Charlie's cases, or as part of a broader picture in Sophie's case. Louis and Sophie were of similar ages, but Charlie was younger.

The family setups were different, as were parents' experiences of being parents (Louis' parents were new to this, with the others having older children). The families were also from differing socio-economic backgrounds. Sophie's mother talked less about other people's mealtimes or ideal setups.

Child illness, difference and special care discourses

In all three families, the child was constructed as ill or different. Louis was a sick child whose needs were not met by professionals, and who was a 'projectile vomit baby', needing more complicated care than parents could be expected to provide in their roles as new parents. This compared to Charlie who was constructed also as having been seriously unwell but who needed different care to his older siblings and different rules and patterns were acceptable for him. Similarly to Charlie, Sophie was constructed as different to her siblings, but as only temporarily needing different care around eating.

Acceptance of the child's eating difficulties

The idea of acceptance and loss is important in considering how families related to the problem, and the three families did this in different ways. Family A were doing everything they could to change Louis' eating, and were angry about the lack of help they felt they should have received. They talked more openly about the loss of mealtimes as they perceived they were for friends (e.g. when Michelle made comparisons) or others (when Rob talked about the ideal way he'd like meals to be).

Because of the way Louis ate, they were excluded from aspects of what they saw as a normal and enjoyable family life. This then translated into their actions at the mealtime (see the next subheading about goals of the mealtime). It seemed that Rob and Michelle were in a kind of protest in not wanting meals to be the way they were: frustrated that the problem had not been solved, and making active attempts to change things.

Karen in Family B framed things differently. This family's difficulties had gone on for a long time (5 years). Karen's almost professional discourse about the problem and her confidence in the set-up of their mealtimes being 'normal for us', gave an impression that she had grown to accept Charlie's eating as being like this for now. Interestingly, this did not mean that she was fully accepting of what happened in the future, as she did express worry and concern about this, but of the current situation, she was clear that through trial and error, they had found a way of running mealtimes that worked for them as a family. There had been sorrow about how things were, and not only about Charlie's eating but about all the effects on his health that had followed the cancer. Karen explained that she had had to do this, as otherwise she would be stressed all the time. Accepting the problem was a necessity. She was not protesting mealtimes being the way they were for Charlie, but had moved onto a practical way to manage.

Maria in Family C was interesting in that she talked about not having initially realised that there was a negative impact on Sophie's health from her lack of weaning. Maria had accepted of the difference that Sophie showed in her eating in comparison to her other children, and had possibly put this down to Sophie's physical disabilities. On reflection, Maria's comments that she 'should have known' suggest that loss and acceptance of the problem was not the appropriate understanding of this, Maria instead had not believed there was a problem. Maria's narrative at the time of her participation in the study also suggested that the problem had now passed. Maria therefore seemed in a different place to the other families in her perception (or lack thereof) of there being difficulties. Instead she had initially seemed to avoid the idea that there was a problem, but then seemed to have moved on to the alternative that there was no longer a problem and that Sophie 'eats like a horse', which began with even the first telephone call to invite her to take part.

Mealtime goals of eating or managing stress and emotions

The discourses about how the family related to their child's eating difficulty are also

important in thinking about what the family's goals were in the mealtimes. This is therefore not a standalone part of the discourse but is contributed to by the other areas of how the problem was constructed in terms of responsibility and the need for it to be solved.

Family A showed an active and involved approach to the mealtime, and used multiple strategies and types of talk. They had a clear motivation to actively persuade Louis to eat, through whatever means they could. The discourses that built the idea that this family were in a place where they wanted to make changes and not accept how things, fit with this approach to mealtimes. They wanted changes to happen.

This was different to the other two families who were much less active in their talk and in their encouragement of their child to eat, instead allowing the child to make choices about how they ate their meals, and allowing them control. This could be seen in Charlie's choice to eat his meal in the living room, away from the rest of the family, and in Sophie's choice to sit on the floor in a place she wouldn't usually have sat, and her coming to take food from Maria's plate.

Karen's goals for Charlie's mealtime were explicitly about reducing stress and 'drama'. Maria was relaxed about it, as she was no longer trying to change Sophie's eating as the problem had resolved, and she would naturally progress like her other children.

Problem construction, responsibility, blame and parental identity

Blame of another was most notable in Family A, where medical professionals were positioned as having withheld the solution to the medical problem, thus worsening it. Responsibility was later positioned with Louis for his 'dictator'-like behaviour and parents began to be implicated through their 'pandering'. By the end of the meal, Rob had observed the difference his and Michelle's actions made to Louis' eating over the course of the meal.

Maria in Family C partially acknowledged her role in Sophie's problem continuing, but focused her talk instead on the problem no longer existing, deflecting blame, or at least demonstrating that repair of any damage had happened.

Karen had less need to negotiate blame for the start of the problem due to Charlie's cancer being the obvious cause. However, she did construct herself as responsible for having found something that worked for them as a family, and that professionals were not helpful in this.

It seemed that for all three families the talk around blame and responsibility constructed their role as parents. Being able to help with the problem, whether through fighting for medical help in Family A; finding a stress-free solution for meals and accepting Charlie's difference in Family B; or being able to have repaired damage in Family C; was used to maintain parents' identity as good parents. The constructions around good parenting are considered more in the discussion chapter.

Summary

Parental discourses related to the problem construction and therefore the responsibility and blame for it; their own emotional reactions and acceptance of the problem. These helped to understand parents' goals for the mealtime and therefore their behaviour when providing a meal for their child. In Family A, anxiety about the problem, and a changeable sense of the problem and therefore responsibility for them to try to facilitate Louis' eating. This contrasted with a more stable problem construction and therefore more stable mealtime approach focussed not on food, but on lowering stress in Family B; or a construction of the problem as having been solved meaning Maria need not have focused heavily on mealtime behaviours. The discourses presented did help make sense of parental approaches to mealtimes.

Chapter 4: Study 2 Online Survey

4.1 Background

Study 2 was designed to complement Study 1, which provides detailed, in-depth data from parents who were receiving specialist help about their child's eating: a cohort for whom the problem was more than might be encountered by most of the population. The difficulty in defining fussy, picky, or restrictive eating has already been addressed in the introduction, but it is apparent that the restriction of food intake in either amount or in the types of food eaten is commonly experienced. Several studies in multiple cultural settings, have found a rough prevalence rate of around 40-50% of picky eating in early childhood, through parental report (Mascola, Bryson & Agras, 2010; Cardona Cano, Tiemeier, van Hoeken, Tharner, Jaddoe et al., 2015). This high prevalence rate demonstrates that there is a significant population who may be considered or consider themselves to be 'picky eaters', and that these are therefore also important to consider.

Many studies have not drawn a distinction between clinical and non-clinical populations. Given the high prevalence of picky eating in the general population, there is likely to be a large proportion of families who would not have met criteria for Study 1. It is not clear what the differences are between families who receive specialist help for their child's eating, and those who do not. Cardona Cano et al. (2015) suggest that the longevity of the problem is what is important, as 46% of children were described as 'picky eaters' at some point in their early childhood, with this reducing with age. It could be guessed that the severity of the problem, or the impact on health or family life may influence whether specialist help is sought or provided. Study 2 does not seek to answer the question of whether the severity of eating problems of children referred and not referred to specialist services differs objectively, but instead, seeks to consider what discourses parents who may consider themselves to have a 'picky' child more broadly produce.

On explaining this study to others, many commented that their child could take part, as they considered their children to be fussy. It was noticeable that there was a low response rate of families receiving specialist help in Study 1, meaning data was available from only 3 families. This reflection alongside the indications of high prevalence of 'picky' or 'fussy' eating within the literature suggests that there are many more families who may have something interesting and important to say about

their child's eating, and which would provide context and a source of comparison for the data collected in Study 1. It was also noted that there was less talk than had been anticipated within the mealtimes themselves for two of the families, and that all families had a lot to say about their child's eating in a more general way as well as the more specific comments and observations about the video-recorded mealtimes. This raised questions about broader discourses around the child's eating in families which have not received specialist help with their child's eating.

The following research question was therefore posed in order to meet the aim of gathering data to provide a context for Study 1's data and a source of comparison. The aim was to gather data from a non-clinical, self-identified sample of parents who felt that their child refused or restricted their food intake.

Research question

What discourses are produced by a non-clinical population of parents who identify their child as being a 'fussy', 'picky', or 'restrictive eater? How does this compare with the data collected in Study 1?

Methodology

Study 1 discussed data from clinical populations. Study 2 therefore aimed to access a broader range of participants who were not specifically accessing specialised clinical interventions for their child's eating. As outlined in previous chapters, discourse analysis can be conducted on talk or text. It would therefore be possible to use transcribed spoken data as with Study 1, or to use written data. Given that the aim was to provide contextual data, a larger sample was needed. It would have been possible to advertise to families to take part in a replica of Study 1, however, this would not meet the aims of Study 2, in part as this would be likely to provide very detailed, in-depth data of the sort gathered in Study 1, which would provide some possibilities of comparison, but would not provide the broader context that is sought from Study 2. It was therefore important to find a method that allowed a larger number of people to be sampled *and* to gather data that allowed discourse analytic approaches to be used.

As discussed in relation to Study 1, discourse analysis can be completed using talk or text (Perakyla, 2005). Silverman (2001) recognises that naturally occurring data can be used. One possible option was to use pre-existing internet parenting forum data: that is online threads of posts made by individuals to discuss different issue. Parenting forums such as mumsnet.com and netmums.com exist in the UK and are

widely used by parents. A wide range of topics are discussed on these forums, but many parents seek advice or opinion on issues related to parenting. Both mumsnet.com and netmums.com have specific areas of their websites dedicated to feeding children, demonstrating that this is a topic on which discussion is had via these sites regularly. One possible option, therefore was to collect this pre-existing, naturally occurring, publically available data and analyse this using discourse analytic approaches. Hugh-Jones, Madill, Verjiekens, and Hetherington (2015, unpublished) used netnographic approaches to examine accounts made by mothers of breastfeeding using a critical discursive stance. Their study used multiple parenting forums and searches of the posts there yielded over 100,000 posts, yielding a total of 506 posts for analysis. While this approach allows access to naturally occurring discourses that have not been altered for the purposes of research, and therefore have the advantage of being free from the potential of bias towards producing particular accounts as a function of the research setting, there are several issues that are raised. The first of these is ethical in nature, around the issue of consent. In the British Psychological Society document (2013) providing guidance on conducting online research, the context of the data and its intended purpose and audience is considered. As posts on these parenting forums are in the public domain, it could be considered that these are not private. However, on contacting netmums.com, they would not permit the use of their users data without express permission, and considered this a breach of their conditions. Mumsnet would permit this, provided they were cited. The other theoretical problem with this, is that no demographic information could be provided, and there may be contributions made by people who are not experiencing this difficulty, but post advice to others. This means that the data gathered from the internet may not provide the possibility for comparison with Study 1's sample. The other difficulty is that the plethora of posts that could contain relevant data are often embedded within unrelated threads, making the practicalities of searching for the relevant data complex. The range of topics covered in relation to this may also mean that there are difficulties in recruiting criteria which are not biased in themselves, therefore resulting in biased results and conclusions.

Study 2 needed to have relatively detailed, talk or text based data, which could be analysed through discourse analysis, but needed not to simply recreate Study 1 with a different population. I therefore considered the use of a self-report survey. Surveys are a well-used approach within this subject area, however this tends to be with much larger samples, and using quantitative rather than qualitative approach. Jansen (2010)

recognised that although the traditional purpose of surveys has been to quantify the distribution of variables within a population, qualitative surveys can be produced for a different purpose, that is for the ‘study of diversity (not distribution)’, or to gather meaning from individual responses. Jansen also recognised the different theoretical approaches that can make use of qualitative studies. This highlighted that qualitative surveys can be developed in a way to meet the theoretical demands of various qualitative methods, to include discourse analysis. I therefore decided that an online qualitative study would be the best approach. Participants would be able to self-select and to provide informed consent for participation, as well as providing their own freely constructed responses, thus providing textual data which could then be analysed discursively.

Given that discourse analytic approaches often use interviews, and this was one of the approaches used in Study 1, my aim was to develop what could be conceptualised as an online, written interview, emulating the interview conducted in Study 1, providing a structure for parents to discuss various aspects of parenting. It was important to carefully consider how to recruit parents, and how to design the survey to provide the most useful and appropriate data.

Sample and recruitment planning

Given that ‘picky’ ‘fussy’ or ‘restrictive’ eating is a commonplace experience or difficulty, there were many routes that could be taken to find a sample. A convenience sample, or a snowball sample, allowing the build-up of participants through the sharing online of the survey was one possibility. The researcher did not want to collect data from people she knew, as this would be likely to bias the findings. The sample would also have been likely to be unrepresentative of the UK’s population, as would begin with my friends, who at the most basic level are not evenly distributed across the UK.

Having considered the use of data from Mumsnet and Netmums online parenting forums in the earlier planning stages, it became apparent that these websites are incredibly well used, with hundreds of thousands of users signed up, and others accessing them who are not signed up. It also seemed that these were much more commonly used than other sites found. It was noted that although both target mothers rather than fathers, however, it did seem that fathers also used these sites. I was unable to find a site that seemed to target fathers and had a large following, an interesting observation in itself. When seeking out more general parenting forums and websites

on which to advertise the study, others were very significantly smaller studies than mumsnet and netmums, with a very small number of posts and users. It was therefore decided that mumsnet and netmums would be the most appropriate forums on which to advertise the study. There was a risk of bias in this sample towards mothers, but it was not clear that this would not also be the case on other internet forums.

Design of materials

The wording of the materials-that is not only the questions asked, but the other materials too- is very important as it is easy to make constructions inadvertently through the use of language, and therefore influence the responses received back. The advertising materials therefore mentioned the behavioural description of the mealtime, asking 'does your child refuse or restrict food?' rather than overtly using other descriptors like 'picky' or 'fussy' without consideration, as this could have then attracted respondents sharing this discourse. The use of behavioural descriptors was not perfect, but any description had the potential to make constructions.

For the questions, the crib-sheet used in the interview for study 1, formed as the basis for the development of questions in the online survey. The wording on all of this was important as the phrasing could inherently construct discourses or ideas on its own. Again, it was important to be as neutral as possible. This was to allow parents' own discourses to be developed through their answers to the questions. The questions allowed free text answers of unlimited length and could be completed on most internet connected devices (mobile phones, tablets, computers) through the Bristol Online Surveys website which allowed creation of the study.

The survey asked the following questions:

- 1. How would you describe your child's eating? (You might like to talk about how your child's eating compares to others).*
- 2. Are you concerned or worried about your child's eating? If so, when did this start? Have you got any ideas about what keeps this going?*
- 3. Have you ever received professional help about your child's eating? If so what was this and have you any comments about it?*
- 4. Please describe what usually happens when you offer your child a meal. (You might want to talk about where they are, who is there, what gets talked about, how food is offered, what sorts of food your child eats, or anything else that feels relevant).*
- 5. How do you feel during or about your child's mealtimes? (you might want to*

talk about how you feel beforehand, how you feel about specific things that usually happen, how you feel after the meal).

6. *How do you think your child feels about mealtimes or eating? (What do you think mealtimes are like for them?)*
7. *Have you any more comments or reflections that haven't come up in other questions?*

Method

Sampling

A thread was made on UK parenting websites mumsnet.com and netmums.com. This contained information on the study and a link to an online survey. This was posted on the sections of these websites dedicated to surveys, as requested by mumsnet and netmums. The post was 'bumped' by the posting of a message seven times over the course of six weeks. The timing of this varied in order that different groups of parents saw it, as it was noticed that the thread would appear in 'active threads' on mumsnet for a short period of time, and the responses tended to come in at the time the 'bumps' were made. It is hypothesised that the survey areas of the sites are not heavily frequented so more people saw it when the thread appeared in 'active'. The netmums post was viewed by 567 people (although several of those would have been me updating it).

Inclusion criteria

- The child of focus must be aged between 2-7 years.
- The parent must state that the child has a problem with eating such as refusing food or restricting what they eat (picky/fussy eating).
- Agreement with the terms of the information sheet must have been provided.
- The family must live in the UK (or have ticked to say they do).

Exclusion criteria

If any questions had not been completed, these data from these would not have been used. If data is in another language or incoherent to the extent it cannot be understood, this was also to be excluded, and if it was apparent the text was not about the participant's own child.

Data collection process and data management

Suitable UK-based parenting discussion forum websites were identified and have provided email confirmation of permission to post a link to an online survey on their website. A thread was started on each website containing information about the study and a link to the online survey through Bristol Online Surveys (BOS). The online survey stored responses which were then exported for analysis. Participants were not required to provide any identifiable details but were invited to email the researcher to provide their email address should they wish for a summary to be sent to them. This was kept separately from any information sent and stored securely on the university's secure servers. One parent chose to do this. The survey was closed and the threads inviting participants to respond not 'bumped' further once sufficient data had been received. It was anticipated 10-40 participants would be sufficient depending on the length and depth of the answers.

Results

Sample and demographics

Total number of participants included	21
Total number of female respondents	21
Number of mumsnet users	13
Number of netmums users	8
Mean age of respondent	34.7 years
Age range of respondent	21-43 years
Number of male children	14 (66.7%)
Number of female children	7 (33.3%)
Mean age of child	4.4 years
Modal number of children	2
Mean number of children in family	3.6

Table 1: Sample characteristics

Data was received from 22 mothers living in the UK. One mother's responses have been excluded from the analysis, due to her having received considerable specialist support, yielding a sample of 21. No fathers took part in the survey (the sampling strategy and use of mumsnet and netmums websites to recruit are considered further in the discussion). Two mothers lived with only their child, with 19 reporting living with a partner or husband. One of these reported they also lived with another, unrelated family. The mean number of children in a household (including unrelated and foster children) was 3.6, but the modal number of children was 2, with 9 households having 2 children. The mean age of mothers was 34.7 years, with a range between ages 21 and 43 years. The mean age of the child they were responding about was 4.4 years, and all were aged between 2 and 7 years as per study criteria. 14 of the 21 children (so 66.7%) were male. No responses from the 21 participants were excluded as per exclusion criteria, although one parent acknowledged that their child may not be considered that fussy (see question 1 above).

13 parents reported that they had received no professional support with their child's eating. 6 said that they had received support from the health visitor and/or GP. One had received support from dietician and gastro-paediatrician and One from a doctor around constipation. One other was not clear. Two parents who had seen health visitors and/or GPs reported being told their child was going through a 'phase' (with one saying this was not helpful). One parent said that advice from the health visitor was helpful: not to pressure and to give the child food they liked. In another answer, mentioned later, another parent reported not being able to follow this advice due to budgetary constraints.

Clearly with 21 respondents, there was considerable variation within the data, with themes often holding two or more different patterns of response by parents. These differences were represented in the analysis and written reporting of the themes. As a quality check, it was ensured at least one quote from the majority of participants was included in the written analysis.

Analysis

A thematic discourse analysis was completed. This differs from a thematic analysis in that the focus was not only on finding common themes linking the data between the participants, but on considering carefully the use of language and the implications in terms of the meaning of the particular constructions made. As with Study 1, the function of the talk, socially or otherwise was a main focus of this

analysis.

The data was read multiple times. Key ideas were recognised and highlighted throughout the text. Text that did not fit with these themes was then reviewed for any further identifiable themes. The themes developed were not always coherent as it was apparent that there was a diverse use of discourses between parents, so it was also important not only to capture similarities between the discourses, but also differences in order that the variation could be appreciated. Although the different questions did guide parents' responses, the ideas referred to often arose multiple times throughout the survey answers. Therefore responses were analysed as a whole not separated into individual questions.

Once themes had been identified, it became apparent that these related to different aspects and actors in the mealtime. The themes are therefore presented under subheadings relating to these. It is important to note that these subheadings do not constitute the themes, which are discussed underneath them, but instead structure the findings. The data was shared and discussed with supervisors.

Findings

For some themes identified in the data, parents offered alternate sides of the same theme, so are discussed together. The overarching aspects that tie the subthemes together relate to the cause of the eating difficulty, and consequent locating of responsibility.

The themes identified have been organised as follows:

- Problem construction: causality and responsibility
 - The problem as a naturally occurring phase
 - The problem as a result of the child's own traits or characteristics
 - The problem as the child's behaviour or choice
 - The problem as caused by the parent's own actions or by those of their partner
- Parental emotional responses
- Ideas about blame and responsibility

Problem construction: causality and responsibility

The attributions made about the cause of the problem were prevalent within the talk, both directly and indirectly. For example, in talk about the child, or about the problem, constructions of these made inferences about where the problem came from,

and therefore simultaneously implied or explicitly made constructions about responsibility for the problem, and inherently within this located responsibility for change differently.

A key subtheme here (presented first) was the idea of the eating difficulty being a 'phase' or not. Subsequently, subthemes around the child themselves are presented: firstly related to the child's characteristics or personality traits; and secondly to the child's behaviour as a choice. Again, the implications made about responsibility and blame are considered here. Blame of the parent (either themselves or the other parent) is also considered as a separate subtheme.

The problem as a temporary and naturally occurring phase

Constructions made about the potential longevity of the problem and the construction of the problems as a 'phase' occurred at multiple points throughout the dataset, both in some parents' own discourses about their child's eating, and in parents' references to professional advice. The Oxford English Dictionary (2017) defines phase as: 'A distinct period or stage in a series of events or a process of change or development' and 'A stage in a person's psychological development, especially a period of temporary difficulty'. It was these ideas that were noted in the dataset, sometimes referred to through use of the word 'phase' and other times, referring to the ideas included in the OED definition. Quotes are used to show the way this idea was used by parents, and reported as having been used by health professionals. What is particularly interesting to note is parents' own reactions to this: sometimes seeing the problem as a phase was reassuring, and at other times, was felt to minimise the existence of the problem. Throughout, this idea has notable implications for responsibility and blame not only for the development of the problem, but also for what (if any) action needed to be taken and by whom. Discrepancy between parental and healthcare professionals' discourses are discussed, indicating the importance of considering the explanations and narratives provided and the importance of understanding where this came from for parents.

The question about whether parents were concerned or worried about their child's eating was where the idea of the 'phase' was most commonly used by parents, although the idea was also referred to at other points. The following segments of text all come from this question. I have not only taken quotes that explicitly use the word 'phase' but have drawn together quotes which link to the definition above, as this was

a concept repeated throughout the text, but phrased differently by different parents.

P3 'I'm not worried...I'd imagine he'll grow out of it'

*P4 (in response to the question about whether they are worried or concerned):
'No, I see it as a phase'*

P18 'Not really concerned as it tends to go in peaks and troughs'

The two key aspects of these first three quotes are firstly the temporary nature of the problem, and secondly the link to this meaning the problem did not cause the parent concern. The response by P3 demonstrates the idea of the problem being something that the child would naturally 'grow out of', clearly marking out the problem as temporary, but also indicating a framing of the problem as a part of the child's developmental trajectory, or growth. P4 uses the term 'phase' to explain their lack of worry. It can be assumed that again, this is a temporally limited problem. P18's quote has more of a focus on the problem being changeable, rather than a simpler version of a phase that is grown out of in a more linear fashion, but she suggests that this is something that 'goes', giving the impression that this is not related to external or other factors, but rather happens on its own, or naturally. If this interpretation that the parents meant that a phase occurs alone, is right this clearly has implications for what can be done about the problem: something that naturally will stop on its own, does not need action of any person to resolve this. It also removes the blame from both the child and parent.

This logical progression of the idea being a temporary phase, and therefore being nobody's responsibility is not explicitly stated, so I wanted to be careful that I was not making my own assumptions about what this meant for responsibility and blame. When considering this more closely, it was not merely the use of the 'phase' discourse alone, but the repeated linking of this by parents to a reduction in worry that built up the idea that there are implications for responsibility and blame. The term 'worry' tends to relate to a feeling of mental distress. More cognitive circles of psychology may also consider this a form of thinking or mental action, perhaps related to solving the problem. If parents do not need to worry, it seems that they may also not need to develop a solution for the problem as it will resolve on its own. The lack of a need for parents to find a solution removes responsibility from them. There may also be implications about where the problem has come from.

The following responses from P10 and P2 demonstrate the implications the 'phase' discourse has on responsibility for resolving the issue more overtly. Additionally, these quotes both illustrate that the 'phase' discourse may be one of multiple narratives held by parents, perhaps as part of a repertoire of constructions. The two following quotes help to explicate some of the more implicit assumptions and to understand the way the 'phase' discourse may be used to explain reduced worry and responsibility, but also to show that for some parents, this discourse is at odds with their own ideas about the problem.

P10 'I see it both as 'a phase' (being sceptical of things he isn't familiar with), my fault as a parent (my partner doesn't like veg so I eat it myself but don't include it as standard in a meal)'

P2 'I just wish health visitors and gps would stop saying it's just a phase it can be really patronising when you are after help and all you get told is the same information and to just keep up with it, hopefully research will come up with something that might give a different approach or advise (sic) for people in a similar situation, all we got was the fussy toddler phase he will grow out of it. Well that has taken over a year and a half to get pass (sic) this phase which he still isn't completely but I think I have done the best I can to get him this far, but looking back it seems hes (sic) just decided to change himself so maybe its a phase but it would be helpful if people understand how long these things can go on for'

P10's quote differentiates the idea of a phase, from the discourse that the parent is at 'fault' and therefore holds responsibility for the difficulty. P2's quote shows that parents may not be fixed on their construction of the problem: initially the parent seems strongly against the 'patronising' usage of the 'phase' discourse by healthcare professionals. This parent positions their wish for help with the problem as at odds with the 'phase' discourse: they wanted help, but the construction by healthcare professionals of the problem as a 'phase' was constructed as having been used as a justification, or excuse, for healthcare professionals to withhold the help the parent felt they should receive from them: it was the professionals' responsibility to understand and resolve the issue.

These two aspects of these quotes demonstrate a link between the 'phase' discourse and responsibility and blame. It is interesting, however, that both these parents locate responsibility in more than one way, showing that this is a complex issue, not only about situating the responsibility away from the parents as the earlier quotes might suggest. Parent P2 starts by constructing the healthcare professionals as withholding help, therefore locating responsibility for resolving the problem with them, then says that she has acted in 'doing the best I can', positioning herself as having taken that responsibility, but then later attributes the final resolution of the problem to the child's decision, thus shifting the responsibility for the problem to him, but using this as an indication that the problem was a 'phase'. This suggests that perhaps the use of the 'phase' discourse can at times locate the problem within the child.

Parent P2 demonstrates the importance of professionals understanding the way parents construct and portray the problem. A mismatch seemingly led to a rupture between professionals and this parent, with the parent feeling 'patronised' and 'left with it'- something that they considered a problem that needed action, rather than waiting for its natural resolution.

These quotes show the complexity of the idea of a phase: this may mean different things to different people at different times. At its most simplistic, the construction of the problem as a 'phase' can remove some of the responsibility and therefore worry and concern about resolving the problem, through the indication that the problem does not need intervention. Parents here seemed to use the 'phase' construct to reassure themselves, and P2's report suggests that healthcare professionals may do so too: the problem will resolve in time as it is a natural part of development, for which no-one was responsible causally, and therefore neither are they responsible for solving. However, when not used in its simplest form, or when the problem seems bigger than a 'phase', there are more complicated implications for responsibility and blame, that are harder to pin down, or that parents are undecided about. It seems from P2, that constructions can change over time. The last part of her quote relates to her child and his behaviour. In other areas of the data, the construction of the child was also important in parents' constructions of the cause of the problem. This is discussed next in terms of the characteristics of the child, and in terms of the problem being related to the child's choices or behaviour.

Construction of the child (characteristics) and their role in the problem (their behaviour or choices)

Text about the child occurred in many of the responses across all 5 of the main questions and constructed the child in different ways using different discursive devices.

Diagnoses

Before referring to more general and personal characteristics ascribed by parents to their children, it is important to note that several parents referred to diagnostic labels of Autism Spectrum Disorder, and possible Sensory Processing Disorder. One parent said:

P11 *'If it is linked to autism, I don't know what to do'*

The attribution of the child's eating difficulties to neurodevelopmental diagnoses shares the idea that it is naturally occurring with the phase discourse, however implicitly does not share the same idea that it would go away. This is interesting, as the mother above's quote shows: the idea that it is a naturally occurring issue again seems to hold similar connotations, that a parent may not be responsible for the start of the problem, and therefore for its resolution, but without the temporary aspect of the 'phase' discourse, this leaves this parent without a sense of what they can do. In this quote, the mother is indicating that she would not have the power to be able to resolve the issue. Loss of responsibility for the development of the problem also seems to lessen parental responsibility to resolve it. In a 'phase' this is reassuring, if not temporary, in this case led a parent to construct herself as lacking knowledge or ability to solve it.

Traits and characteristics

A considerable amount of talk served to position the problem eating within the child. For example, parents labelled their children with words like: *'fussy'* or *'difficult'*, a *'terrible eater'*, *'selective-wilfully'*, *'not adventurous'*, *'has always been tricky'*. This labelling relates to the child, not only their behaviour and ascribes this as a trait or characteristic. This way of describing the child situates the eating difficulty as being within them, and related to this trait. Although in general the use of the labels positions the child as the holder of the problem, this is done to a different extent by different parents. For example, one parent's description of their child as *'selective-wilfully'* frames selectivity as a behaviour, but with the additional implication that he

is ‘*wilfully*’ choosing to behave in this way, also suggesting an adversarial relationship here. As with descriptors like ‘tricky’ and ‘difficult’ implications are made about the relationship between child and parent: this is how the parent sees them or experiences them, but the labelling in this way situates this as a trait within the child. Another parent uses the phrase ‘*Not unmanageable but challenging*’ in response to the question asking them to describe their child’s eating which actually draws out the problem positioning to include them as a parent in needing to *manage* the child’s eating or child themselves. Some parents reinforced this positioning of the problem as being situated within, or even belonging to, the child through demonstration that it was not a family problem by commenting on the eating of others in the family, as in the following quotes:

P15 ‘My son is a terrible eater, and given the choice would not eat most days. His siblings are good eaters as are we...’

P2 ‘His twin sisters complete opposite’

P21 ‘I have no idea why she is how she is with food. She ate really well as a baby and was offered everything as were my two elder daughters’

The quotes from P15 and P2 show the differences in the child to others in the family. This could be seen as a kind of subtle stake-inoculation, in that the parents here are pre-emptively countering the idea that there is a family problem or with the way parents have fed or parented the child. This is particularly done through the comparison with siblings rather than other children as they too have been parented by the respondents, thus implying that their parenting is not the cause of the problem. It is important to note here that the question did suggest that comparison to others may be helpful, however, not necessarily comparison with siblings. These two parents create a dichotomy: the child is the ‘opposite’ to his sibling, or a ‘terrible eater’ versus ‘good eater’. Interestingly P21 gives a more behavioural and less trait-based description, and hints at rather than so definitely stating the difference between the child and her siblings. Her difficulty with eating is also not seen as fixed: the child’s eating changed from when she was a baby. It is not clear what constructions are made from this about future eating, but the mother is clearly saying that she has done the right thing (offering everything as with her other two children), thus still situating the problem within the child. Constructing the child or their behaviour can therefore keep

the positioning of the difficulty, and therefore the culpability for the problem with the child.

While these characteristics are ascribed as belonging to and being located within the child, these were not always given the status of being permanent as changes over time were also described. The meaning of these changes alters across quotes. In the following quote, the child is given credit for trying, despite their characteristic of fussiness. In the quote after this, the impression given is that the change is more random, differing between days.

P2: 'getting better finally after over a year of being extremely fussy...only now has just started to taste new things, although mostly isn't keen but at least tries...'

P8: 'massively varies from day to day, although he refuses food more often than he accepts it'.

At other times, the changeability of the child's eating was related to setting or who is there when the child is offered food.

P3 'He will sometimes eat other things (veg, meat, different flavour yogurts) for other people when eating with other children.'

P5 'will eat slightly better at school and for others than for me'

P9 'I will cook a meal and they won't touch it but child would eat the same meal at someone else's house'

P14 'the Creche he attends three days a week claim he eats a perfectly reasonable range and quantity of food'

Parent P14 here is implying that she may not believe that her child eats differently in the crèche she talks about through use of the word 'claim', hinting that there is some doubt around the truth of this. The relationship between mother and child is implicated through the description of different behaviour not only in other settings, but with other *people*. The third quote here has more of an emotional tone than the more tempered 'sometimes' and 'slightly better' eating used by the first and second parents quoted about their child's eating with others.

As well as the idea that children eat differently in different settings, it is important to note the way the word 'for' is used in the above quotes, implying that the

child's feeding is not only for their own benefit, but 'for' the feeder or adult involved in providing food. This implication also indicates that the feeder has something to gain from the child's eating, whether this be a sense of satisfaction or relief perhaps. This also adds emphasis to the relationship between parent and child, and the meaning of whether a child will eat *for* their parent as opposed to *for* another carer, perhaps tying in with the idea of parents being skilled or good enough to get their child to eat. There is the sense of the eating being a 'gift' to the parent here. Alternatively, this could be seen to be about obedience and whether the child was deciding that they were going to behave in the way the parents wanted or not.

The child 'refusing' to eat or 'choosing' not to eat were descriptions that came up particularly often, thus suggesting that the child's conscious will was the reason for the problem. 'Choosing' not to did so especially, as the implication is that there were other choices the child could have made. Parents sometimes hypothesised about why their child was making these choices, and made attributions about their internal worlds:

P17: '...can be fussy depending on his mood. (If for example he has decided he hates pasta after devouring it a few days before).'

P3: 'I think a lot of it is about him having control over what he eats.' (other parents expressed similar views)

P5: 'Did used to gag/vomit a lot on solids until she was 2 and has some speech and language issues which I sometimes wonder if are related' (other parents expressed similar views)

P17's response suggests their child is deciding based on how they feel whether to eat. The split between 'hating' then 'devouring' the pasta builds a sense of the child as contrary and wilful, rather than rational: deciding on a whim. Parent P3 put forward an idea about the need for control. This was an idea that other parents also put forward.

Parents as responsible or to blame

Some parents also made references to themselves or their partners being to blame for the eating difficulties.

P20 'My fears made it worse. Have tried to minimize my stress about his eating and it massively improved'

P14 'I feel like a bad parent'

P6: 'Husband started taking the girls to KFC a lot. 3.5 year old became

restricted around this age. However she is now being assessed for ASD so could be related to this. What keeps it going...Dinner table is still stressful as Husnand (sic) tries to force her to eat'

The parents here either held themselves responsible or their partners. P6 clearly makes blaming statements, linking her child's eating to her husband's action. She also relates to Autism in her response, which is interesting as she makes multiple constructions which place blame outside of herself. P20 holds herself responsible in a more positive light, recognising changes in her child's eating were related to her actions. This illustrates the emotions that parents face, alongside a positive framing suggesting empowerment of holding responsibility. P14 reports feeling like a bad parent, suggesting that she blames herself. The emotions within these ideas of blame and responsibility are apparent were also reported overtly.

Parents' emotional responses

Given the differences in the level of worry expressed by the parents when discussing the constructions of their child, the construction of parents' own emotional responses was tied by their talk to their discourses about the problem. Although there were some parents who expressed a lack of concern or worry about their child's eating broadly, in reporting their experiences of actual mealtimes, parents mentioning emotional words (not all respondents made explicit statements about their emotional experiences, but explained what they did in mealtimes some more), almost universally expressed negative emotions. Frustration, stress, anger, sadness, and upset, were all words used frequently (frustration was used by 6 parents). The word frustration suggests a desire for things to change, but a lack of ability to do so.

Reported reasons for these feelings varied between parents. At times parents related this to the waste of food. The second parent below relates to the idea that she had made a meal (gone to effort) and that it had not been eaten.

P2 'I would get angry and upset for all the food being wasted and the fact that he must have been hungry'

P9 'Feel frustrated after meal time, get annoyed that you have made a meal and its gone to waste'

Some reported concern about the food the child is consuming or about the impact on their child's health. This could tap into societal discourses about healthy eating and the government's and societal messages about providing healthy diets for children.

P19 'They make me feel stressed as I would like her to eat a varied and balanced diet'

P6 'I'm worried about her health and weight'

P12 'Stressed as I want him to have a very (sic) diet'

Parents also talked about their more personal emotional reactions, such as a sense of being rejected by their child, or what it means to them when they are not able to act in a way which helps them.

P11 'I'm sad with they (sic) he behaves. I'm sad I can't give him the food he'd like most. I get frustrated with his behaviour but try not to show it. My food tastes good and it's healthy. After the meal I feel defeated and deflated I keep trying, I'm patient...'

P5 'Anxious, resigned, guilty'.

P14 'I don't put too much effort in anymore because I get caught up in my hard work being 'rejected''.

These responses all serve to demonstrate that these parents have made an effort in relation to their child's eating: they have positioned themselves as having taken some responsibility for the change in making this effort. The first of these acknowledges her own emotional responses, but also is very clear that she has continued to make an effort in spite of this an aspect of this suggest that this mother is keen to show that she is taking responsibility for her child, at her own expense.¹ The parent who used the words '*anxious, resigned, guilty*' seems to give a relatively simple response, but when examined further, these provide their own narrative. This gives a sense of her concern, a sense of powerlessness to act effectively in her sense of resignation, and guilt, perhaps in not being able to do so. This mother's talk serves to demonstrate that she is concerned about this with the guilt perhaps justifying the resignation, and implication therefore that the parent has not resolved the issue. This particular combination of emotions suggests that this mother's discourse about mealtimes is also about her efforts as a parent and her feelings about this.

Parents' attempts to manage their own emotional responses

The third quote here begins to demonstrate a further feature of talk that was prevalent within the survey responses: the way parents talked about altering the

approach they took to mealtimes. Often this was in order to reduce stress or emotional responses, or to prioritise smooth running of the mealtime rather than continuing to push for development or progress. The third mother above suggests that she no longer makes special effort, as the rejection was not tolerable to her. She constructs this change in action as a way of protecting herself from the rejection put upon her by her child. At times, the construction was more about acceptance of the issue. Others seem to frame it more as a development of indifference following a lot of difficult emotions and stress.

Issues around control were mentioned by several participants. Of particular interest is the way that P14 (quote below) reflects on her own emotional reaction in the face of this perceived control and wonders if her feelings about her child's eating behaviour is coming from her rather than really being to do with her child's response to her.

P14 'I feel like it's a control thing as much as anything, but he's a good natured child so its crossed my mind that I may be personalising his pickiness'

The first mother in the next set of quotes describes a more emotional distance between her and her child. She also frames this as a candid admission (blunt honesty), giving a suggestion that there is shame attached to her emotions. The second mother below talks about withdrawing herself from her child's mealtimes, and from the child himself. There is a creation of physical distance, an avoidance of engaging at all in the mealtime described here. The third mother talks about not being able to afford the stress, constructing her own resources as being drained by the worry, therefore having to 'give it up' in favour of acceptance. Her talk changes to what she encourages the child to do: she swaps priorities in the mealtime from pushing to acquiescing to spoon feeding, with the caveat that he eats. This phrasing suggests that spoon feeding him is not something this mother wants to do and feels the need to justify. It is important that all three of these mothers precede their comments about withdrawing or distancing themselves, with their emotional responses having been stressful. They are demonstrating that they have cared and been concerned about their child's eating, but that it was too stressful to continue that way.

P8 'Used to feel stressed and angry and upset if I'd cooked something from scratch for it to be refused, stopped caring to be bluntly honest'

P7 'Used to find it very stressful. I'm now quite indifferent and try to potter around or ignore him completely I often do jobs while he eats.'

P11 'I have always been worried but can no longer afford to...I have all but given up getting stressed over it and I am much more accepting of it. I no longer push him to eat and if he wants me to spoon feed him I will if it means he eats'

Other parents also talked about their approaches to mealtimes not being about getting the child to eat, but to reduce the stress or not create stress. There is less justification around this for the following two parents and therefore make different constructions. The first relates her own experience, and thus gives a sense of confidence that the difficulties can be gone through. The second retains the goal that the child eats something, giving a hint that an ideal goal may have been about the child having more than just 'something to eat'.

P13 'I don't like to put pressure on him as I was a fussy child myself and remember what it's like not to like many foods'

P18 'Try not to make a big deal of it-as long as she has something to eat'

P3 'I try not to worry and try not to worry about what everyone eats'

Comparison and Social Norms

A smaller theme was about what parents thought mealtimes should be like. This was not as prevalent as other areas discussed, but was still important to mention. A large number of families mentioned that they sat at the table. This is important as they seem to be demonstrating their cohesion with social norms, as if that is what a good family meal is.

Sometimes comparison was positive and sometimes negative:

P8: 'I have no idea why she is so difficult but a lot of friends have similar complaints with their children'

P20 'I feel like a bad parent because everyone else seems to be concocting these beautifully healthy and varied balanced diets and I'm just trying to make sure he eats one thing in a day that isn't a complex carb'

Here, P8 puts forward the idea that this is a common experience, albeit 'difficult', however P20 sees her child's mealtimes as very different to others. She relates this difference to others and the overtly positive words she uses to describe others' eating. This comparison seems important to this mothers construction of herself as a parent too.

Summary

The results from the 21 parents provided good data that was useable for discourse analysis. It showed that there are many different constructions and discourses that are made by parents. Parents position responsibility and blame quite directly at times. Ideas around blame and responsibility in relation to the way the problem was constructed were key, with various ways in which the problem was located. Parents also talked about the differences between their own constructions and those of professionals.

Chapter 5: Discussion

In this chapter, the aims and the research questions for each study are revisited. The results for each study are then summarised briefly, then drawn together with reference to the literature. Strengths and limitations, and future directions and clinical implications are discussed before conclusions are drawn.

Aims

The key aim was to understand discourses developed by parents of children who restricted their food intake, about their child's eating and mealtimes. An aim was also to consider how this data can support understanding of mealtimes in these families.

Two studies were conducted to meet these aims. Study 1 research participants were a clinical sample of families accessing services related to their child's eating. For each family a mealtime was video-recorded and the parents were subsequently interviewed while playing back the video of the mealtime. Both the mealtime itself and the interview were analysed using discourse analysis. In Study 2, a larger, non-clinical self-selected sample of parents who responded to an invitation to complete a qualitative online survey asking similar questions to the in-depth interview, including parents' reflections and feelings about their child's eating and mealtimes. This additional data was collected in order to compare and triangulate the data from Study 1.

The following research questions were asked:

Study 1

In a clinical sample of families accessing services in relation to their child's eating:

1. What discourses are constructed or drawn on by parents about their child's mealtimes or eating, either within an observed mealtime, or more generally?
2. How do these discourses contextualise and provide understanding of the observed mealtime?

Study 2

What discourses are produced by a non-clinical population of parents who identify their child as being a 'fussy', 'picky', or 'restrictive eater'? How does this compare with the data collected in Study 1?

Findings

The results of each study are initially summarised separately with answers to the research questions. These ideas then lead to discussion of key discourses represented in both data sets. The direct interview data is primary here, but links are made with data from online interviews in study 2. These are therefore a combination of the most important findings from both studies.

Brief summary of results for Study 1

The results of Study 1 demonstrate large variation and complexity in the discourses and narratives told by the three families. This variation was apparent despite the fact that ostensibly they all faced the same issue of having a child who was experiencing difficulties eating. These discourses provided a backdrop against which the way in which mealtimes had been set-up could be understood. The talk and discourses portrayed not only ideas about the mealtimes and the food eaten or not eaten, but also more complex ideas about what this means for parents especially in terms of responsibility, emotional response and acceptance of the way things are. The main ideas represented were: child illness, difference and special care discourses; problem construction, responsibility, blame and parental identity; acceptance of the child's eating; mealtime goals of eating or managing stress and emotions. The different ways in which parents constructed talk and ideas about these themes provided layers of understanding and explanation for parental approaches to mealtimes.

The construction of the child's difficulty eating by the parents, especially as related to medical problems, situated blame within the relationship between parent, child and professionals. Importantly, parents of all three children in this sample developed discourses about their child being ill or needing different or special care compared to other children. This linked into how accepting parents were of the problem, with Louis' parents trying to find a solution, Charlie's parents having found more acceptance, and Sophie's mother constructing the problem as having been resolved. These ideas seemed to link to the primary focus or goal for the mealtime, which could be seen as either getting the child to eat, or reducing stress and having a more pleasant mealtime. Louis' parents focussed on doing things that would get Louis to eat; whereas Charlie's mother focussed on reducing his stress rather than changing his behaviour. Sophie's mother was less directed in terms of goals for the mealtime, but this also reflects the idea that the problem was largely resolved. The

ideas were consistently bound up with parental responsibility and blame, and parents' portrayal of themselves as good parents. This is indicative of the importance of mealtimes for parents themselves, and their assessment of their own success as parents, regardless of the different constructions made about their children's eating and mealtimes.

Brief summary of Study 2 findings

Data from 21 mothers through an online qualitative survey was analysed using a thematic discourse analytic approach. Again, there was considerable variation between the discourses constructed by different parents. As with Study 1, there were constructions made about similar ideas, objects or themes but there were different ways in which these were constructed by parents. Problem construction was a central theme and particularly related to identifying the cause of the problem and finding situating responsibility for both the problem and for making changes to address it.

The themes developed were around problem construction and causality and responsibility and included the problem as a naturally occurring phase, the problem as a result of the child's own traits or characteristics, the problem as the child's behaviour or choice, or as caused by the parent's own actions or by those of their partner. Parental emotional responses were discussed in relation to how they managed this, for example by withdrawing from meals with their child. Ideas about blame and responsibility were also constructed.

Overarching Summary

In the following sections, the major themes recognised in both studies are drawn together and related to literature and theory. A key finding in itself is the diversity and complexity of the data. This is discussed in more depth in relation to existing literature and offers a different perspective.

In both studies, parents' narratives and discourses provide a backdrop and a way of understanding the reasons for these different approaches in more detail, and highlighting some of the key areas of discourse that occurred in the two datasets:

- Problem construction together with responsibility, blame and parents' identity
- Acceptance and loss
- Management of emotions within mealtimes

These three areas cover a large amount of the talk about mealtimes, and offer a

possible framework for understanding why parents may approach mealtimes in certain ways. These discourses, gathered from talk in the interview, provide additional scope to understand the way mealtimes were run, compared to studies which solely used mealtime interactions (Wiggins, Potter & Wildsmith, 2001).

Diversity and Complexity

The data in all parts of the study was complex and diverse. Despite all families taking part essentially experiencing the same difficulty: having a child who restricts their food intake, there were very different stories and ways of understanding and managing the problem.

The first way in which this diversity and complexity became evident was in the setup of the mealtimes in Study 1. This was a small sample, but the approach taken by each family varied significantly. When I came to analyse talk about their child's eating and about the way they had managed the observed mealtime and mealtimes more generally, it was apparent that they also had very different ways of talking about them and the history of what had gone before. This variation in discourses produced was echoed in the data gathered through Study 2. In addition to variation between parents, there was often conflict between discourses made in different parts of individuals' data. Complexity was apparent through the interlinking of different discourses and connections between them. While three main areas are discussed next, there were many ways that the data could have been drawn together.

In this study, recognising complexity and diversity within the datasets is important as doing so offers a different way of understanding mealtimes compared to previous research. Studies have largely tended to take a quantitative approach, seeking to make links between quantitative variables defined by researchers. This is a different ontological perspective that seeks to simplify and generalise links and clearly has a different epistemological and ontological basis. However, the complexity of the current findings demonstrate potential limitations for studies making broad links to support understanding of what is happening within individual families. A key example of broader links in literature are between coercive parental approaches and limited eating (e.g. Haycraft & Blissett, 2011; Farrow & Blissett, 2007; Powell, Farrow & Meyer, 2011; Wardle & Carnell, 2006). These studies vary in their perspectives on the direction of causality between parental feeding practices and child behaviour, although agree there is a link. Other studies have gone a step further back to

understand more about parental factors and child eating, such as maternal depression (e.g. Haycraft, Farrow & Blissett, 2012) or more general approaches (Blissett & Haycraft, 2008; Hubbs-Tait, Kennedy, Page, Topham, & Harrist, 2008). The literature clearly demonstrates links between parent variables and child eating behaviours in these studies. However while these links are apparent in the large samples explored in this literature, these links may not exist for each individual family.

In considering the current data, links between coercive feeding practices and child restricted eating made in the literature above is borne out to a degree in Family 1 in Study 1, as Louis' parents take a more involved approach, and have a more problem-based narrative to other families. However, it was not evident that his eating was more restricted than that of Sophie or Charlie in that each of the children did eat some of the food they were provided with in the observed mealtimes. This highlights the complexity of trying to gather an objective account of restricted eating and is another example of the complexity of the data and differences between families, and the difficulty with the application of large-sample data to individuals. Understanding types of discourse may have greater utility for understanding individual families.

Problem construction, responsibility and blame and parents' identity

This is a collection of interlinking ideas. The construction of the problem and its positioning or location, set the scene for constructions of responsibility for the problem in individuals' discourses. There were clear logical links between how the problem was constructed and where responsibilities lie for both the problem itself and its resolution. Discourse around these issues arose in Study 1 and Study 2, both very explicitly, and less overtly.

Medical problem

An example of this is that Rob and Michelle in Family A made clear statements about the medical root of Louis' eating difficulties, leading to them making equally clear comments that the problem should have been solved by medical professionals. It logically follows that a medical problem should have a medical solution, therefore the medical problem discourse feeds into a medical solution discourse, which positions responsibility with healthcare professionals and away from parents.

Family B were the family who least drew on the ideas of responsibility and blame in relation to the construction of the problem, but had an overt and clear discourse around the cancer being the start of the problem, as the issues had not been present prior to this. It seemed that there was no need to hold individuals accountable:

the problem had an external cause. It cannot be said whether these constructions are truthful in a factual sense, but the way the problem is understood has clear implications for both responsibility and blame, and therefore actions leading to resolution.

Some mothers in Study 2 also drew on these ideas, especially in relation to possible or diagnosed Autism Spectrum Disorders, or something being wrong. Discourses about other illnesses were less prevalent however, which is an interesting and notable but unsurprising difference between the clinical and non-clinical samples represented in the two studies.

Phase

In contrast to the idea of a medical problem, several parents including Maria in Family C, and several online survey respondents, related to the problem as a phase, with nobody to blame, and therefore nobody to act. They related to the eating pattern as normal, not a problem, and with nobody and nothing to blame. This consequently works to distance parents from blame themselves and from needing to take action, as the problem would resolve by itself. This helps us to understand why this phase discourse was reported to have been used by healthcare professionals: this could be a reassurance that parents are not at fault, but neither are they and that nobody need act or worry about being to blame.

Child factors

Families also drew on ideas about whether the child held some responsibility, such as the idea that this was a choice the child was making or part of their character. This was evident in both Studies 1 and 2. Louis in Family A was described as ‘dictating’, positioning him as responsible for his eating behaviour, however with recognition that he may have been affected by the medical problem. This discourse almost positions the parents as powerless.

Blame and responsibility

These discourses indicate that when a child doesn’t eat, people look for a cause or an explanation, and may situate the blame for the problem with different people or phenomena. When considering this, the literature was also considered, such as that cited in the section on diversity and complexity, that also seems to be searching for a cause of the problem. Logically, this makes sense, as knowing a cause is likely to indicate the direction of a solution. From the data gathered, it is clear that the discourses raised many possible causes, often at once, reflecting the complexity of the

situation. It was also apparent that parents used these discourses to construct who was to blame, and therefore who was responsible for change.

Psychological theory can help to explain this. The idea of locus of control, often used within health psychology, relates to how individuals situate control over their lives, for example internally, meaning they have control, or externally meaning others do. Ajzen (2002) suggests that beliefs about control reflect self-efficacy. In this study, some parents (e.g. Rob and Michelle) reflected not knowing how to act, suggesting low self-efficacy. They also drew on more responsibility discourses. It was only at the end of the interview when they talked of noticing their behaviour making a difference in the recorded meal, that they were able to position some of the responsibility with themselves. Kelley (1967) puts forward attribution theory as describing processes for people to 'attain a cognitive mastery of the causal structure of his environment' (p192). This suggests that people may want to achieve mastery of this situation. Perhaps anxiety plays a part here too, with parents anxious to make things okay or to prevent the anxiety that could be associated with feeling to blame. Blame within families can be constructed at other times, for example in family therapy, Patrika, and Tseliou (2016) found in their discourse analysis that families construct the patient as straying from normality, thus being to blame. In some cases, that happened within this data, especially when child characteristics or behaviour was constructed.

Parents' identity

The constructions of parents' own identity as a good parent or not was key, especially within the social context of a research interview, which may lead to a high level of social desirability bias and the wish to portray themselves in a positive light according to prevailing social norms (King & Bruner, 2000). While the talk produced by Karen in Family B focussed less on the responsibility of the problem, her talk constructed her as responsible for knowing what would work with her child and taking responsibility for what happened in the mealtimes. Her use of expert language and reference to knowing the expert advice, constructed Karen as a good parent. Maria in Family C acknowledged her failure to recognise Sophie's problems, but consistently referred to her experience with her other children, and the resolution of the problem, thus repairing the image she had of herself as a good parent. This feeds the idea that

good parents are able to take responsibility for the problem and to solve it.

Kokkonen (2009) in a Finnish discourse analysis of material on a website drew out the idea of child overweight representing ‘bad motherhood’. Users of the website held parents responsible for the cause of the child’s ‘fatness’. This societal discourse, although related to over- rather than under-weight could go some way to explaining the prevalence of talk pertaining to responsibility and blame throughout the mealtime. If alternative discourses are not developed, the fall-back is for parents to be blamed. Murphy’s (2000) paper discusses responsibility and justification, which fits with the findings here.

Discursive devices and public health discourses

Stake inoculation was the primarily identified discursive or rhetorical device (Potter, 1996). Others were identified, such as the use of detail, generalisation, and categorisation, and these other strategies tended to be used to support statements or arguments. Stake inoculation differed as it reflected the anticipated viewpoint of the researcher, and involved participants defending themselves in advance of potential criticism. This highlights the emotiveness and sense of judgement around children and eating.

This can be considered in the context of public health discourses and perceptions. The studies by Lupton et al. (2008), where mothers recognised the pressure put on them and by Puhl, Peterson and Luedicke, (2013) suggested that there is stigma attached to negative messages around obesity. Linked with Friedman’s (2015) findings that parental blame and the need for child protection are commonly used discourses around obesity, it seems possible that ideas around the responsibility held for healthy behaviours by parents and for which they are held accountable is likely to transfer to more general child-feeding related scenarios.

Reflections on responsibility and blame

This is an issue I contemplate regularly in my professional life working clinically with families, more so as I have been completing this research simultaneously. There is a huge amount of emotion attached to whether parents are doing the right or wrong thing or whether they are to blame for their children's difficulties, and this is something that needs constantly to be negotiated. Society seems to place a lot of pressure on parents to be good and to be happy. This is evident in social media and internet forums like mumsnet and netmums, websites used by participants in Study 2, where people seek advice or share worries or concerns anonymously. It seems that the idea of removing responsibility perhaps helps people to feel better about the problem, but also removes agency to take responsibility and to act. Clinically, this can be difficult to manage and while completing this research has become more of a focus of my reflections.

Managing emotions (parent and child)

The range of emotion words used by families in Study 2 indicate the high levels of emotionality for both parents and children at mealtimes when a child is restricting their food intake. Several parents including Karen in Family B, made very clear statements about how their approach to mealtimes was to manage these difficult emotions. Most striking was the discourse that parents and children had limited resources that needed to be preserved or had already been used up. These parents in Study 2, and Family 2 made it clear that an important goal of the mealtime was to limit stress and worry, for them and their child. This discourse seemed strengthened when families felt the problem was long-term, therefore necessitating preservation of resources which needed to last. This was true of Karen in Family B in particular, who talked about not wanting 'drama' in mealtimes, for herself or for Charlie. Parents in Study 2 talked about not engaging with their child during mealtimes in order to be able to manage the stress themselves and not become burnt out. Discourse about the need to preserve emotional strength helps to contextualise the relative lack of engagement with the child. Murphy's (2000) study found that mothers talked of 'good mothers' doing what their child needs 'regardless of personal cost', which contrasts with the discourse of preservation of resources developed here. Reducing stress within mealtimes fits with advice on how to manage mealtimes, either through professionals

reassuring parents (Ong, Phuah, Salazar and How How, 2014), or through reducing stress for the child (Department of Paediatric Nutrition and Dietetics, NHS Wales, 2015).

Parents of children with early feeding problems have been found to be more concerned with how their child presents when eating a meal (Harding, Wade & Harrison, 2013). The idea that parents may be more concerned and make more overt efforts to persuade, encourage, or to pressure their child to eat who limits their food intake to eat (whether this is a response to, or a precipitant of the child's eating problems) fits logically and is borne out to some degree in the current study. In Study 1, the families all faced difficulties around their child's eating and all reported some level of concern about this. However the response to this concern varied. The way in which concern related to the mealtime could also be linked to how parents related to the problem. Acceptance and loss, especially of the idealised family mealtime was another key issue.

This area also relates to ideas around parenting stress, confidence and self-efficacy. Self-efficacy is an idea around self-belief about ability, usually in a specific area. Lee and Kwon (2006) in a Korean study around breast- and bottle-feeding found that Parenting Stress Index scores were significantly negatively correlated with Maternal Role Confidence scores suggesting that higher stress and lower confidence were linked in mothers of young infants (with more favourable outcomes in terms of higher confidence and lower stress in the breast-feeding group). The link between confidence and stress is interesting in the context of this study, in that the talk of Karen in Family B presented her as more confident, and as making focused efforts not to be stressed, and to do things to avoid feeling stressed. The avoidance of stress through the use of particular practices (such as withdrawing from a meal) was echoed by families in Study 2. Conversely, Rob and Michelle in Family A in Study 1 used talk that suggested lower self-efficacy, such as that around being first time parents, without a manual. They also talked more about being worried and concerned. Self-confidence and efficacy in relation to parenting and the portrayal of this through talk could be an interesting future line of research. Sanders and Woolley (2005) found that mothers whose children were accessing clinics around their behaviour reported lower self-efficacy. It is not possible to tell in which direction any causal link would go: it is possible that the presence of a problem could lower parental confidence. It seems that responses to a lack of confidence may vary, for example, Family A utilised many

strategies to try and find a way to problem solve, whereas Family B seemed more confident that they understood the way in which the problem should be solved. It would be interesting to consider parental emotional experiences and regulation and how this might relate to feeding strategies in future research.

Acceptance and Loss

Parents in Studies 1 and 2 related to the idea of ‘normal’ mealtimes or mealtimes of other children, and how different their own child’s mealtimes were. This can be understood in terms of loss and acceptance of their situation. The parents’ levels of acceptance could be seen to fit both Worden’s (2008) four stages of grief, indicating that accepting the reality of a loss needs to occur, working through pain and adjusting and Fisher’s (2012) personal transition curve, which shows a trajectory of acceptance covering recognition of the problem, to denial about the change, then acceptance. These models suggest people need to perceive the change as happening, may protest this and experience sorrow and despair, and then need to find a way to move on. There may be ways in which they protect themselves from the pain of this, e.g. anger.. In Study 1, Maria in Family C’s discourse was about how she did not recognise a problem initially, she then did, and took action to address Sophie’s eating, meaning the problem had now resolved. It seemed that Maria’s focus was on constructing the idea that there was no problem. This is different to how Rob and Michelle related to Louis’ difficulties. Michelle and Rob’s discourses suggested anxiety, fear, anger, and guilt, which in Fisher’s personal transition curve is the first part of the curve, prior to acceptance and moving forward. They are desperate to make change, and this is represented in their mealtimes with the large number of different strategies used. The denial Maria could be seen to be in is an alternative to this route when change happens. Karen seemed to be further along the personal transition curve, towards gradual acceptance and moving forward although there are still aspects of sorrow and loss which are hinted at. This also fits with the findings of Hewetson and Singh (2009) who conducted a phenomenological study about lived experiences of parents of children with chronic feeding problems which suggested that parents experienced loss and grief before moving on.

This also ties in with comparison to others which arose on multiple occasions, and noticing whether there is something to mourn in response to others. This was evident in the online data, but also within Family 1 in particular, with the loss of

normal family mealtimes. Conclusions are drawn at the end of the chapter.

Strengths and Limitations

Use of Study 1 and Study 2

The use of three types of data across these two studies allowed both a deeper and broader picture to develop of the discourses constructed by parents about their child's eating and their mealtimes. The introduction of survey data from an arguably less socially influenced group of parents in study 2 (due to the lack of direct contact with the researcher) allowed the main data from study 1 to be contextualised, as well as for similarities and differences between the types of discourse drawn out, allowing some consideration of whether there was a significant difference between the studies.. This gave greater understanding of the discourses about restrictive or fussy eating in the broader population. There were, however, limitations in the lack of clarity over the problems experienced by families in either study, due to the vagueness precipitated by the multitude of ways problems eating can be described. While the aim was not necessarily to create a homogenous sample, the heterogeneity of the sample could not be clearly assessed, other than through the use of individual accounts. The use of some descriptive data on the perceived frequencies of behaviour could have given further insight into the characteristics of the sample without detracting from the recognition of individual differences within the analyses.

Recruitment and sample

Study 1: The main limitation was the smaller than planned number of families participating (4 had been hoped for as a minimum). The clinical population being targeted through specialist teams did not yield as many participants as hoped. This was surprising for the identifying teams as they had expected more families would wish to take part. Unfortunately reasons for non-engagement were not recorded by the teams recruiting, however, when clinics were attended to recruit participants, those parents who declined cited the high number of other health appointments they needed to attend, being busy, and having other children. One interested parent's spouse did not agree, indicating the need for both parents to be in agreement. Self-consciousness was expressed by Karen in Family 2, but she had experience of taking part in research, and put this aside.

The age range was, on reflection, too great given the small number of families who took part, and the study may have benefited from a smaller range. Developmentally, it could be said it is appropriate for older children to have more

control, and for younger children to need more help. This age range was determined in order to reflect the age range seen by the services, and was recommended by the research panel, however, it caused some difficulties in relation to the data itself. The younger children in this study had limited speech, although for Family 1, with two parents present, this did not seem to reduce talk occurring in the mealtime.

There was a limited extent to which a sample of 3 could be diverse in terms of characteristics, but there was no variation in ethnic background, with all families being white British. There was some variation in socio-economic status. Strengths were that there was clinical involvement for all three families in Study 1, thus this was clearly a clinical sample. Delineation of the type of clinical sample in future studies would address this limitation.

Study 2:

Limitations of recruitment, were that through the use of mumsnet and netmums, only mothers took part. Attempts were made to find other more inclusive forums, but this was not possible at the time of the study's completion. There could also have been bias in terms of the types of parents who did answer the study versus those who did not. It seemed the number of people who would see the information about the study posted about the study would be limited by where the invitation was placed. Inclusion criteria demanded that families were resident in the UK, and that their child was aged 2-7 years but there was a range of maternal ages, and of family setups were represented.

Joint use of naturalistic observation and interview in Study 1

The use of both naturalistic observation and an interview was a real strength in the research as this allowed much richer understanding than either alone, as links could be made between them, for example different constructions of the problem and parents acceptance of this, could be matched up with the way the mealtime was carried out. Additionally, parents were able to reflect (particularly with family 1) and were observed to alter their discourse over the time spent watching the video. This potentially has clinical utility as it enabled parents to make reflections on the mealtime. A limitation of this approach, was variation in the amount of data from each family, and differing links between video and interview data, meaning finding a way to structure the data analysis across families was more difficult and did not always

show links as clearly as had been anticipated. This was partly also due to the lack of speech occurring in two of the three mealtimes.

Video recording

The use of video recording had many positives: the researcher was able to see, as well as hear, what was happening. This was particularly important for families where the child's speech was limited, as an audio recording would not have been sufficient to understand the actions and interactions taking place. The use of video was more reliable than live observation in that it could be watched multiple times rather than relying on an initial interpretation made quickly, and it increased accuracy of recall in parents. For discourse analysis it was vital for a recording to be made in order that the talk was available for transcription and analysis.

There were limitations to this approach. The families are likely to have, at least initially, been self-conscious and therefore may have adjusted their behaviour. Being video recorded is likely to have deterred some families from taking part. One parent did express embarrassment about being video recorded, especially for the interview, and made comments about how tidy the house looked in the video. Sophie in Family 3 was reported to act differently from usual, choosing to eat her meal in the spot where the camera had originally been set up, and not where she would usually eat. This meant the researcher needed to enter the room to rearrange the equipment and this may have had further impact on the mealtime. However, by asking questions about this in the interview it was possible to at least partially understand what was different to usual about the meal.

Online data

The use of online data allowed context to be provided. Anonymous provision of information by participants significantly lessens the level to which social desirability bias may impact on the data, as there is no human interaction and no way of identifying who the participants are, however this is still likely to have been an issue. It could be considered that the lack of ability to verify the position or demographics of participants accounts is a limitation. It certainly seemed that some parents had different views about what constituted restrictive eating, but this tended to be revealed in the text and was part of the understanding of their data. A further limitation was the wording of the questions needing to fit a range of potential

participants, which sometimes meant it felt vague, or leading. In the live semi-structured interviews, this was not an issue in the same way, as the researcher could be responsive, but this is not possible within an online survey.

Defining eating difficulties/restrictive/fussy/picky eating

One particular problem encountered throughout this study was finding a shared definition of what constituted an eating problem or difficulty, or picky or fussy eating, a problem recognised by, amongst others, Mascola, Bryson and Agras (2010). This was particularly true in Study 2. In the clinical sample of Study 1, this was managed through criteria for inclusion, in that children had to refuse to eat in some way, whether this was reduced food intake in terms of amount or type of food. To be included families also needed to access specialist intervention or services in relation to their child's eating. However, there was more difficulty in knowing how parents completing the online survey had defined these issues and what they would look like for different families. As this study utilised a discourse analysis approach, which places emphasis on the language used to convey ideas, this created additional challenges for the wording used in recruitment and other materials as a possible influence on participants' use of language when taking part. These materials therefore deliberately did not make absolute definitions of these terms to allow parents to define what constituted a problem or difficulty for them. However, this approach produced its own challenges as it led to a highly diverse collection of families choosing to take part. Therefore caution should be exercised in making generalisations across the sample. In this particular study, which recognised individual family experiences and differences rather than aiming to be able to generalise from findings. This could be considered a strength, as it may represent differences in definitions of what are considered eating difficulties, restrictive, fussy, and picky eating within the general population. Despite this, the difficulty in definitions does make it harder to situate the type of problem this family experienced.

Analytic approach

Discourse analysis uses whatever talk or text is produced, resulting in different amounts of data generated for analysis. This was a strength of the study, as although there was relatively little data from two observed mealtimes, it was possible to use the data that was generated. However, some interaction data not represented by talk may be missed. The transcriptions of the videos included annotated descriptions of what

could be seen happening, when language was not being used, or in addition to the language, this included physical actions and non-verbal vocalisations. This enabled fuller understanding and interpretation of the complete data recorded.

Clinical Implications

The diversity and complexity of the data indicates that clinicians need to recognise the many different ways that a difficulty eating can be constructed and that this has significance for how parents subsequently manage mealtimes. The clinical implications here largely surround the need for careful consideration of which discourses a family are using to construct the problem, their role within it, and the way this leads to a response. These considerations are covered, with some practical suggestions relating to the use of video-reflection studies. Some responses indicated a divergence between professional and parental discourses around the problem parents were left feeling powerless when they felt a problem was present, but professionals were not. Although Ong et al. (2014) recommend reassuring parents about their child's eating, it is important that there is recognition of the starting point of parents' concerns or the constructions they have about their child's eating problem. Some parents indicated a sense of being invalidated when this was not recognised, such as when Family 1 and others in Study 2 were told the problem was a phase, but they did not share this view.

The ideas of blame and responsibility are particularly important when working with parents, as it is necessary to understand where they position the cause of the problem, and therefore who needs to take responsibility for its resolution. If a parent constructs professionals as to blame and as therefore responsible, it is important to acknowledge this first rather than simply countering with an opposite discourse of parental responsibility. The parents in Family 1 in particular showed movement in their discourses throughout the interview, demonstrating that discourses do not need to be seen as fixed, but as a dynamic process. The role of the clinician may then be to facilitate parents' recognition of the discourses they use, and through discussion and questioning enable a shift in these or reflection.

The possibilities of acceptance and loss and the emotions generated within mealtimes are important for clinicians to bear in mind, in order to consider actual and potential experiences of parents and how they may construct and relate to these. The way in which parents manage their emotions must be considered by clinicians. The different ways in which parents described trying to make their mealtimes feel better

or less emotionally difficult provides some directions for this, such as whether they withdraw from being active with their child, in order to avoid feelings of rejection, or whether they try multiple approaches repeatedly or in more haphazard way.

The use of video is of possible clinical utility as families are able to bear witness to what happens in mealtimes through an external viewpoint. This allows them to take a different perspective and to be able to make observations which are not possible from within the mealtime. At times it seemed that being allowed this different perspective challenged some of the ways parents talked about their child's eating from memory. Viewing a video seems to generate greater reflective capacity when presented with evidence rather than from memory. Within the current study, this increase in reflective capacity through watching the video meant that Family 1 developed a different construction of the influences on their child's eating. Direction from the researcher was not used to push a particular alternate construction, but rather open questions were asked to support parents' to talk about what they saw. This may be a supportive and non-confrontational way for families to consider their own discourses.

Video Interaction Guidance (VIG) is an approach used to support the building of attachments with parents and children (Kennedy, Landor and Todd, 2010) and other behaviour problems (Klein Velderman, Bakermans-Kranenburg, Juffer, van Ijzendoorn, et al. . 2006), and support this possibility. Video-feedback Intervention to promote Positive Parenting (VIPP) (van Zeijl, Mesma, van Ijzendoorn, Bakermans-Kranenburg, Juffer et al., 2006) who say that these types of intervention 'provide an opportunity to focus the mother's attention on her child's videotaped signals and expressions thereby stimulating her skills and empathy for her child' (p995). In videotaped mealtime interactions parents are also able to focus on these aspects, as well as the effectiveness of the strategies or techniques they may have developed. The Tavistock and Portman clinic (<https://tavistockandportman.nhs.uk/training/cpd-courses/video-interaction-guidance/>) describe the videos used within this as 'better than usual' examples of how a parent and child may communicate and the focus is on how to develop the relationship. It is interesting to consider that the interaction in Family A was not 'better than usual' but they were still able to utilise the video to actively make reflections, and recognised that the times when they were not encouraging, were the times when their child ate more food, which was a surprise to them. For other families however, new realisations were not as evident, but may be if

facilitated with this intention in mind.

Future directions

There are a number of additional pieces of work that could be done to extend the scope of the findings. There was less involvement of fathers within the dataset of the current study. A comparison of mealtimes with healthy families would be worthwhile in providing understanding about the talk that occurs within and about mealtimes where there is no perceived problem with a child's eating, and whether similar or different ideas about eating and actions are evident. In addition, comparing the interactions between parents and siblings who are perceived or not as having a difficulty with eating could be important. The cultural variability within the participants was also significantly limited and future studies would benefit from working with a sample from a range of cultural, socioeconomic, and ethnic backgrounds.

As well as a greater range of participants, a greater number would also be helpful in further understanding the range of different discourses that parents may use. It is notable that there was only one father included in the current study's data (although in Family B, the father was present and answered some questions, he was not present or as involved in the child's mealtimes).

In order to access a greater range and number of families, sampling methods need to be considered. Recruitment via other more general social media networks or sites such as Twitter may be viable alternatives to reaching a high number of potential participants, from a wide range of backgrounds.

- Families with different cultural backgrounds were also not well represented in this study, and it would be important to understand whether there may be cultural differences in the types of discourses produced.
- A longitudinal study to track the development of discourses or change over time would be useful, as it was apparent that these are moveable.
- A study about the interactions between clinician and parent discourses could have very important clinical implications.

Further study around parental views and how this may relate to the way in which they manage their child's mealtimes, to include consideration of self-efficacy and confidence could also be useful.

Conclusion

The aims of this study were around understanding how parents talked within mealtimes and how they talked about mealtimes. The data gathered in this study demonstrated clearly the diversity and complexity in discourses produced by families in their talk about mealtimes and their experiences of their child's eating difficulties. This data was highly complex and discourses altered over the course of some individuals' datasets, with multiple and at times conflicting discourses being utilised. This indicates the instability and changeability of the constructs used. While all families included had a child whose food intake was restricted, the approaches taken to mealtimes varied considerably and could be understood in particular in relation to three main sorts of construction made within parents' talk. Firstly, the way in which the problem was constructed related to responsibility and blame, which also linked strongly to parents' constructions of themselves and to societal discourses about good parenting. Secondly, the way in which parents managed their emotions also gave context to management of the mealtimes. Thirdly, acceptance and loss was key in how parents related to feeding their child. The study provides insight into how different discourses can be represented within mealtime interactions. More than the understanding that parents' feeding practices may influence the child's behaviour, as found in previous research, the study highlights the many sorts of understanding and processes that are brought to bear in the child's mealtimes. Parents' talk about their experiences of parenting, their own emotional responses and their goals and expectations for mealtimes, and their constructions about who or what is to blame contextualise the differences observed in mealtimes, and help to explain some of what happens. This data has significant clinical implications for how clinicians work with these discourses to support families and recognise the significance of how discourses are created.

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Appendices (Presented in order they are mentioned in the text)

Appendix 1: Crib Sheet for Interviews

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds
These notes are for GCPH/Research
Interview crib sheet V1.0 27.08.15

Mealtime study interview crib sheet

NB: This is a guide rather than a script and is intended to be used flexibly depending on what issues are raised during the interview.

Support participant to feel comfortable and get used to watching themselves on video.

Initial introduction (go over information sheet).

To explain that we are watching the video as a way of hearing your reflections, thoughts and feelings about that mealtime. Either of us (researcher and participant) can stop the video at any time, and say something. I might ask some questions about what you might have been thinking and feeling then, and what you might be thinking or feeling while you are watching it, but you can say anything that comes to mind.

Before we start I wanted to hear a bit more about how you'd describe your child's eating and mealtimes?

How would you describe your child's eating?

How would you describe your child's mealtimes?

Self

What thoughts were you having then?

How did you feel at that point?

Was there anything around you that was making you feel like that?

What feelings are you having now?

What were you doing then?

View of child

Did you have any feelings about X (child) then?

What do you think they were doing then?

What do you think they felt towards you then?

Have you got any thoughts on why they might have done that?

Values and assumptions

Was there anything you liked about what happened there?

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds
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Was there anything you didn't like?

At end of video:

Hopes and intentions

Is there anything you wanted to happen?

What do you think X (child) expected of you?

Links with past/everyday experiences

Does this happen at other mealtimes or at other times? How typical is this?

Is this a usual thing to happen?

Did it remind you of anything else?

Reflection

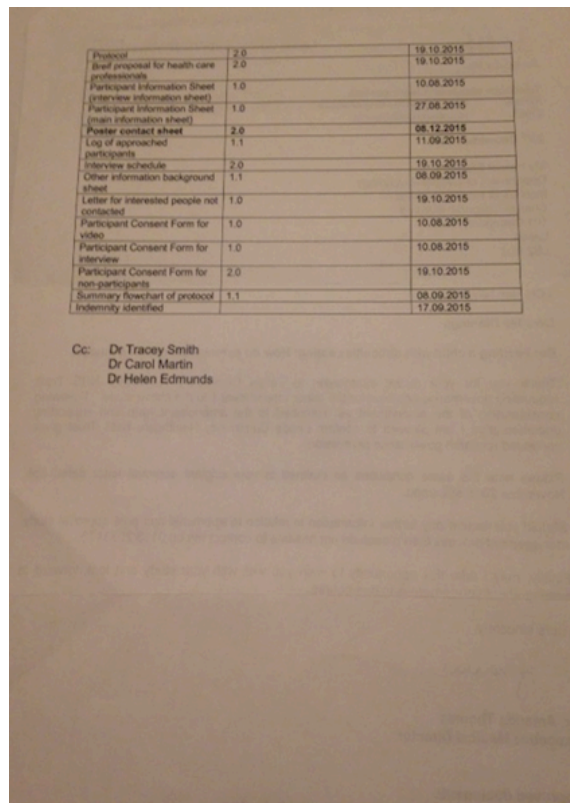
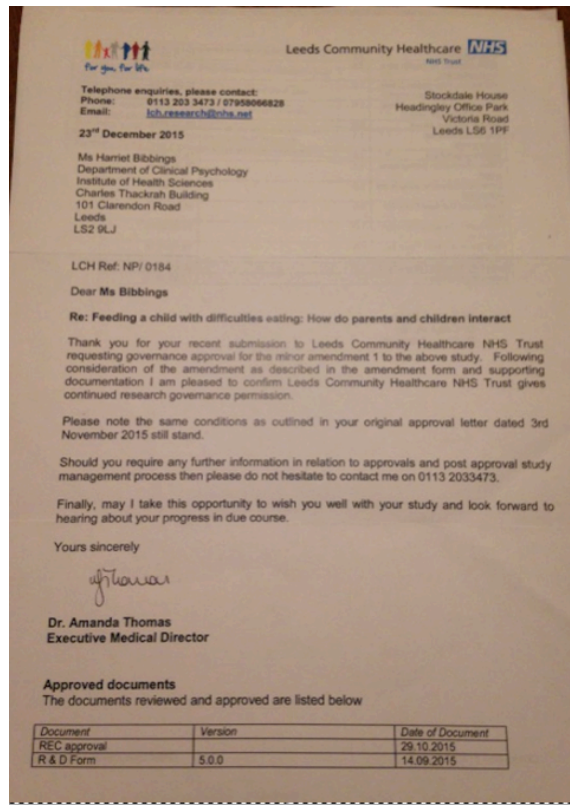
Do you know why you did or said that?

How do you make sense of what happened (specific or whole mealtime related),

Ending

Anything you haven't had a chance to say?

Appendix 2a) Trust 1 approval



Appendix 2b) Trust 2 approval

The Mid Yorkshire Hospitals **NHS**
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If you need this correspondence in a larger font size please contact: 01924 543175

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11 February 2016

JH/CSC/N-R&D(16/1034)

Dear Harriet

Feeding a child with difficulties eating: How do parents and children interact during mealtimes and how do parents reflect on this?
CSP 181261 REC 15/YH/0143 R&D 16/1034

Your research study has been approved by the Trust's Research Committee.

There are some conditions to this approval:

- The study may only begin after appropriate Research Ethics Committee approval has been received. I can confirm receipt of the latest REC approval letter dated 8 December 2015.
- To comply with the Research Governance Framework (DOH, 2001), the Local Investigator/Researcher should ensure that the study is conducted in accordance with the approved protocol. Informed consent must be obtained in accordance with the protocol and a copy given to the participant, a copy kept in the medical record, where appropriate, and a copy kept by the investigator in their research file. The Trust may audit these requirements.
- Research activity must be monitored by the Trust. A copy of letters or reports received following monitoring visits or inspections relating to the conduct of this study, at this site, must be sent to this office.
- Research involving radiation exposures must comply with local Trust policies and procedures, including authorisation by a named local Practitioner.


Chairman - Jules Preston MBE Chief Executive - Stephen Eames

- Annual progress reports will be required, and a copy of the final report. We will contact you annually to ensure we have up to date contact details and to confirm the status of the project.
- Any researchers not employed by this organisation who will be conducting research on Trust premises may require a research passport, an honorary contract, or a letter of access. If you require help with this, in the first instance, contact myself.
- For research within the scope of the Medicines for Human Use (Clinical Trials) Regulations 2004, investigators must provide evidence of appropriate ICH-GCP training. The Trust may audit this requirement.
- You have specified that this study will be completed on 28 September 2016. If you require an extension to this date, this must be submitted to R&D for approval.

If you agree with the terms stated, please will you sign a copy of this letter and return it to this office.

May I take this opportunity to wish you every success with your research.

Yours sincerely



Judith Holiday
RESEARCH MANAGER

cc: C.Martin@leeds.ac.uk (Academic Supervisor 1); T.E.Smith@leeds.ac.uk (Academic Supervisor 2); governance-ethics@leeds.ac.uk

Document	Version Number	Date
REC letter		08 December 2015
Protocol	1.2	11 September 2015
Copies of advertisement materials for research participants	2.0	08 December 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Uni of Leeds Confirmation of Liability Insurance]	1.0	17 September 2015
GP/consultant information sheets or letters [Log of approached participants]	1.1	11 September 2015
GP/consultant information sheets or letters [Brief proposal for healthcare professionals V2.0 19.10.15]	2.0	19 October 2015
GP/consultant information sheets or letters [Information for healthcare professions, V2.0 19.10.15]	2.0	19 October 2015
Interview schedules or topic guides for participants [Interview Crib Sheet V1.0]	1.0	27 August 2015
Letter from sponsor [Letter from sponsor]		26 August 2015
Other [Background information log sheet]	1.1	08 September 2015
Other [Background information 1.1 11.09.15]	1.1	11 September 2015
Other [Letter for interested people not contacted, V1.0, 19.10.15]	1.0	19 October 2015
Participant consent form [Consent form for video V1.0, 10.08.15]	1.0	10 August 2015
Participant consent form [Consent form for interview V1.0 10.08.15]	1.0	10 August 2015

Page 2 of 3

Appendix 3: Information for professionals

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds Thesis project for [UMHB@LEEDS.AC.UK](mailto:umhb@leeds.ac.uk)
Information for healthcare professionals, V3.0 29.01.16

Mealtimes in families where a child has difficulties eating Information for healthcare professionals

Thank you for agreeing to help me in identifying participants for my research project. The study is part of my Doctorate in Clinical Psychology. I hope the research will be of use to you and your team. This information is to help you identify eligible families. Please also see the brief protocol I have sent for more information on the background of the study.

This sheet contains information for you to share with families. I am aiming to complete the research with 4-5 families.

Identifying Eligible Families

Please use the inclusion and exclusion criteria to help you decide which families to talk to about this study. It is likely that not all eligible families you talk to about the study will choose to take part, so I will make contact with your team to let you know when enough families have contacted me to say they want to take part.

Inclusion Criteria

If there are any changes, you will be informed straight away.

Inclusion criteria.

1. Due to the focus on feeding problems, participants (or their children) must refuse food at times (not only have difficulties with eating in a physical sense)
2. Families receiving services/interventions in relation to their child's feeding or eating may be included at any point during this.
3. Younger children are most often referred to the identifying services in relation to their feeding problems. By age 2, the child is likely to have been experiencing difficulties for a considerable amount of time, and is also more likely to be taking an active role in the mealtime. Therefore, the child must be aged 2-7 years.
4. English must be the main spoken language within the home in order that the researcher can understand the nuances of what is said by parents and their children and the analysis is as full as possible.

Additional information: the child may or may not have additional diagnoses or disabilities, as long as there is an issue around food refusal/restriction.

Exclusion criteria

1. Families do not speak English as their main language at home.
2. Families will be excluded if the child's eating difficulties are due to purely physical causes and they do not refuse food, but rather, struggle to consume it physically but still try.
3. Families approached by clinicians must not have an open safeguarding referral.
4. Children or families must not have an open safeguarding referral. This is to minimise stress to families who may already be struggling more than others, and also to limit the potential for concerns to be raised and confidentiality broken.

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds Thesis project for [UMHB@LEEDS.AC.UK](mailto:umhb@leeds.ac.uk)
Information for healthcare professionals, V3.0 29.01.16

- A contact poster
- A copy of the information sheet
- A stamped, addressed envelope
- Please add to the log sheet.

If families do not wish to take part:

- Please complete the log sheet if you can, with a reason why families have chosen not to participate.

Thank you! Harriet Bibbings, Psychologist in Clinical Training, umhb@leeds.ac.uk
Please do not hesitate to contact me if you have any questions/issues arising.
Study mobile: 07599 081193

Academic Supervisors:

Dr Carol Martin (C.Martin@leeds.ac.uk)
Dr Tracey Smith (T.E.Smith@leeds.ac.uk).

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds Thesis project for [UMHB@LEEDS.AC.UK](mailto:umhb@leeds.ac.uk)
Information for healthcare professionals, V3.0 29.01.16

Information to share

Main points:

Research aims to help understand what mealtimes are like for parents and children.

- Involves videoing a mealtime at home and watching it back with Harriet, to have a chance to talk about it from your (parent's) point of view.
- This service won't know who has taken part unless you want us to and it won't affect any service you receive from us or anyone else if you don't want to take part.
- There is a contact sheet to send your contact details to the researcher who may then contact you to see if you are still interested.
- Information sheet: please explain that this has more detailed information to help parents decide if they wish to take part.

Potential script

- There is a research project being conducted with families referred to this service.
- The study is trying to find out more about how mealtimes work for parents and children, when the child has a problem with eating.
- It is hoped that this will help professionals working with families where a child has a difficulty with eating by getting a really good understanding of mealtimes and what you think.
- Harriet would like to video-record a mealtime involving you and your child at home to see what things are like for you and your child.
- She would like to watch the video with you a few days later (somewhere convenient to you) and ask you about your thoughts and feelings about the mealtime that was videoed.
- This might be a chance for you to share what you are thinking with someone who isn't connected with you in any other way.
- I am asking today whether Harriet could contact you to see if you would like to take part.
- You are completely free to choose whether or not to take part.
- We in this service won't know whether you have taken part unless you want us to.
- It won't make any difference to the service you receive from us whether you take part or not.

If parent is interested:

- Here is a contact details sheet for you to fill in.
- You can take it away with you and send it to Harriet in this envelope (give envelope) if you like, or you can give it to me or Tracey and we will send it to Harriet.
- Or contact by phone or email.
- There is an information sheet to help you decide if you would like to take part.
- If you send it to Harriet, she may contact you on the phone and you will have the chance to ask her any questions you have then or you can contact her on the details on the sheets.

Checklist for you (these are in the packs provided)

If the families are potentially interested in taking part, please give them the following:

Appendix 4: Log of approached participants

Log of approached participants (for recruiting clinicians),
Mealtimes, 30 families with a child who has difficulties eating, V1.1, 11.09.15
Harriet Bibbings, University of Leeds

Log of approached participants



Clinician name:.....

Recruiting team trust:.....

I would like to know what proportion of people taking part do get in contact with me. It would also be helpful to have an idea of the reasons why people would prefer not to take part. Please could you complete this, I will collect a version from all the clinicians identifying participants. Many thanks, Harriet

Please complete the table below (add a line to a tally in the relevant box each time you speak to parents about participating). Please do not record any identifiable information.

Action of parental participants	Tally (e.g. a line per family, IIII)
Took a information sheet/contact sheet	
Returned a contact sheet to you	
Declined to take part/take information	

Please list a reason for each family/parent who declined to take part or take information sheets (please number these so that I can see how many families declined for each reason, use additional sheets if necessary). Please do not use identifiable information. If no reason given, please also record this.

.....
.....

Appendix 5: Study precis sheet for professionals

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds Thesis project for G000000004
Brief Proposal for healthcare professionals, V2.0 19.10.15



Mealtimes in families where a child has difficulties eating: How do parents and children interact during mealtimes and how do parents reflect on this?

Background and brief introduction

Mealtimes have been a focus of the literature around feeding problems in children. Links have been made between parental behaviours and practices at mealtimes (e.g. coercion) and child eating behaviours (e.g. food refusal). However, it is not clear how these links develop as some studies have suggested parental behaviours predict child behaviours, and others that child behaviours predict parental behaviours. Nuances of what happens between parents and children at mealtimes are also often missed, due to the quantitative nature of the majority of studies. This study therefore aims to understand in more depth what happens between parents and children during a mealtime where a problem has been identified with the child's eating. It is planned that there will be a focus on the way talk is used socially and functionally between parents and their children and how any societal or other ideas may be brought into the interactions between parents and their children.

Parents views and representations of mealtimes and what happens between them and their child has tended to be neglected. This study also seeks to bridge this gap by asking parents to reflect on the recorded mealtime (while watching it back with the researcher) and their thoughts and experiences of it. The way they talk about what happens will be the focus of the analysis, as well as any other ideas about feeding problems, parenting, themselves or their child that parents might raise.

Research Questions

1. How do children and parents talk together and interact at mealtimes?
2. How do parents talk about or construct the mealtime when watching a video of it?

Method

Participants

Between 4 and 5 participant families will be recruited to take part from local services (this means only a small number from each referring service). This number is relatively small due to the complex analysis required for the two stages of the study (described next). Participants will be parents or carers of children who refuse or restrict food intake and their child with an eating difficulty. The key characteristic of these families will be that a problem with the child's feeding has been identified, and a specialist referral has been made as a result.

Inclusion criteria.

1. Due to the focus on feeding problems, participants (or their children) must have met the referral criteria for intervention from the participating NHS services, specifically surrounding a feeding problem. The child must refuse food at times (not only have difficulties in a physical sense).
2. Families should be near the start of the service's involvement with their feeding problem (ideally still within the assessment phase, rather than currently undergoing interventions).

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds Thesis project for G000000004
Brief Proposal for healthcare professionals, V2.0 19.10.15

This is to avoid the potential impact of the interventions on the way parents and children talk at mealtimes or parents talk about the mealtime/child's eating.

3. Younger children are most often referred to the identifying services in relation to their feeding problems. By age 2, the child is likely to have been experiencing difficulties for a considerable amount of time, and is also more likely to be taking an active role in the mealtime. Therefore, the child must be aged 2-7 years.
 4. English must be the main spoken language within the home in order that the researcher can understand the nuances of what is said by parents and their children and the analysis is as full as possible.
 5. The child must refuse food at times (not only have difficulties in a physical sense).
- Additional information: the child may or may not have additional diagnoses or disabilities

Exclusion criteria

1. Referral not accepted for feeding problem.
2. The feeding problem is a relatively insignificant part of the reason for referral.
3. Families should not have already received extensive intervention in relation to the feeding problem from the team.
4. Families do not speak English as their main language at home.
5. Families will be excluded if the child's eating difficulties are due to purely physical causes and they do not refuse food, but struggle to consume it.
6. Children must not have an open safeguarding referral.

Stage 1: Video-recorded mealtime

A usual daytime mealtime will be video-recorded in the family's own home. Participant families will be asked to keep this as similar to their normal mealtimes as possible, so the length of the video may vary according to the natural variations of the mealtimes between families. This may mean that other family members are recorded. Consent will be obtained for this.

Stage 2: Interview with parents: reflections on the video

The parents will watch the video and simultaneously talk about it with the researcher in the form of a semi-structured interview. Prompts will be used to ask parents to talk about what they are seeing. This is similar to the Interpersonal Process Recall method often used within counselling training; the purpose is to prompt the memory of specific parts of the interaction to encourage greater depth of reflection.

Analysis

Data from stages 1 and 2 will be fully transcribed and analysed using discourse analysis.



Dissemination

This project is part of a Doctorate in Clinical Psychology thesis. It is planned that it will be published within a peer-reviewed journal and written up as part of the course. The results may be shared in presentation form with the teams supporting recruitment and in the university context.

Harriet Bibbings Psychologist in Clinical Training...Department of Clinical Psychology, Charles Thackrah Building, 101 Clarendon Road, Leeds, LS2 9LJ
Study Mobile: 07599 081193 (Please leave a message if I don't answer and I'll call you back)
Academic Supervisors: Dr Carol Martin, C.Martin@leeds.ac.uk, or Dr Tracey Smith, T.E.Smith@leeds.ac.uk.Tel: 0113 343 2732 (for ether).

Appendix 6a) Original poster

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds Thesis project for DClasPsychol
Contact sheet V1.1, 08.11



Mealtimes in families where a child has difficulties eating
My name is Harriet Bibbings and I am a Psychologist in Clinical Training at the University of Leeds and I am conducting the research as part of my degree.

This study aims to find out more about what mealtimes are like and what happens at mealtimes for parents and children in families where a child has a problem with eating or feeding. It also aims to hear more about what parents say about their child's mealtimes. Having a better understanding of what happens at mealtimes may help professionals support other families where children have difficulties eating.

You are being invited to take part in a study about mealtimes, as your child and you are accessing services in relation to your child's eating or feeding.

If you do choose to take part, the study would involve me coming to your home at a time convenient to you, to video a usual mealtime. I would like to find out what mealtimes are like and what happens in mealtimes for you and your child.

I will invite you to watch the video back with me and share your experiences, thoughts, and feelings about it up to 1-3 weeks after. This could be a chance to tell someone outside your clinical team about what you feel and think about what happens at mealtimes. It would be great to hear what you have to say, but you do not have to do this. This will also be recorded.

If you like, the video can be shown to your clinical team to support your clinical care.

There is a more detailed information sheet for you to read about this to help you decide if you would like to take part. You can either return the form below to me in the freepost envelope (in the post or to your clinician) or call me on **07599081193**. I may then contact you by phone about taking part (I may not be able to contact everyone who wishes to take part). I am more than happy to answer any questions you may have. Thank you, Harriet.



.....
Mealtime study
Would you be willing for Harriet to contact you about this study? (Saying yes does not mean you have to take part in the study, Harriet would make contact to see if you would like to take part and for you to ask any questions to help you decide). (Please circle) YES NO

Name.....
Address.....
Preferred contact number..... Additional contact number.....
Best times of day to call.....

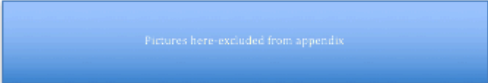
Please return in the envelope provided or to: Harriet Bibbings, Psychologist in Clinical Training, Charles Thackrah Building, University of Leeds, Charles Thackrah Building, 101 Clarendon Road, Leeds, LS2 9LJ, or call Harriet to provide your details, Study Mobile: 07599 081193

Appendix 6b) Newer version poster

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds Thesis project for DClasPsychol
Poster Contact sheet V4.0 10.05.2016



Does your child (aged under 7) have difficulties eating like restrictive, picky or fussy eating?
Would you like to take part in some research about what mealtimes are like: for them and for you?



Some children don't eat very much or might only eat a few things (sometimes called restrictive, picky or fussy eating). If this sounds like your child, you might like to take part in this research. The aim of the study is to find out from families about what mealtimes are like for parents and children when a child is having difficulties eating.

Please see the attached information sheet for more details on what taking part would involve (I would make a video of a mealtime, and we would watch this together).

If you are interested in taking part, or would like to find out more please either:

- Return the form below in the **freepost envelope** provided,
- Call me on **07599081193** (if you leave a message and number, I'll call back), or
- Email me at: **umhb@leeds.ac.uk**

Thank you, Harriet Bibbings, Psychologist in Clinical Training, University of Leeds

.....
Mealtime study: Would you be willing for Harriet to contact you about this study? (Saying yes does not mean you have to take part in the study, Harriet would make contact to see if you would like to take part and for you to ask any questions to help you decide). (Please circle) YES NO

Name.....
Address.....
Preferred contact number..... Additional contact number.....
Best times of day to call.....
Where you found out about this study.....

Harriet Bibbings, Psychologist in Clinical Training, ~~Dept~~ of Clinical Psychology, Charles ~~Thackrah~~ Building, University of Leeds, Charles ~~Thackrah~~ Building, 101 Clarendon Road, Leeds, LS2 9LJ Study Mobile: 07599 081193
Supervisors: Dr Carol Martin and Dr Tracy Smith, University of Leeds (please use above address)

Appendix 7 Participant information sheet

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds. This project for DCliaPsychol
Information sheet, V1.1 08.15



Mealtimes in families where a child has difficulties eating Information Sheet

My name is Harriet Bibbings and I am a Psychologist in Clinical Training at the University of Leeds. As part of my degree, I am conducting a study about mealtimes. I am interested in finding out about what mealtimes are like for parents and children when the child has a problem with their eating like refusing food or restricting what they eat. You are invited to take part in this study about mealtimes. The information in this sheet is to help you decide if you would like to take part or not, so please read it carefully. If you have any questions about the study please feel free to contact me as the lead researcher using the details at the end of this sheet.

Why have I been invited to take part?

You have been invited to take part in the study because you are accessing NHS services about your child's eating. Families with a child who is having problems with their eating are being asked to take part.

Do I have to take part?

No. You can choose freely whether or not to take part. If you decide to take part you will be asked to sign a consent form. You may withdraw from the study at any point, and do not have to give a reason. Not taking part in the study will not affect any services you receive.

What is the purpose of the study?

The aim of the study is to find out more about what happens between parents and children at mealtimes, and what mealtimes are like for parents and children when the child has difficulties eating. Having a better understanding about mealtimes may help professionals support families where a child has difficulties eating.

What will happen to me if I take part?

I would like to make a video-recording of a typical mealtime in your home and talk to you about your experience and thoughts about the mealtime, while we watch the video together.

- If you think you might be interested in taking part, you can let me know in several ways:
 - please fill in the contact sheet. You can send it to me in the freepost envelope your clinician should have provided, or give it straight to your clinician to forward on to me.
 - if you would like to talk to me, please call on 07599 081193 (study mobile). If I am not available, I will call you back if you leave a message to say you are interested in the study.
- Once I have your contact details:
 - I will contact you by phone. You will be able to ask questions and if you are happy to, we can arrange a time convenient for us both, so I can visit to make a video of a mealtime at your home. You may change your mind and opt out at any time.
 - I will visit you at home. Firstly, I will go over the study and give you a consent form to complete if you are happy to take part.
 - I will make a video of your mealtime. This can be on a separate visit. I will set up a tripod and video-camera and leave the room or stay out of the way as much as I can, whichever you are more comfortable with.
 - I will invite you to watch the video with me at a later date, and to talk to me about your thoughts or experiences about it. You will be able to let me know whether you are happy for me to contact you about this.

If you become unable to consent to the interview, but did consent to the video the video may still be used.

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds. This project for DCliaPsychol
Information sheet, V1.1 08.15

What are the possible disadvantages of taking part?

Some people feel embarrassed or anxious about being filmed. You can ask for the video to be stopped at any point during the meal. You may also ask for the video to be destroyed and withdrawn from the study within 1 week of it being completed (using the study mobile number) or if you choose to take part in the interview, 1 week after the interview.

What are the possible benefits of taking part?

Some parents enjoy taking part in research that may help other families in the future, or find it helpful to talk to a researcher about themselves and their families.

If you wish, the video from the mealtime may be shared with your clinical team, so that it may contribute to the care you receive. You are free to choose whether you want this to happen or not.

Will my details be kept confidential?

Your details will be stored confidentially and securely in accordance with the Data Protection Act. Your data will be assigned a study number and any names and location data will be changed (I will ask if you'd like to choose a nickname I can use instead of your real names) or excluded from any write-up. If you choose to share your mealtime video with the clinical team, they will not keep a copy. I will take it to them so they can watch it (without me present) and take it away afterwards. Videos will be kept in locked storage, and on secure computer servers or encrypted storage devices in line with the University of Leeds data protection policy and Data Protection Act. Videos will only be accessed by members of the study team in strict confidence. They will be kept for 3 years after the end of the study and then destroyed (as is usual procedure for University studies).

What are the limits of confidentiality?

If I became concerned that you, your child, or somebody else were at risk of harm, I would have to share this information. Firstly, I would contact my main consulting supervisor without sharing your details. If necessary, I will then contact the local safeguarding team for further advice, which I would then be required to follow.

What will happen to the results of this research study?

The research will be written up for submission to the university. The study may be published in academic journals or presented at academic conferences. The findings (which won't be identifiable) will also be shared with your clinical team and others who have taken part. If you choose, you may be sent a short summary of the results. Identifying information will not be included in any of these materials. Data will be stored securely by the University of Leeds for 3 years after the end of the study.

What if I have any concerns or questions?

I would be happy to answer any questions when I make contact with you or at any point in the study if you choose to take part. You may also contact with me using the contact details at the end of this sheet.

What if there is a problem or I want to make a complaint about this study?

If you are harmed from taking part in this study, there are no arrangements for compensation. You may make a complaint to your clinical team. If you wish to make a formal complaint, you may contact Clare Skinner, Faculty Head of Research Support, Faculty of Medicine and Health Research Office, Room 10.110, Level 10, Worsley Building, University of Leeds, Clarendon Road, Leeds. LS2 9NL

Who has reviewed this study? This study has been reviewed and approved by NHS Ethics

Harriet Bibbings Psychologist in Clinical Training, Department of Clinical Psychology, Charles Thackrah Building, 301 Clarendon Road, Leeds, LS2 9LJ
Study Mobile: 07599 081193 (Please leave a message if I don't answer and I'll call you back)
Academic Supervisors: Dr Carol Martin, C.Martin@leeds.ac.uk, or Dr Tracey Smith, T.E.Smith@leeds.ac.uk Tel: 0113 343 2732 (for either).

Appendix 8 Video consent form

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds. This project for DCliaPsychol
Consent form for video, V1.0 10.08.15



Mealtimes in families where a child has difficulties eating Consent form: Mealtime video

If you agree to the statements below, please initial them in the boxes and sign at the bottom.

Initial here

	I confirm that I have read the information sheet and been able to ask questions about the research.
	I confirm that I am choosing freely to take part in this research (not taking part will not impact on any services received).
	I confirm that I am the legal parent/guardian of the child included and provide consent to take part in this research.
	I understand that my child and I will be video-recorded during a mealtime at home.
	I understand that I can stop the video or withdraw my and my child's data at any point without giving a reason.
	I understand that the video and any transcriptions will be kept securely, in accordance with the Data Protection Act (with no real names used in written material).
	I understand that my data is confidential unless there is something of general which may need to be shared (in accordance with NHS trust policy).

(You and the researcher sign two copies and keep one each).

Participant Name: _____ Child name: _____

Participant Signature: _____ Date: _____

Researcher Signature: _____ Date: _____

Please circle yes/no as appropriate below (you may choose to decide later):

I would like my video to be shown to my clinical team. **Yes/No**

Participant signature: _____ Date: _____

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds. This project for DCliaPsychol
Consent form for video, V1.0 10.08.15

A summary of the research findings will be written.

If you would like a copy of a summary report, please circle yes and provide the address you would like this to be sent to if you would like a copy. If not, circle no.

I would like a summary of the research findings. **Yes/No**

I would like the summary report to be sent to the following address:

.....
.....
.....
.....

Appendix 9 Consent form for non-participants

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds. Thesis project for DPhil/PhD/EdD
Consent form for non-participants, V1.0 27.08.15



Consent form for adults or children present during the mealtime video

Summary information [please also see main information sheet]

- A video is being made of a mealtime as part of a research study to find out more about what mealtimes are like in different families.
- The study is being conducted as part of a Doctorate in Clinical Psychology.
- The video of the mealtime will be transcribed and therefore things you or your child say will be included in the transcription if you are present. Things you say may be included in the analysis too.
- You do not need to do anything different to usual.
- The video will be watched back by the researcher, Harriet, and a parent will be asked about it as part of the research.
- The videos will be stored securely on the University's secure servers and will be destroyed three years after the end of the study.
- No real names or identifiable information will be used in the analysis. Your relationship to the family may be noted.
- Data will be kept anonymous and within the context of the research. Please read page 2 of the main information sheet.
- The study will be written up and may be published in academic journals or presented at conferences. A summary report will also be shared with local clinical teams and participating families. The video may be shared with the family's clinical team.
- If I became concerned that you, a child or someone else was at risk of harm, I would have to share this information. Firstly, I would contact the lead contact from the family's clinical team and/or a university or clinical supervisor. If I still had concerns, then I would share my concerns with the clinical team and the local safeguarding team. If possible, I would let you know that I planned to do this. This may result in contact from other services.

Please initial all statements you agree with below

	Initial
I understand that this video is being made as part of a research study.	
I understand that things I/my child (please circle relevant one) say in the mealtime may be transcribed and may contribute to the research.	
I understand that all data will be kept securely in accordance with the Data Protection Act, 1990, and have read the limits of confidentiality.	
I understand that if the researcher became concerned about a risk of harm, then this information would need to be shared as described above.	
I understand that no identifiable information will be used in the write-up.	
I understand that the video may be watched by the parent and/or local clinicians involved in the care of the main family.	
I provide consent for me/my child (circle relevant) to be included in the video of the mealtime.	

Signature..... Date.....

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds. Thesis project for DPhil/PhD/EdD
Consent form for non-participants, V1.0 27.08.15

Your relationship to family (optional).....

Researcher signature..... Date.....

Harriet Bibbings Psychologist in Clinical Training, Department of Clinical Psychology, Charles Thackrah Building, 101 Clarendon Road, Leeds, LS2 9LJ
Study Mobile: 07599 081193 (Please leave a message if I don't answer and I'll call you back)
Academic Supervisors: Dr Carol Martin, C.Martin@leeds.ac.uk, or Dr Tracey Smith, T.E.Smith@leeds.ac.uk Tel: 0113 343 2732 (for either).

Appendix 10: Interview information sheet

Mealtimes in families where a child has difficulties eating Harriet Bibbings, Psychologist in Clinical Training, University of Leeds. Thesis project for DPhil/PhD/EdD
Interview information sheet V1.0, 10.08.15



Mealtimes in families where a child has difficulties eating Parent Interview Information

You are invited to take part in part 2 of the mealtime study. ~~This is an informal interview about the mealtime video that we have already recorded.~~ I would like to talk about your experiences of, and thoughts and feelings about the mealtime that was videoed while we watch the video back.

We will do this by watching the mealtime video together somewhere that is private and convenient to you (like your home or the university). I will make another video of us watching it. During the video we may both stop the video at any time to say something about the video. I may ask you questions about your thoughts, feelings and experiences. I would really like to hear what you have to say.

You may also wish to talk about other mealtimes or other issues that come up for you. I may also ask you some questions about your experiences of mealtimes or other related issues.

You may choose not to take part in this stage in the study. If you have taken part in the video this does not mean you have to be interviewed about it if you would prefer not to.

Your data will be kept securely in the same way as was described in the first information sheet I gave you (please see this for reference, feel free to ask for another copy). The video of your interview will not be shown to your clinical team.

You may stop the interview at any time and withdraw your data from the study up to one week after the interview.

Harriet Bibbings
Psychologist in Clinical Training, Department of Clinical Psychology, Charles Thackrah Building, 101 Clarendon Road, Leeds, LS2 9LJ
Study Mobile: 07599 081193 (Please leave a message and I'll call you back)

Supervisors:
Dr Carol Martin, Email: C.Martin@leeds.ac.uk, and Dr Tracey Smith, Email: T.E.Smith@leeds.ac.uk
Telephone: 0113 343 2732 (for either)

Appendix 11: REC Ethical Approval Letter



29 October 2015

Ms Harriet Bibbings
Department of Clinical Psychology, Institute of Health Sciences
Charles Thackrah Building, 101 Clarendon Road,
Leeds
LS2 9LJ

Dear Ms Bibbings

Study title: Feeding a child with difficulties eating: How do parents and children interact during mealtimes and how do parents reflect on this?
REC reference: 15/YH/0431
Protocol number: Protocol 1
IRAS project ID: 181261

Thank you for your correspondence of 23 October 2015 responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Miss Kathryn Murray, nrescommittee.yorkandhumber-sheffield@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publicly accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Copies of advertisement materials for research participants [Poster contact sheet V1.1 27.08.15]	1.1	27 August 2015
Covering letter on headed paper [Covering letter 2]	2	11 September 2015
Covering letter on headed paper [Covering letter 3 (response)]	1.0	23 October 2015
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Uni of Leeds Confirmation of Liability Insurance]	1.0	17 September 2015
GP/consultant information sheets or letters [Log of approached participants]	1.1	11 September 2015
GP/consultant information sheets or letters [Brief proposal for healthcare professionals V2.0 19.10.15]	2.0	19 October 2015
GP/consultant information sheets or letters [Information for healthcare professions, V2.0 19.10.15]	2.0	19 October 2015
Interview schedules or topic guides for participants [Interview Crib Sheet V1.0]	1.0	27 August 2015
IRAS Checklist XML [Checklist_16092015]		16 September 2015
Letter from sponsor [Letter from sponsor]		26 August 2015
Other [Academic Supervisor CV - Tracey Smith]	1.0	27 August 2015
Other [Background information log sheet]	1.1	08 September 2015
Other [Background information 1.1 11.09.15]	1.1	11 September 2015
Other [Letter for interested people not contacted, V1.0, 19.10.15]	1.0	19 October 2015
Participant consent form [Consent form for video V1.0, 10.08.15]	1.0	10 August 2015
Participant consent form [Consent form for interview V1.0 10.08.15]	1.0	10 August 2015
Participant consent form [Consent form non-participants V2.0 19.10.15]	2.0	19 October 2015
Participant information sheet (PIS) [Interview information sheet V1.0 10.08.15]	1.0	10 August 2015
Participant information sheet (PIS) [Main information sheet V2.0 16.10.15]	2.0	16 October 2015
REC Application Form [REC_Form_16092015]		16 September 2015
Referee's report or other scientific critique report [Transfer assessment panel report]	1.0	27 August 2015
Research protocol or project proposal [IRAS Protocol V1.2 11.09.15]	2.0	19 October 2015
Summary CV for Chief Investigator (CI) [Harriet Bibbings CV]	1.0	10 August 2015
Summary CV for supervisor (student research) [Carol Martin brief CV]	1.0	27 August 2015
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Brief Summary Flowchart Protocol V1.1 08.09.15]	1.1	08 September 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

A Research Ethics Committee established by the Health Research Authority

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at
<http://www.hra.nhs.uk/hra-training/>

15/YH/0431 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely



pp.
Professor Basil Sharrack
 Chair

Email: nrescommittee.yorkandhumber-sheffield@nhs.net

Enclosures: "After ethical review – guidance for researchers" [SL-AR2]

Copy to: Faculty Research Ethics and Governance Administrator
 Ms Linda Dobrzanska, Leeds Community Healthcare NHS Trust

