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Picky Eating and Positive Outcomes From Healthcare Interactions: A Narrative Analysis of Interviews With Parents Identifying Pathways to Progress

An appreciative inquiry into positive healthcare provider appointments by parents help-seeking for their child's picky eating in Aotearoa New Zealand

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Abstract

With estimates of clinically diagnosed picky eating prevalence greater annually than that of autism spectrum disorder in the paediatric population and negative outcomes for those children experiencing feeding issues, it is unsurprising research in the area is increasing. However, globally absent is qualitative exploration of parents' experiences in primary care when help-seeking for their child's picky eating. Prior research, when touching on the subject, primarily documents lack of support. This study therefore sought to establish via an appreciative inquiry what positive medical experiences look like, and whether affirmative appointments lead to good outcomes. Eleven parents participated in semi-structured interviews, with Wong and Breheny's (2018) three levels of narrative analysis employed to explore the data. The key finding was evidence of a clear, three-part structure across the narratives, consisting of parental management of picky eating, the positive appointment with the doctor, and the outcomes from that interaction. Within these, four key themes were explored. First, the challenge of defining picky eating and the impact on decision making for participants. Second, the effect on participant behaviour of wider social discourses of motherhood and its interaction with public health messages. Third, the importance of the relationships between doctor–parent and doctor–child. Finally, that doctors were limited by a range of factors in the care they could provide. The study showed that positive experiences are characterised by personable, caring doctors but that picky eating was neither well-understood nor resolving it prioritised.

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Glossary

Appreciative Inquiry – AIQ

Appreciative Inquiry is an approach to change for organisations and other groups. It is collaborative and strengths based. The term Appreciative Inquiry refers to both the paradigm and principles, and the methodology that effects a positive change in a system (Cooperrider, 2019).

Avoidant Restrictive Food Intake Disorder (ARFID)

ARFID was added to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), 2013 (American Psychiatric Association (APA), Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, 2013). According to the DSM-5, ARFID is diagnosed as lack of interest in eating or avoidance of food with ongoing inability to meet energy or nutritional needs. The inability to consume sufficient nutrition leads to one or more of the following: weight loss or failure to grow, nutrient deficiency, dependence on supplements, and significant disruption to psychosocial functioning. These are not the result of food shortage, cultural practices, another medical or mental issue, or body dysmorphia (APA, DSM-5, 2013).

Ensure

Ensure, produced by Abbott Nutrition, is a nutritional supplement for older children and adults.

ODD

A childhood disorder characterised by defiant and disobedient behaviour to figures in authority.

Pediasure

Pediasure, produced by Abbott Nutrition, is a nutritional supplement for children aged 2–15.

Pediatric Feeding Disorder (PFD)

PFD is defined as "impaired oral intake that is not age-appropriate, and is associated with medical, nutritional, feeding skill, and/or psychosocial dysfunction" (Goday et al., 2019, para. 6). It was conceived as a unifying definition and is recognised in the ICD-10.

Picky Eating

PE results from an inadequate consumption of variety or quantity of foods due to the rejection of a substantial amount of both familiar and unfamiliar foods (Dovey et al., 2008).

Food neophobia, the unwillingness to eat new foods, a subset of PE, is included in this definition for this study.

SAD

Social anxiety disorder is a mental health condition where social interactions produce anxiety.

Sensory Sensitivities

Children with sensory challenges experience either/or both hypersensitivity and under-sensitivity to sensory stimuli. Sensory processing disorder is the clinical diagnosis.

Chapter One: Introduction

Myself as Researcher

I came to health psychology as someone already working to support parents of children who are picky eaters. Seeking to extend this mission through research, this project considers parents' experiences of positive healthcare professional interactions. The project's focus is in response to both the limited research on parents' experiences, and the lacunae on positive appointments. I argue that understanding these positive experiences will shed light on how services may better meet the needs of children who are picky eaters and their parents and wider family. Below, I outline a literature review that serves as the introduction to this project. I start by defining picky eating (PE), the problems of ongoing feeding issues, and the prevalence of PE in both general and neurodiverse populations. Factors that may cause or exacerbate PE are then considered, including how cultural, gender-based, and health messages impact on families. Finally, the literature around doctor–patient relationships in general, specific to PE and in studies using appreciative inquiry (AIQ), will be discussed.

Introduction

Feeding children is a core responsibility for caregivers and possibly the most important skill learned by children themselves (Silverman, 2010). It is also a primary focal point of parenting in the early part of a child's life and an integral part of caregiver–child relationship building and infant socialisation (Lamm, 2022). Adequate and appropriate nutritional intake is important in the early years ensuring physical growth and neurodevelopment essential for long-term positive outcomes (Balasundaram & Avulakunta, 2023; Yang, 2017). In part due to this importance, assessment of feeding is frequently used by both caregivers and health professionals to gauge the wellbeing of babies and infants (Delaney & Arvedson, 2008). When feeding goes well, caregivers feel they are fulfilling their role to nurture their child and even self-evaluation of their parenting improves (Silverman, 2010). However, when feeding is challenging there are negative ramifications for children, caregivers, and the wider family unit (Cunliffe et al., 2022; Rubio & Rigal, 2017). This study focuses on one such issue, known as picky eating.

Chapter Two: Picky Eating

Picky Eating

Although researchers have highlighted the negative consequences of feeding problems, defining these issues precisely remains difficult. It is important to acknowledge that the way PE has been framed and measured impacts on comparisons between existing research and in relation to this study (Taylor & Emmett, 2019; Wolstenholme et al., 2020). Once an understanding of the issues presented by PE has been discussed I will engage with the complexity around conceptualisation.

In this research project, I will be using the definition of PE proposed by Dovey et al. (2008), which suggests PE exists where an inadequate consumption of variety or quantity of foods results from the rejection of a substantial amount of both familiar and unfamiliar foods. Food neophobia, the unwillingness to eat new foods, has been framed as a subset of PE and will also form part of this definition. To understand PE appropriately, it is also important to acknowledge that feeding challenges are experienced along a spectrum (Kerzner et al., 2015). Some children are more severely affected than others. Therefore, as a working definition, PE is a complex issue describing children who eat limited quantities and/or varieties of food, with harmful outcomes psychologically and physiologically. Overall, it is an important issue with a range of consequences.

Medical Consequences of PE

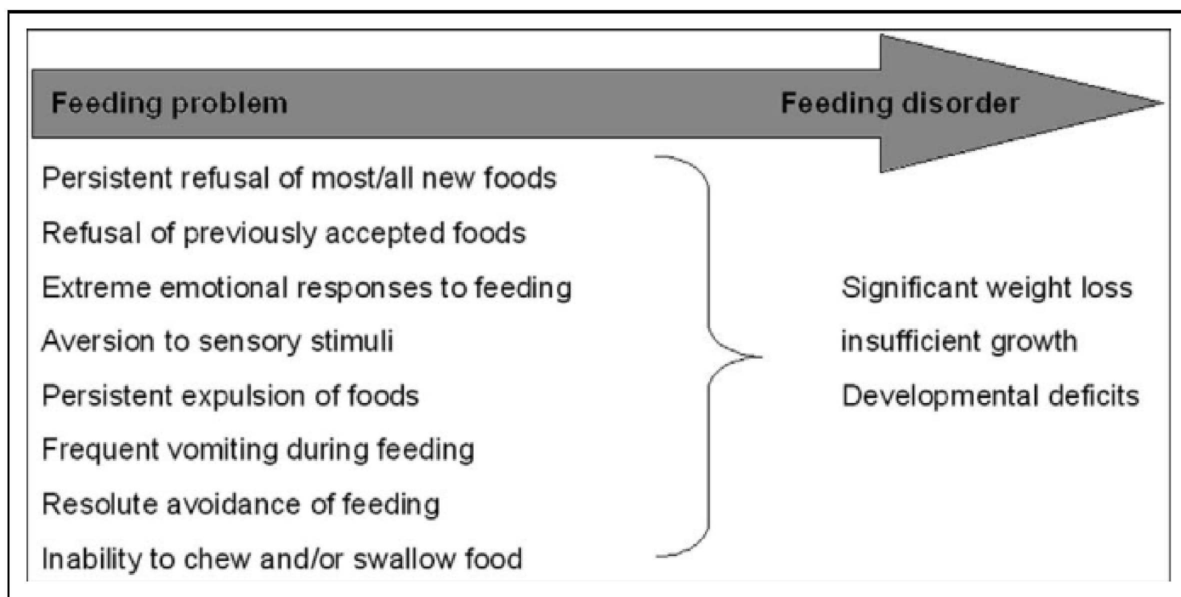
Outcomes for children with more extreme PE and therefore impaired nutrition can be poor (Goday et al., 2019; Sharp et al., 2017; Yang, 2017). For picky eaters, there is a greater risk of nutrient deficiencies and inadequate consumption of fibre (Galloway et al., 2005). The consequence of this may be lethargy, poor concentration, immune and digestive issues, and in extreme cases malnutrition and neurocognitive dysfunction (Bosaeus, 2004; Bryant-Waugh et al., 2010; Dovey et al., 2008; Yang, 2017). Similarly, deficiencies of nutrients at critical periods of development may reprogramme a child’s metabolism, resulting in permanent negative health changes and increased susceptibility to illness later in life (Białek-Dratwa et al., 2022; Grey et al., 2021; Wardle & Cooke, 2008). For children with co-morbid developmental or physical issues, a lack of nutrients may also exacerbate existing problems (Estrem et al., 2016). For these reasons alone it is essential to recognise the

importance of research that explores PE and particularly for children where problems are ongoing.

The general development of children can be affected by PE. A study following children for 15 years in Europe found that enduring PE in pre-schoolers resulted in lower weight and height as teens than non-picky peers (Grulichova et al., 2022). Similarly, in Aotearoa New Zealand (ANZ), dieticians have reported weight change and even lack of growth as the result of extreme feeding problems (Jackson et al., 2022). However, it is important to recognize that despite normal growth PE may still be a factor (Goday et al., 2019). Indeed, Aldridge et al. (2010) propose that behavioural components of PE present prior to physiological effects. The inability to see physical manifestations of PE from the outset is a critical point. Outwardly, a child may seem healthy according to widely accepted benchmarks, yet factors may be impeding normative eating and therefore long-term optimal health. The difficulties recognising problematic feeding are also compounded by a normative phase where eating can be challenging (Cunliffe et al., 2022; Wolstenholme et al., 2020).

Figure 1

Feeding Dysfunction Continuum



(Aldridge et al., 2010)

Temporality

During the preschool years, children are more likely to be PE (Tiemeier et al., 2017). Partly, this is due to an evolutionary tendency towards food neophobia, a protective trait initially thought to prevent toddlers from ingesting harmful foods (Çinar et al., 2021; Hazley et al., 2022; Rozin & Todd, 2015; Torres et al., 2020). Food rejection, although less adaptive contemporarily due to improved food safety is nevertheless widely positioned as a normative phase (Białek-Dratwa et al., 2022). Age-appropriate food refusal and PE have become synonymous for many parents and clinicians (Sdravou et al., 2021). The belief that feeding problems will pass is important as it affects how PE is seen and acted upon. Indeed, many caregivers do not seek help as they believe it is a transitional phase. Medical professionals, in general, have similar beliefs (Jackson et al., 2022). Neither of these positions are surprising given a societal lack of emphasis on the importance of early intervention for PE (Sdravou et al., 2021). Even researchers agree that PE will spontaneously resolve itself for many children (Lamm, 2022; Taylor & Emmett, 2019). However, these same authors also conclude there are children for whom this is not the case, and therefore argue the importance of establishing who is at risk of long-term PE.

Rather than being transitory, PE can be a stable trait for some children and food aversion in early childhood can easily become a fixed behaviour (Białek-Dratwa et al., 2022; Dharmaraj et al., 2023; Fernandez et al., 2020; Steinsbekk et al., 2017). Unfortunately, this leads some parents to initially accept eating challenges before later realising the problem has become established (Sdravou et al., 2021; Trofholz et al., 2017). Indeed, Fernandez et al. (2020) suggest entrenched PE can already be established by four years old. To compound this, critical windows where there is greater receptivity to exploring new foods can be missed (Cashdan, 1998). There may also be a genetic contribution to food neophobia (Białek-Dratwa et al., 2022; Cooke et al., 2007). These and other factors influence a child's susceptibility to PE and contribute to whether it is transient or more protracted. Evidence substantiating that PE is a longer-term issue is demonstrated by childhood picky eating continuing into adulthood (Barnhart et al., 2021; Dial et al., 2021; Ellis et al., 2018). However, enduring PE is not a widely discussed concept and therefore PE is more generally situated as transitory (Zohar, 2023).

Psychosocial Consequences of PE

Additional problems, such as psychosocial issues, may also arise from PE, particularly if persisting into adulthood (Barnhart et al., 2021). A link has been established between PE and conditions such as anxiety, depression, problem behaviours, and social difficulties (Bryant-Waugh, 2013; Farrow & Coulthard, 2012; Jacobi et al., 2008; Zucker et al., 2015). Moreover, an increased severity of PE corresponds to greater psychopathological symptoms (Zucker et al., 2015). Psychosocial issues are frequently discussed by parents as of key importance for both them and their child. Similarly, feeding problems are often associated with disruption to family functioning (Silverman et al., 2021).

The negative impact on family can be substantial. Conflict often arises between caregivers and between parent and child (Jacobi et al., 2003; Zucker et al., 2015). Other members of the family may also be affected by stressed relationships and disruptions to social events, holidays, and communal meals, as eating is an integral part of family occasions (Estrem et al., 2016). Despite often being framed as a problem associated with an individual, like many childhood challenges, the impacts are felt more widely. For example, extreme PE may affect income for caregivers as additional time may be required to attend to children's needs.

Parents of picky eaters may need more community resources (Okada et al., 2022). Medical services in ANZ are primarily publicly funded (Fitch, 2017); therefore, the costs to the healthcare system should also be considered. Unfortunately, these can increase over time, for example, if enteral nutrition is necessary (Lamm, 2022). As demonstrated by Estrem et al. (2018), Lamm (2022) and Simione et al. (2020), PE for certain children is likely to become entrenched and clinical presentations apparent. However, even with extreme sub-clinical presentations such as in Chilman et al.'s (2023) and Cunliffe et al.'s (2022) studies, costs needed to manage and treat PE may increase over time. Further, despite publicly funded healthcare in ANZ, there may also be many additional costs incurred by families of picky eaters. Everything from essential supplements to visits to specialists take time and money (Lamm, 2022). In Australia a study of families with picky eaters found distance to travel, time away from work/school, and out-of-pocket expenses were all barriers to treatment (Raatz et al., 2021).

There are multiple reasons therefore why early identification and treatment of PE is essential. Research suggests many problems may be either preventable or simple to treat

(Nieuwenhuis et al., 2016); however, left untreated they may develop into more serious conditions (Dharmaraj et al., 2023; Lamm, 2022; Sdravou et al., 2021) and may also lead to secondary complications (Okada et al., 2022). When eating does become an issue, historically, there has been little consensus around how to define, and thus treat, despite the necessity (Chilman et al., 2023; Cunliffe et al., 2022; Lamm, 2022).

Debates on Defining PE

A long-term issue for both researchers and health care professionals (HCP) involves definition. Feeding problems have been variously defined within the medical and scientific community (Wolstenholme et al., 2020). Parents too have used their own explanations of PE and its presentation (Rubio & Rigal; Trofholz et al., 2017). Terminology issues have implications for this study, as much of the relevant literature uses different interpretations of what constitutes PE. Terms such as picky eater, fussy eater, selective eater, food neophobic, failure to thrive, and more recently pediatric feeding disorder (PFD) (Goday et al., 2019) have been used, sometimes interchangeably. Feeding challenges have also been classified as eating disorders and variously termed. For example, eating disorder not otherwise specified (EDNOS) and, since 2013, avoidant restrictive food intake disorder (ARFID).

Feeding challenges can also present variously, as limited food choices, textural or temperature hypersensitivity, and oral motor issues such as pocketing food (Mayes & Zickgraf, 2019; Rubio & Rigal, 2017; Trofholz et al., 2017). Heterogenous symptoms and behaviours also affect children diverse in age, stage, backgrounds, and needs (Berlin et al., 2009; Estrem et al., 2016). The diverse presentation of PE introduces yet another complication for both parents and HCP. The heterogeneity has also led to treatment being conducted by a range of medical professionals from dieticians to pediatricians, general practitioners (GPs), speech language therapists, and psychologists (Goday et al., 2019). Each discipline has also approached PE from the standpoint of their respective specialty. To account for some of these issues pediatric feeding disorder (PFD) was conceived (Goday et al., 2019). The PFD diagnosis was proposed to resolve many of the ongoing issues around classification and measurement providing a unifying definition.

PFD was designed to consider functional limitations that impact quality of life. Accounting for the wider effect of feeding problems on families is important and confirms the necessity of more research in this area, particularly in ANZ. Of related importance, PFD was accepted

as part of the World Health Organization (WHO) International Classification of Diseases and Related Health Problems nomenclature (ICD) on the first of October 2021 – ICD-10-CM R63.31 (Galai et al., 2022; WHO, 2022). These ICD classifications are used within the health system in ANZ (Claudino et al., 2019). Although an accepted diagnosis, PFD is not yet widely recognised as a medical condition within ANZ, no local literature exists, and anecdotal evidence from my own practice suggests awareness of PFD is virtually nil.

PFD is defined as "impaired oral intake that is not age-appropriate, and is associated with medical, nutritional, feeding skill, and/or psychosocial dysfunction" (Goday et al., 2019, para. 6). The diagnostic system accounts for the effect of PFD on children's physical, social, emotional, and cognitive functions, alongside the impact on the relationship between child and caregiver (Galai et al., 2022). However, although this diagnosis offers promise for the future, its widespread acceptance is likely to take time.

Gauging PE Prevalence

Although it is necessary to define the size of the problem, particularly for context in this study, it is not straightforward and similar issues to that of definition have arisen in quantifying the prevalence of PE (Wolstenholme et al., 2020). Researchers have used various measures and qualifying parameters, making direct comparisons, or even generalisations challenging (Taylor & Emmett, 2019). Many studies have also used self-report by parents, which can result in under- or over-reporting (Brenner & DeLamater, 2016). PE may present particular bias as feeding is a biological imperative with young children requiring constant feeding, so problems are likely front of mind. Further, assessment of PE has used evaluations that range from a yes or no response through to in-depth multi-item questionnaires and clinical testing (Taylor et al., 2015; Zucker & Hughes, 2020). The challenge is further complicated by the developmentally normal stage of toddler food refusals and the necessity to evaluate what is typical and what is dysfunctional (Białek-Dratwa et al., 2022; Chilman et al., 2023).

To afford a level of confidence in gauging prevalence, Kovacic et al.'s (2021) study uses data viewed through the lens of PFD parameters. As a comprehensive diagnosis, PFD provides a way to interrogate PE across domains and side-step inconsistencies notable in previous studies. The researchers were also not reliant on parent-report. Instead, the authors conducted a retrospective cohort study across public and private insurance databases in

two states, Arizona and Wisconsin in the United States of America (US). Patient claims were used to identify diagnoses and the study was conducted across over 50 million individuals (including adults in the family), annually, focused on five years of data. It found that in 2014 the annual prevalence of PFD was between 1 in 23 and 1 in 37. For children with other chronic conditions the figures were 1 in 3 to 1 in 5. The researchers also found PFD numbers seem to be increasing. Similarly, Raatz and colleagues (2021) in Australia believe PE numbers will increase due to advances in healthcare improving survival rates for medically compromised children. Kovacic et al.'s (2021) study found the percentage of children with PFD is greater than those of children recognised as having autism spectrum disorder (ASD) annually.

However, these figures may not be representative of all western nations or, indeed, all states in the US. Similarly, excluding families who are uninsured may affect results as prevalence may be different for families across income brackets. The study also included children who displayed challenges in one of the four feeding domains specified by a PFD diagnosis, which may indicate less severity. Conversely, psychosocial issues may not be included in medical records and therefore not registered, introducing potential confounds on both sides. The study found PFD continues to be common throughout childhood, but further analysis was done only on children between 2 months and 5 years of age. Despite these potential issues, Kovacic et al.'s (2021) report appears to provide the most comprehensive overview of PE prevalence. Their results are also reflected in other studies with, for example, consensus on the greater likelihood of PE affecting neurodiverse children.

Potential Causes/Factors that Maintain PE

There is a substantial correlation between feeding challenge and ASD (Kerzner et al., 2015; Ledford & Gast, 2006; Sharp et al., 2013). Similarly, attention deficit hyperactivity disorder (ADHD) is frequently associated with feeding challenges (Råstam et al., 2013). However, finding accurate figures that reflect PE estimates among neurodiverse populations is again challenging. There is though, general agreement that significantly higher rates of PE are found in neurodiverse children, particularly those with ASD (Margari et al., 2020; Petitpierre et al., 2021; Romano et al., 2015).

To explore prevalence in children with ASD comparative to other populations, Mayes and Zikgraf (2019) used standardised testing administered by licensed psychologists. Their

study sought to establish atypical eating behaviours across 2102 children, the majority of whom had ASD. PE was found to be 70.4% for children with ASD. However, the prevalence figures reported for both children with other disorders such as language difficulties and ADHD, and typically developing children was low comparative to other studies. Several factors may have influenced these results. For example, stringent parameters, an ASD specific questionnaire, low numbers of participants without ASD or including ages 1–18 years old. However, researchers agree that for many children with ASD, developing competent eating skills is not easy. Further, ASD specific behaviours intersect with feeding to create problems, for example, rituals and repetitiveness, dislike of novelty, inflexibility, and desire for uniformity (Margari et al., 2021; Petitpierre et al., 2021).

Children with both ASD and ADHD commonly experience sensory sensitivities, and these too may exacerbate feeding issues, despite not widely being recognised as problematic (Cunliffe et al., 2022; Ghanizadeh & Moghimi-Sarani, 2013). Sensory sensitivities are not, however, confined to children with additional diagnoses yet may be a factor in PE (Cunliffe et al., 2022). Simione et al. (2023) found sensory aversions were the most prevalent impairment for children with feeding problems with no additional diagnoses in a US study.

Other factors that may independently and comorbidly affect PE are medical conditions and skills deficits. Eating is a complex physiological undertaking generating many points where difficulties may arise (Goday et al., 2019). Understanding there are underlying factors that may drive PE beyond the typical developmental phase is important. It may also explain why PE is not restricted to the toddler years for many children. PE is also not limited to those children with other medical disorders, for example, Chilman et al.'s (2023) recent study in Australia of extreme picky eaters included primarily neurotypical children without comorbidities.

Feeding is also, particularly in the early years, relational. Inappropriate caregiver intervention may inadvertently exacerbate PE. Unhelpful, habit-driven behaviours can develop for both child and adult with problematic mealtimes exacerbating issues as relationships and the eating experience are negatively affected bi-directionally (Cole et al., 2018; Walton et al., 2017; Wiggins, 2023). For example, sensory processing sensitivities can cause difficulties as even small differences or brand changes may elicit food refusal (Cunliffe et al., 2022). High-stress environments can contribute to less effective parenting, in turn

reinforcing negative mealtime behaviour even if problems are transient (Cunliffe et al., 2022; Neece et al., 2012; Silverman et al., 2021). Moreover, the caregiver's perception of the severity of their child's feeding problems may produce stress, thus contributing to poorer mealtime interactions (Lim et al., 2021). Research also shows there is a correlation between young mothers and PE, perhaps due to inexperience in dealing with behaviour and relative lack of nutritional education (Galloway et al., 2018; Tharner et al., 2014). These are important factors to consider as they demonstrate how PE is not a static condition and that multiple influences can change outcomes and severity over time.

Research also shows PE may inequitably affect families on lower incomes (Elkins & Zikgraf, 2018; Kovacic et al., 2021). For example, providing fruit and vegetables, and modelling eating them may be difficult despite research suggesting early exposure to fresh foods leads to better consumption (Rubio & Rigal, 2017; Schwartz, 2011; Skinner et al., 2002). Food shortages and/or living in food deserts introduce additional provisioning problems (Lim et al., 2021). In ANZ growing inequity may exacerbate issues, with food insecurity a reality for one in five ANZ children (Ministry of Health, 2021). Internationally, Estrem and colleagues' (2022) in their meta-analysis of PE express concern that data recording sex, race/ethnicity, and socioeconomic position are frequently absent. Unfortunately, those children needing the most support are likely missing from such data.

How eating is culturally understood may also contribute to whether feeding is seen as a problem. Tastes and activities at mealtimes are family specific and contingent upon history, culture, socioeconomic status, and experience (Bialek-Dratwa et al., 2022; Harris, 2008). The social context in which it occurs therefore significantly shapes eating practices (Sdravou et al., 2021). Moreover, the various factors that contribute to eating patterns are interrelated (Bialek-Dratwa et al., 2022). In ANZ it is therefore important to assess potential differences in feeding problems between ethnicities.

To date there is no specific study of PE for Māori or Pacific children in the research literature. Some studies on food-related matters do mention PE, such as Glover et al. (2019) in their study of Māori food provisioning decisions. Similarly, Haszard et al. (2015) discuss how overweight, and PE intersect for low-income parents, including Māori and Pacific families. Greater reference to PE, is though, made in McKelvie-Sebileau and colleagues' (2023) analysis of free lunches in low-income schools. The document discusses a variety of topics

obtained via focus groups with students, family members, and principals, such as family and student perceptions, and experiences with the lunches provided. Similarly, Galloway et al. (2018) discuss PE in depth in their survey of parents of young children. The study focused on the influence of socioeconomic parameters and PE on growth. However, despite having many Māori and some Pacific participants in both these studies there is little discussion about cross-cultural differences.

Despite lack of current research, culturally appropriate approaches to food and feeding may indeed vary between ethnicities. Glover and colleagues' (2019) study using focus groups found low-income Māori parents had specific beliefs around mealtimes, weight, and general provisioning of food. In general, PE, although noted, was not a primary concern for families. However, despite the lack of literature, non-European families still struggle with PE. For example, the clinical nurses from Ora Toa, the Māori-focused Wellington-based health centre, communicate many Māori parents struggle with food refusal similar to their ANZ European counterparts. Similarly, in private practice I work with clients from many different communities, including Māori. Therefore, it is important for research in ANZ to explore PE across ethnicities while being mindful that ideals are in part determined by prevailing discourses.

Wider Social Discourses Shaping PE

Over the last 50 years many western countries, including ANZ, have adopted a neoliberal political and economic ideology (Barnett & Bagshaw, 2020). Within this framework is a focus on individual responsibility. Personal obligation encompasses the health sphere, where people are deemed in control of their wellbeing (Barnett & Bagshaw, 2020). These principles also extend into parenting, with mothers particularly responsibilised (Lupton, 2014). A useful lens through which to understand this ideology was developed by Hays (1996).

Within Hays's (1996) concept of intensive mothering, a mother becomes duty bound and responsible for the physical, social, emotional, and cognitive development of her child (O'Brien et al., 2020; Riley et al., 2019). In the health domain, Lupton (2009; 2014) showed in her study of 60 Australian mothers that women drew upon discourses that situated good health as controllable, the outcome of careful management, and therefore the importance of constant promotion of the child's wellbeing as the mother's responsibility.

Discourses surrounding motherhood are conceived, supported, and disseminated through the media, peers, institutions, and families (Eccles 2011; Lupton, 2011; O'Brien et al., 2020; Tosun et al., 2020). These sites of communication often inform each other, creating a set of regulatory discourses (Riley et al., 2019). Further, in a world where social media is ubiquitous, idealised notions of child-rearing have created a new locus for social comparison as well as support (Coyne et al., 2017; Henderson et al., 2016; Tosun et al., 2020). Although understandable that parents use their own and their children's peers to gauge conformity such as eating competence (Estrem et al., 2018), discourses of good motherhood are often contradictory, introducing uncertainty.

There is also the risk of censure should parenting not conform to accepted norms (Knapp, 2021; Verniers et al., 2022). However, idealised parenting has been received, internalised, resisted, or adapted to varying degrees by individuals (Hamilton, 2016; Riley et al., 2019). For example, research into parents of PE has shown that some acknowledge they are located with within normative discourses of parenting (Chilman et al., 2023; Cunliffe et al., 2022). Relatedly, that social messaging has impacted on help-seeking trajectories (Cunliffe et al., 2022; Rubio & Rigal, 2017). Mothers do not want to be seen as unable to feed their child properly, and often feel judged by others (Cunliffe et al., 2022; Harman & Cappellini, 2015; Lamm, 2022). Indeed, Lamm (2022) found parents were unwilling to speak to other parents who did not appreciate the extent of their issues.

Stigmatisation may also be experienced particularly where there should be support, such as among extended family (Cunliffe et al., 2022; Estrem et al., 2019; Silverman et al., 2020). In Rubio and Rigal's (2017) research on families with young picky eaters, parents were judged for not meeting social expectations, were asked to justify why their child was not eating, and their parenting skills were challenged. Therefore, in a culture where individual responsibility is promoted the failure to meet standards is often situated as an individual failure but one that may be hard to avoid publicly, for example, through the contents of a lunchbox (Watson-Mackie et al., 2022).

Conversely, evidence that mothers may not appreciate the influence of wider discourses has also been demonstrated. In the US, Henderson and colleagues (2016) found that 26% of their study participants, mothers aged 18–50, felt parenting expectations came from

themselves. Rather than situating influences as external, they internalised blame for not being the perfect mother while simultaneously striving to live up to normative ideals. Cultural norms determined subjectivity by appearing as a given (Riley et al., 2019). In fact, Foucault (1985) argues that what may be thought of as unilateral decision-making within the family is at least partially determined by biopolitics, and Wiggins (2023) found there were even normative patterns in the way parents talk about food (Lupton, 2014).

There are also particularly gendered aspects to parenting social dictates, also demonstrated in practice. Despite mothers routinely being in paid employment, women are still primarily in charge of domestic chores and the advent of children exacerbates the division between genders (European Commission, 2018). Cognitive labour of care as coined by Daminger (2019) has also frequently been allocated to women. In this role mothers are a household project manager, ensuring needs are met and progress achieved, particularly in relation to children. The pressure to manage competing interests can be fraught, but with an imperative to execute well.

Indeed, the expectation to be the ideal parent, but more so, mother, has become ubiquitous (Harman & Cappellini, 2015; Henderson et al., 2016; Rubio & Rigal, 2017). In Henderson's (2016) study of mothering in the US, additional stress, anxiety, and impaired self-efficacy occurred under pressure to be perfect. Guilt if not achieving parenting expectations specific to feeding has been shown to occur frequently alongside worry and frustration among parents of picky eaters (Cialdini, 2005; Wolstenholme et al., 2020). However, Henderson (2016) found internalised guilt was evidenced even when not subscribing to an idealised mothering discourse. Similar results were found by Seagram and Daniluk (2002) in Canada where mothers measured themselves against perceived standards of motherhood even if recognising they were unachievable. Unfortunately, cultural norms are the way in which individuals make sense of self, and the constitution of the good mother can be an integral part of self-identity (Lupton, 2009).

Many scholars agree that children's dietary intake is situated primarily as a mother's responsibility, part of good mothering and subject to moral discourses determining parenting quality (Berger, 2022; Faircloth, 2021; Harman & Cappellini, 2015; Hays, 1996; Lupton, 2009; Maher et al., 2013; Watson-Mackie, 2022). The gendered aspect is apparent in research studies. Despite numerous recent qualitative studies including male caregivers,

they are always a minority and often recruited as part of a parenting dyad (Chilman et al., 2023; Cunliffe et al., 2022; Estrem et al., 2018; Lamm, 2022; Rubio & Rigal, 2017; Trofholz et al., 2017; Simione et al., 2020).

While the feeding sphere seems to attract particular scrutiny for all women, some mothers experience this more intensely. For example, Lupton (2014) found mothers from a lower socioeconomic background attracted more surveillance of their parenting both socially and from HCP. Intersectional analysis of these patterns of parental experience is therefore important since race, age, and socioeconomics intersect with gender. For example, Lupton (2014) found teenage mothers may not be afforded the same respect as older women in medical encounters. Relatedly, children may be viewed through a notion of normality. Feelings of inadequacy and even blame may therefore be levelled at or felt by parents whose children have developmental or behavioural differences.

However, the focus on mothers has also not only been at the individual level. Government policy and media attention pertaining to long-term outcomes of food choices made by mothers have also been widely discussed. Gendered aspects in social and governmental directives that prioritise health thereby become entrenched (Maher et al., 2013; Lupton, 2014; Watson-Mackie et al., 2022).

ANZ, like many nations internationally, has set dietary guidelines for ideal consumption of fruit and vegetables per WHO mandates (Curran-Cournane & Rush, 2021). Locally, five servings per day, per person, have been advised (Curran-Cournane & Rush, 2021). Across the life course, whole and minimally processed foods prevent malnutrition and adverse side-effects including non-communicable diseases, and substantial research confirms the protective effects of fruit and vegetable-rich diets (Aune et al., 2017; Donaldson, 2011; Sattar & Forouhi, 2021; Wang et al., 2021; WHO, 2018). However, in ANZ, the Ministry of Health (MOH) finds, in general, vegetable intake is low, although, despite the overall protective effects of vegetable consumption, specifics are challenging to isolate (MOH, 2019). How humans eat is complex and nutrients combine from multiple foods in complicated, interrelating ways (Sattar & Forouhi, 2021).

Additional complexities and emphasis arise when discussing children (Lupton, 2009; WHO, 2012). In part this is due to the importance placed on early habits for best long-term

outcomes, but also, as children's food choices rely on adults, who control the immediate environment and food-provisioning decisions (Lupton, 2009; Lupton, 2014; Maher et al., 2013). Children also have a reduced capacity for understanding longer-term consequences of behaviour (WHO, 2012). Despite the power differential, it would, however, be naïve to position children as totally subordinate to adults or passive without individual choice or preferences (Lupton, 2014). A child's capacity for independent decision making will also change as they age. Nevertheless, contemporarily, the importance of children's consumption of sufficient vegetables is a social mandate with responsibility resting with parents, particularly mothers (Lupton, 2011; Riley et al., 2019). There is, however, little recent qualitative research pertaining to vegetables and PE with only minor reference in the studies of Chilman et al. (2023), Rubio and Rigal (2017), and Trofholz et al. (2017).

Importantly, research shows parents are generally well-informed about nutritional advice (Watson-Mackie et al., 2022). Therefore, children not consuming "5 a Day" is likely due to the complexity of compromise between guidelines and the practicalities of feeding children (Lindsay et al., 2021; Lupton, 2014; Maher et al., 2013; Riley et al., 2019). Multiple considerations from budgetary and time constraints to availability of food and children's preferences are necessary and yet these are not accounted for when assigning responsibility to mothers (Lupton, 2013; Lupton, 2014; Maher et al., 2013; Watson-Mackie et al., 2022). Maher et al. (2013) cite an example from an Australian state government website that reassures parents that two year olds are likely to refuse food. The importance of establishing healthy eating patterns is then explained as a way to prevent obesity and eating disorders. Parents are simultaneously warned their child may not eat and cautioned they must eat. Similar seemingly contradictory and therefore potentially unattainable goals through government messaging have been cited by Lindsay and colleagues' (2021), often with a social and moral imperative attached to following advice (Watson-Mackie et al., 2022).

Implicit messages are also prevalent, for example, 5 a Day is optimal and therefore by logical extension, not meeting this is bad. These messages may serve to disempower mothers by undermining their confidence (Riley et al., 2019). Although not specific to mothers, these messages have a particularly gendered aspect.

The necessary language of compromise is also often absent from health guidelines (Lindsay et al., 2021). However, comprises are inevitable when a child eats a limited diet. Watson-Mackie and colleagues (2022) found mothers of picky eaters ensured their child ate at school by catering to preferences, a practice deemed even more important for neurodiverse children. Indeed, in PE research, eating according to healthy guidelines was found difficult for some children (Chilman et al., 2023; Lamm, 2022, Simione et al., 2020). Studies have also found acceptance that feeding is non-normative can be supportive for parents (Chilman et al., 2023; Cunliffe et al., 2022; Trofholz et al., 2017). However, parental compromise, may introduce internal conflict.

Uncertainty, although uncomfortable, may though facilitate resistance of some social pressures, and support better parenting, which at its core is relational and responsive (Pugh, 2005). In fact, unique knowledge of a child and the ability to reject inappropriate advice is part of effective nurturing (Lupton, 2014; Maher et al., 2013). Unfortunately, refusing to accept social and/or medical recommendations may also disempower parents, unable to both follow normative health dictates and care for their child (Harman & Cappellini, 2015; Lupton, 2014). Experiencing negative emotions can also affect the ability to parent as successfully with effective feeding dependent on parent/child relationships (Riley et al., 2019; Wiggins, 2001).

Mothers may also allocate some blame to themselves for their child's PE (Wolstenholme et al., 2020). Not only do parents feel culpable, but higher levels of stress, anxiety, and depression have been found in mothers of picky eaters (Chilman et al., 2021; Lim et al., 2021; Silverman et al., 2021). Through PE, women are potentially placed in a position where they are unable to perform the role of good mother, which is a highly emotive subject position (Riley et al., 2019). Their self-beliefs may also underscore behaviour.

Supplements as a Solution

The importance of vitamins and minerals for overall health is long-standing (Tardy et al., 2020). Therefore, if PE prevents adequate intake, many parents turn to supplements like multivitamins to fill the gap. Although seemingly logical, research questions the efficacy of multivitamins. Martini and colleagues (2020) echo many researchers in considering a balanced diet as the best source of nutrients, particularly during growth, with evidence-based medicine dictating supplement use (Chen et al., 2019; Lentjes, 2019). However, Bailey

et al. (2013) explain there is little available scientific evidence or indeed scientific inquiry into supplement benefits even for nutrient-deficient children. Nevertheless, many children are deficient in one or more vitamins or minerals (Martini et al., 2020; Nogueira-de-Almeida et al., 2023; Stewart et al., 2015; Woźniak et al., 2022). Indeed, Black et al.'s (2014) study of children in the US found it was impossible to meet requirements for certain vitamins, even when eating fortified foods on a "standard" diet.

Stewart and colleagues (2015) examined supplement use among children with autism in the US. They concluded there was no difference in requirements between children with ASD and their neurotypical peers; however, children with autism were more frequently given multivitamins (Stewart et al., 2015). Although not focused on picky eaters, their results are important and corroborated by other studies focused on children from the general paediatric population (Bailey et al., 2013; Dwyer et al., 2013). These researchers found common nutrient gaps for vitamin D, calcium, potassium, choline, and pantothenic acid, due to dietary deficiency and these were not adequately supported by multivitamin supplementation. Further, even after specific supplementation, a large percentage of children still showed inadequate levels of calcium and vitamin D.

Conversely, micronutrients readily obtained from the diet such as vitamin A, folate, and zinc were present in multivitamins causing in some cases excess consumption (Bailey et al., 2013; Dwyer et al., 2013; Stewart et al., 2015; Zhang et al., 2020). Moreover, a study of supplements in Canada found many contained higher doses of multiple micronutrients over recommended intake (Elliott, 2019). Excess intake comes with risk. The probability of overconsumption is greater in younger children due to lower daily needs and labelling often based on adults (Stewart et al., 2015). Excess intake of micronutrients may also be exacerbated by fortification of foods. Fortification is widespread in foods that are frequently consumed by picky eaters, such as cereals and grain-based products (Stewart et al., 2013). There is concern that supplements are not well-regulated, and assumptions made by consumers that may be incorrect or even risky (Bailey et al., 2013; Dwyer et al., 2013; Elliott, 2019).

Specific nutrients may however be necessary under medical supervision to correct deficiencies (Martini et al., 2020). Iron deficiency, for example, is the most common micronutrient lacking for children worldwide (Saavedra & Prentice, 2023). Rectifying iron

deficiency is important for optimal development and is commonly tested for; however, it may not be the only micronutrient lacking in a restrictive diet (Armitage & Moretti, 2019; Bailey et al., 2013; Dwyer et al., 2013). In their meta-analysis, Saavedra and Prentice (2023) caution that attention to nutrient deficiencies in school-aged children has been disproportionately low with focus primarily on those younger. However, the school years represent a time of growth, and essential stages of development such as puberty.

Ensuring that children grow and develop optimally is important; however, perhaps it is more relevant for picky eaters. In a small clinical trial in Brazil supplement intervention for picky eaters aged 2–5 years increased weight (Nogueira-de-Almeida et al., 2023). However, the weight gain was noted to be stature rather than fat. Lampl et al. (2016) argue which metrics are measured and deemed important is critical. They caution against using weight as a parameter as it is not a growth proxy. The authors discuss this particularly in the context of supplement drinks such as Pediasure (a children's supplement drink produced by Abbott Nutrition). Pediasure contains a high percentage of sugar and oils. As Lampl and colleagues' (2016) point out, these excess calories produce weight gain, but this is not growth.

A trusted research base on the necessity of supplement drinks such as Pediasure for PE is absent. Most published studies are either sponsored or conducted by corporations with vested interests in promoting supplement intake. There were, however, other studies available not specific to PE, focused on the downsides of supplement drinks for the general paediatric population. Both recent studies, and the American Academy of Pediatrics (Milanaik et al., 2019) advise supplement drinks are only applicable when children cannot consume sufficient nutrients from their diet (Beulick et al., 2020). Lampl et al. (2016) further caution against potential unintended side-effects from Pediasure such as stunting flavour and texture preferences and building a predilection for high-sugar drinks and food.

For some parents, supplement drink use may also cause tension (Maher et al., 2013). In their study of mothers in Australia the authors found Pediasure usage was a source of guilt despite the recommendation from their HCP. The drinks enabled a commitment to child wellbeing by providing additional nourishment; however, this was not the responsibilised norm and so deviated from best practice. Further, it was, to a degree, evidence of failure to meet good motherhood injunctions of being able to feed a child sufficiently without medical intervention.

Chapter Three: Picky Eating and Medical Practitioners

Doctor–Patient Relationship, Implications for PE

Patient-centredness is internationally recognised as integral to optimal care (Bodegård et al., 2019; Jeffrey, 2016). Both the Organisation for Economic Co-operation and Development and the WHO made patient-centredness central to ensuring patients' needs, values, and preferences are prioritised (Epstein et al., 2005). Despite this emphasis, no country ranks consistently well across all measurable indicators of patient-centred care (Paparella, 2019). Simione and colleagues' study (2020) exploring medical care for PE found that family-centred care was critical for improving a child's overall health and quality of life, and in general medicine, Munthe et al. (2012) found recurring themes in the literature around patient-centred care, such as collaboration and narrative. Shared decision-making is, however, only possible if a doctor enables the patient's narrative.

A patient's narrative is their initial outlining of their problem, including thoughts, feelings, and experiences, and their agenda that lays out ideas, expectations, and concerns (Barry et al., 2000; Bodegård et al., 2019; McKinley & Middleton, 1999). From this, a doctor can summarise questions and answers enabling a patient to receive the information required to participate in decision-making (Matthys et al., 2009). Critical to doing this effectively is trusting patient or caregiver intuition, believing they know when something is wrong (Glynn, 2014).

Unfortunately, if patient-centred elements are not prioritised, information is frequently missed in the communication between doctor and patient (Lin et al., 2005). Unsatisfactory communication results in less positive outcomes, from patient dissatisfaction to rate of recovery (Matthys et al., 2009). Medical interviews/consultations are still considered the best diagnostic tool for doctors, so positive initial interactions are crucial for best outcomes (Kennerly et al., 2012; Khawaja, 2022). A patient-centred approach is particularly important for the vulnerable (Little et al., 2001). Caregivers of PE may indeed be vulnerable when experiencing stress and worry about their child's condition, particularly where problematic eating may be seen as a reflection on their parenting.

A patient-centred interaction facilitates the core interlinked functions a GP performs: first, information gathering, second, forming and sustaining a therapeutic relationship, and third, imparting information. If there is a breakdown in any area, quality of care is lost (Dorr Goold

& Lipkin, 1999; Liddell et al., 2022). Similarly, a better encounter is achieved when patients feel heard (Dorr Goold & Lipkin, 1999). The length of time spent addressing an issue appears to be less important than the perception a patient is heard. Open and responsive communication is essential to build understanding, produce accurate decisions, and show care (Beitat, 2015).

Care is an important word in medical encounters, particularly for the vulnerable. An overly positivistic stance, focus on the biomedical, the commercialisation of medicine, overwork, and mechanistic systems can all reduce empathy and psychosocial concern (Jeffrey, 2016). Similarly, empathy is important in fostering relationships and Mercer and Reynolds (2002) suggest this quality in doctors means the ability to fully comprehend a patient's perspective and situation and act upon these collaboratively.

Empathy is particularly important in multi-cultural societies. It is a way to communicate that utilises cognitive and affective ways to comprehend a patient's experience while simultaneously respecting and preserving difference (Jeffrey, 2016). When working with patients from diverse backgrounds, appreciation of difference is important. Empathy is also integral to GP–patient interactions, finding balance between professional distance and compassion (Coplan & Goldie, 2011). Further, empathy is essential for effective diagnosis and treatment as it enables better understanding of the patient's situation and therefore the appropriate course of action (Jeffrey, 2016; Mayer et al., 2008). Indeed, empathetic doctors have better clinical outcomes and patient satisfaction (Derksen et al., 2013; Mercer et al., 2008). Empathy is best understood to improve outcomes through trust building (Halpern, 2012).

The relationship with the practitioner is, therefore, important. A dislike or mistrust of the GP may interfere with communication and disclosure of information (Dorr Goold & Lipkin, 1999; Fitch, 2017). Moreover, when expectations of trust are not met then ongoing trust is eroded (Lewicki et al., 2006). Trust is particularly important when patients are revealing potentially sensitive information with expectations that it will be handled appropriately and with best intentions (Fitch, 2017). Indeed, trust is an essential component of effective interactions, affecting everything from level of satisfaction to medical outcomes (Bova et al., 2012; Brennan et al., 2013). Trust may also be contingent on the background and culture of the patient or doctor. Glynn (2014) found medical literacy was an important factor in

determining the quality of health-service interactions and this was frequently contingent on socioeconomic position. Similarly, Fitch (2017) established that Māori and Pacific patients were less likely to trust GPs than NZ Europeans. The power differential between doctor and patient and/or coloniality may contribute to this.

The ongoing shift from a more paternalistic relationship towards patient self-care and contribution to decisions makes trust an important component, particularly in the age of mass media and accessibility of information (Shrivastava et al., 2014). The rise of the informed consumer could also either support or interfere with medical interactions (Glynn, 2014). When caregivers are more informed trust is built only if their opinions are respected. Relatedly, trust in public health overall can affect the way individual doctors are perceived (Hardie & Critchley, 2008). Trust is a two-way concept necessitating trust of both doctor by the patients and the reverse (Brennan et al., 2013).

Establishing a rapport is therefore critical in providing optimal care, and ideally the relationship is ongoing (Detz et al., 2013). A systematic review of the importance of continuity of care found it was associated with lower mortality rates (Pereira Gray et al., 2018). Patients across nationalities and backgrounds benefit from ongoing care with either their GP or specialist medical practitioner (Haggerty et al., 2003). Unfortunately, the system in ANZ does not always support this and, yet, interpersonal factors are repeatedly shown to be important, regardless of technological advances in medicine (Silwal et al., 2023; Skirbekk et al., 2011). Indeed, in their PE study in the US, Simione and colleagues (2020) interviewed parents to ascertain the most important attributes of a HCP. The number one characteristic was personable, second, that the HCP was accessible in the community, third, that the HCP was knowledgeable and experienced, and, finally, that the doctor collaborated with caregivers and other professionals. All these speak to the importance of the relationship between HCP and caregiver. In ANZ these findings are particularly relevant within a system that is not consistently able to provide continuity of care.

It is also important to recognise care may not be equally accessible and appropriate across communities or cultures. Even within a publicly funded health-care system, out-of-pocket expenses, for example, to access primary care may be exclusionary. In a study of pre-schoolers Jeffreys et al. (2022) found approximately 5% of children in ANZ were unable to visit a GP when necessary, and this inability to access care primarily affected Māori and

Pacific families. Further, Reid et al. (2016) found quality and non-discriminatory care was more likely when Māori patients were able to access their preferred GP.

Therefore, a presumption that a GP will act in accordance with a child's best interests and that an issue is taken seriously is important and also indicates respect (Croker et al., 2013; Fitch, 2017). If caregivers perceive this is not the case, they are left struggling to find viable alternative options. Reduced trust in that GP and even the medical profession as a whole may result (Fitch, 2017). As the interaction with a GP is a two-way relationship doctors may also find they are not able to meet the expectations of caregivers (Fitch, 2017). However, a compassionate GP may provide comfort to caregivers even though they are unable to resolve issues (Ong et al., 2014). Finding compassion and validation of concerns when help-seeking may be invaluable. However, in the case of PE the first hurdle may be finding a HCP with appropriate knowledge of feeding issues.

Doctors and Picky Eating

Multiple studies reflect the lack of adequate education around nutrition in general for doctors (Adamski et al., 2018; Caldow et al., 2022; Carter et al., 2022; Crowley et al., 2019). Relatedly, a biomedical reductionist focus may silo problems and seek specific solutions in individual medical problems rather than seeing the child more holistically (Rocca & Anjum, 2020). Isolating issues, for example, PE and sensory challenges, may not lead to best outcomes (Cunliffe et al., 2022). Despite this, parents with PE often start help-seeking through primary care (Silverman, 2010).

In ANZ, Jackson, and colleagues (2022) analysed survey responses from HCP using both quantitative and qualitative methods. They found limited understanding of PE challenges among GPs, and local research into the area virtually non-existent. Internationally, five recent qualitative studies have touched on appointments with doctors when help-seeking for PE (Chilman et al., 2023; Cunliffe et al., 2022; Estrem et al., 2019; Lamm, 2022; Simione et al., 2020). Although not the focus of their research, the studies show struggles to find help, that HCP lack knowledge about PE issues, and that criticism of parenting may be apparent. These issues may lead to mistrust of medical professionals (Lamm, 2022) and prohibit early intervention. Overall, the research suggests limited experience and protocols around PE are barriers to treatment (Cunliffe et al., 2022; Simione et al., 2020). The assessment and management of problems is further complicated by the diverse

presentation and progression of PE issues (Mudholkar et al., 2023). Indeed, Chilman et al. (2023) found practitioner evidence-based knowledge of ideal feeding practices was desirable by parents. Similarly, Cunliffe et al. (2022) concluded awareness of parental lived experiences by GPs is important for better comprehending issues.

Unfortunately, misunderstanding by a HCP, particularly when combined with that of family and friends, may lead to caregivers doubting their competence and therefore internalising doubts and stress (Silverman et al., 2021; Thomlinson et al., 2002). Indeed, stigma can prevent help-seeking (Lamm, 2022) and having concerns dismissed or receiving ineffective care challenge parental perceptions and impact on quality of life (Cunliffe et al., 2022; Estrem et al., 2018; Fracchia et al., 2017; Galloway et al., 2018; Lamm, 2022). Relatedly, Ong and colleagues (2014) found that superficial medical reassurance that feeding issues are not a concern potentially increased anxiety and frustration rather than helped caregivers. The situation is magnified for children who are perceived to be underweight or not growing well.

However, both Cunliffe and colleagues' (2022) and Lamm (2022) have found parents are well placed to determine whether their child has problematic feeding that requires intervention. Therefore, for all parents, a medical professional who does understand is important confirmation of caregiver worries for their child and experienced as relief, as shown across studies (Chilman et al., 2023; Cunliffe et al., 2022; Lamm, 2022). However, Lamm (2022) also found parents felt lucky and were surprised when this happened.

Relatedly, and importantly, agentic parents able to advocate for their child is a core feature of positive outcomes (Chilman et al., 2023; Cunliffe et al., 2022; Lamm, 2022). Lamm's (2022) study, along with those of Estrem et al. (2018) and Simione et al. (2020), focused on parents of children with clinically diagnosed presentations of feeding issues where medical attention was essential and therefore determinedly pursued. Similarly, in Chilman et al.'s (2023) and Cunliffe et al.'s (2022) research into parents with extreme picky eaters, once PE was believed to require medical support, they took action, although it is unclear how long they waited before help-seeking. Medical intervention was not prioritised to the same degree in other qualitative studies where PE was not perceived as extreme, and therefore not seen as damaging (Rubio & Rigal, 2017; Trofholz et al., 2017).

However, there is argument that, regardless of the severity of the issue, parents should be taken seriously by a HCP (Kerzner et al., 2015). Saarilehto et al. (2004) take this one step further and feel if a parent says there is a problem, there is. As behavioural manifestations are likely to be apparent before physiological change (Aldridge et al., 2010) more acknowledgment of caregivers' concerns may be prudent. Research suggests there are several tools that could readily be implemented to recognise feeding problems. For example, a modified Infant and Child Feeding Questionnaire (Barkmeier-Kraemer et al., 2017) with six screening questions has been used effectively in the US. Other authors have suggested that screening tools can be used effectively to assess caregiver stress as this too can impact on feeding behaviours (Dharmaraj et al., 2023). However, Estrem and colleagues (2016) believe it is far simpler: restrictive or selective eating in combination with problematic feeding behaviours are indicative of an issue. Should these two factors be evidenced, the next step is to ascertain where on the PE spectrum children sit. To not intervene when necessary is to potentially risk a child's development, contravening their rights, and also possibly affect wider family wellbeing.

In line with these recommendations, both researchers and experts in PE caution that traditional methods of measurement are not sufficient to detect and understand the extent of feeding problems (Chao & Chang, 2017; Lim et al., 2021). Growth charts are one measurement within one aspect of a condition that spans four domains. Weight or growth may also not be the key issue; in fact, even obese children may be PE (Davies et al., 2006). Similarly, Chilman et al. (2023) conducted a study of extreme picky eaters in Australia and all were normal weight or above. Lamm (2022) cautions though, that parents may make considerable effort to ensure their child maintains weight. Indeed, in her study, calorific intake was a priority. Conversely, a dogmatic focus on calories, "fed is best", may cause conflict for some parents as found by Chilman et al. (2023) and Simione et al. (2020). Therefore, on several levels, using weight gain or statis as confirmation PE is absent potentially misrepresents problems, or misses considerable numbers of children with feeding challenges (Kerwin, 2003).

Further, not attending, for example, to the stress caused by interactions between child and caregiver may lead to poor outcomes (Lim et al., 2021). Harmonious meals have been shown to improve PE (Walton et al., 2017). As learning to eat new foods is often a process requiring

ongoing effort, positive interactions and perceptions are important (Wolstenholme et al., 2020). Research therefore suggests early and involved intervention with child-centred care alongside working with the family as an integrated and integral unit is essential (Coyne et al., 2016). Caregivers should be an intrinsic part of feeding solutions. Feeding takes place multiple times per day so empowering parents facilitates better outcomes. Caregivers also have unique insights into their child (Dokken et al., 2015).

The importance of appropriate support for caregivers of children with co-morbid developmental or physical challenges is perhaps more essential, as the pressure to provide optimal nutrition can be more pronounced (Estrem et al., 2016). Similarly, certain medical labels may affect caregiver behaviours, even after an issue is resolved. For example, failure to thrive (FTT – a failure to grow, add, or maintain weight) labelling can introduce long-term concerns (Estrem et al., 2016). Stigmatising language may be detrimental at any point in the help-seeking journey (Dokken et al., 2015). However, there is naturally some tension between what is developmentally normal food neophobia and what is a protracted problem with evidence that GPs do situate PE as a normative phase (Chilman et al., 2023; Lamm, 2022).

To avoid these often-escalating problems there are calls for medical professionals to support parents by providing education that may avoid common mistakes that can exacerbate issues and to help establish normative feeding (Ong et al., 2014). Indeed, gentle intervention may prevent PE becoming a problem (Brown & Perrin, 2020). As important as attention to PE though, is the way caregivers are received, acknowledged, and their concerns about their child validated. As GPs are the face of the medical system, what transpires in this first meeting may be critical.

GPs as first port of call and “gatekeeper” for referral services are in a unique position to influence the trajectory of a feeding problem (Cumming et al., 2014). Red flags indicating a problem can be identified and action taken (Estrem et al., 2016; Kerzner, 2009; Ong et al., 2014). Indeed, there is argument for feeding issues to be part of medical health checks, a suggestion made 45 years ago and not yet acted on (Sills et al., 1978). Unfortunately, effective treatment options are still being sought and tested, and referral to specialists fraught (Bourne et al., 2020; Goday et al., 2019). Zucker and Hughes (2020) find contemporarily HCPs are not adequately managing PE in children and that even research is

not where it needs to be. Perhaps these failings also point to a systemic issue requiring more importance placed on feeding across communities and public health (Silva et al., 2016).

Therefore, we know that the GP is first port of call, they do not specialise in feeding problems, PE is a contested issue given the normative transitory nature of some aspects of food refusal, and that inadequate care can have long-term negative consequences. What we need to establish is how HCP can better work with caregivers to identify and treat problematic PE in its nascent stages. One way to do this is to ask caregivers of picky eaters about their experiences of the health care system to provide insight into ways PE can be better managed. Qualitative interview studies provide an excellent way to hear parents' voices and appreciate the nuance of situations that may be lost even in comprehensive questionnaires. Understanding unique standpoints is important, particularly in PE where caregivers often have a wealth of experience both of feeding challenges and help-seeking.

Exploring the positive aspects of help-seeking sits within a wealth of literature showing the importance of an affirmative approach in organisations (Armstrong et al., 2020). One such approach, appreciative inquiry (AIQ), has been used in health-service research, including studies by Arnold et al. (2022), Chohan et al., (2020), Cooperrider et al. (1986), and Hung et al. (2018).

These studies show AIQ puts particular focus on the people within the system and invites individuals to discuss potentially sensitive issues in an ethical way. Many AIQ projects conducted in healthcare, such as hospitals, for example, also involve patient input (Carter et al., 2007). The current project will seek to do the same, speaking directly to caregivers about their experiences with their HCP where questions are designed to yield information about what is working well in ANZ. Participant experiences are an integral part of an integrated wider health system. An AIQ thus offers important direction for research on enhancing health outcomes for PE.

Aims and Rationale

As outlined above, research suggests PE is a substantial and growing issue. Moreover, left untreated, it can be detrimental for both children and families. PE must also be situated within a neoliberal and gendered focus on responsibility for children's health through diet, that places pressure on mothers in particular. However, research shows that

seeking help for PE may not be straightforward, and there are hurdles prior to, during, and after help-seeking. What the literature does not show is what happens when parents in ANZ visit their HCP and have a positive experience. Exploring these encounters is important, as is conducting research in an affirmative way. Accordingly, I pose two research questions:

What makes experiences positive for parents of PE when visiting their HCP?

Have their positive interactions with GPs led to effective treatment of picky eating and, if so, what are the pathways/treatment options?

Chapter Four: Methodology

Introduction

I have a long-term professional interest in PE, running a private practice working with parents of picky eaters. Therefore, this thesis develops research in an area where I was aware of a lack of prior study. The research questions, designed to contribute to the existing literature, were answered using appreciative inquiry informed interviews (AIQ) for data collection and narrative analysis (NA) for analysis. As both use the same epistemological approach this section begins by discussing the theoretical underpinnings and a detailed rationale for choosing these methods.

Theoretical Framework

Epistemology

Epistemology is the theory of knowledge and in research it is important to explicitly state what knowledge is, where it comes from, and how it presents in human existence and experiences (Crotty, 1998). The epistemological standpoint provides context and a grounding of assumptions, which in turn informs the methodology and methods section (Carter & Little, 2007). Different epistemological positions lead to different ways in which research is completed and the outcomes presented. Indeed, Ludema et al. (1997) argue that what a study discovers is determined by the epistemological stance, which in this study was social constructionism.

Social Constructionism

Social constructionism presents a post-modern understanding of the nature of reality where people, their language, and their interactions shape the world and how it is understood (Burr & Dick, 2017). The core understanding is that our perception of reality is a social construction (Andrews, 2012). Therefore, individuals understand things differently dependent on background, culture, and the context of that understanding, without there being a true reality discoverable (Burr, 2018). Social constructionism does not search for an objective truth, but an appreciation of how individuals understand an issue, and how this understanding shapes thoughts, feelings, and behaviours.

Methodology

Appreciative Inquiry

AIQ is underpinned by social constructionism, because it argues that the meaning people attribute to reality is generative, as it leads to action, and that what is focused on becomes our reality (Armstrong et al., 2020). Further, that focus in AIQ is centred on positives. Rather than address deficits, AIQ recognises, appreciates, and nurtures the favourable. In this way a positive perception of reality is self-fulfilling and constructs positive social realities. Although this is accepted by most proponents of AIQ, there is some critique in this area. Van der Haar and Hosking (2004) question whether the insistence on the positive introduces an inadvertent contradiction, by producing the imperative to communicate in a specific way and therefore preclude genuine openness in communication. Cram (2010), however, resolves this tension by arguing that affirming questions result in both positive and negative responses, therefore providing contextualised answers useful for understanding a topic in rich detail. Further, Bushe (2013) argues AIQ is not in fact looking for positives. Instead, and this is an important distinction, it is seeking the generative, which he defines as a challenge to the status quo (Bushe, 2013). People envision new options that may not have been previously apparent, and they become the goal. Indeed, AIQ was not designed to ignore difficulties or problems, rather that a positive agenda is chosen to begin a project (Michael, 2005).

However, to appreciate why AIQ was chosen as method of data collection, it is important to understand its roots, contextualise how the core principles came about, and appreciate why they are central to the methodology. As AIQ was developed from participatory action research (PAR) by Cooperrider & Srivastava (1987) in the late 1980s, discussion begins there.

PAR grew from the need to address issues with disadvantaged members of society (Kidd & Kral, 2005). The integration of the three core tenets – participation, action, and research – led to a novel way of addressing issues within a community. PAR is collectively underpinned by an assumption that the group of study are experts in their own lives (Cornwall & Jewkes, 1995; Nelson, 2017). The community of study are, therefore, those who provide the solutions. Through participation that is democratic and equitable, agency and voice are afforded to those not normally heard. AIQ uses these core tenets, being focused on co-creation of knowledge with input from all contributors to the project valued, and

information used to formulate ongoing action. AIQ emanated from Cooperrider's (1987) study of doctors in a medical centre. He was surprised at how innovative, cooperative, and collaborative staff were when at their best (Coghlan et al., 2003). Cooperrider et al.'s (2003) observations led to his hypothesis; a focus on the positive aspects of an organisation alongside questioning what creates those strengths and makes it successful leads to positive change.

AIQ was deliberately chosen for its positive approach and positioning. However, it was also important the methodology aligned with the tenets of Te Tiriti o Waitangi. According to Cram (2010), AIQ is appropriate for use as a whānau research method. Affirmative questioning also has the potential to enhance cultural identity (International Institute for Sustainable Development, 2000). Adhering to culturally appropriate practices is consistent with an AIQ interview framework. As a Pākehā researcher I sought to follow Cram's (2010) suggestions for researcher conduct working with Māori (see Appendix A), while having the principles of AIQ front of mind.

AIQ is based on five key principles, derived not only from social constructionism, but also image theory and grounded theory (Cram, 2010). Image theory proposes that the vision a person has of their future influences their decisions. From grounded theory, AIQ borrows the assumption that people provide the means to understanding their culture and lifeworld, and that to research is also to intervene (Whitney & Trosten-Bloom, 2003). Organisations are positioned as dynamic systems that change when members contribute to the dialogue and transformational process (Bushe & Kassam, 2005). There are also core beliefs about human nature and organising that are foundational to AIQ and rooted in social constructionism. For example, individuals and groups possess innate unique skills and practices that can be leveraged (Whitney & Trosten-Bloom, 2003). The five core principles are discussed below.

First, the constructionist principle, whereby AIQ assumes individuals co-create their understanding of the world and the meanings given to interactions or experiences. Truth and reality are what we make of them. The social constructionism assumptions underpin the other four principles of AIQ. Second, the simultaneity principle, that all questions are leading questions. In asking a question change is created, linking firmly back to the constructionist epistemological stance; what we ask is fateful. Finding the question that

leads to the right direction, rather than choosing the perfect question, is the key. Third, the anticipatory principle, that images inspire action. People and human systems expend energy to move towards their future image. A positive conceptualisation of the future inspires a more positive contemporaneous action. Fourth, the poetic principle. Researchers choose what to study and that choice, in line with the epistemological underpinning, matters. Where you focus is what you find, so attention to problems begets more problems and conversely seeking success will yield more successes. Finally, the positive principle. Positive questions lead to positive change. Best results are gained from positive questions that amplify inherently positive aspects. Therefore, Hung and colleagues' (2018) believe AIQ has the ability to address information gaps using co-production of knowledge.

AIQ is generally used within organisations. Therefore, this study has been a relatively novel application, despite a growing body of AIQ research in health-care settings. However, many authors also believe it can be used in small groups, or even to facilitate change for individuals (May et al., 2011; Sandars & Murdoch-Eaton, 2017; Sullivan, 2004). It can also be applied to specific circumstances rather than needing to be all-encompassing. In this study, although not focused on an organisation in the traditional sense, medical services, which include consumers as well as providers, form an integrated system. Health is also a community concern and what happens in one part of the medical system is relevant across the organisation. Patients represent a specific and sizeable segment of that organisation. In this study, parents commented on the interface between patient as voluntary consumer and the wider medical arena. As GPs are gatekeepers and primary entry point into the public health system, what happens between a doctor and help-seeker is critically important. In order to explore this in ways likely to generate rich data and useful insights, the principles of AIQ were used.

The primacy of the underlying principles of AIQ rather than specific phases sometimes used in organisational studies, appears to be how practitioners in ANZ best use the methodology (Neumann, 2009). It also seems more indicative of Cooperrider's (1987) original intent. When Cooperrider first conceived of AIQ, he refused to delineate precise methodology, instead illustrating the principles (Bushe & Kassam, 2005). There is thus considerable latitude in designing processes that are fit for a project while adhering to the principles of AIQ. Despite this, an understanding of how other researchers have applied AIQ in projects

was important. Many have used a four- or five-phase system designed to create a practical process for formulating change across a system (Sanders & Murdoch-Eaton, 2017). Although focusing on the principles of AIQ, a brief description of the methodological phases will follow, with modifications specific to this project discussed.

Phase one was defining the topic of inquiry and the importance of determining what the system needs more of, specifying the project's purpose, content, and goals to achieve. Phase two, the discovery phase, requires carefully crafted questions, as what is asked can affect how ideas are framed (Ludema et al., 2006). Questions help identify the positive core, what is currently working (Cooperrider & Godwin, 2012). The discovery phase in this project explored what happened during encounters with a HCP, and why participants believed it was a good interaction. Heterogeneous families' stories were brought together to better appreciate factors contributing to affirmative appointments.

The third, or dream phase, is a collective envisioning of possibilities (Cooperrider & Godwin, 2012). In this study, participants were given the opportunity to comment on what would be ideal and/or how their experience could be replicated. Participants enthusiastically outlined their ideas for better future systems. Reflecting on positive experiences is also an affirming practice (Arnold et al., 2022). Indeed, Arnold and colleagues (2022) see AIQ as the intervention as well as the research methodology. Therefore, there can be benefits for participants right from the start. The fourth, design, and fifth, destiny/delivery, phases are focused on implementing change within organisations and so not relevant to this project's research question. The study therefore used AIQ in a non-prescriptive manner (Cram, 2010). However, in line with a view to change, results will be presented to interested health professionals for discussion.

Narrative Analysis

NA is a qualitative research methodology also underpinned by social constructionism (Neumann, 2009; Wolgemuth & Agosto, 2019). It draws attention to the importance of stories and how these are used to construct people's lives and discover more about individuals, cultures, and society (Wolegmuth & Agosto, 2019). NA may also represent knowledge that is not easily accessed through more traditional scientific methodology (Scheffelaar et al., 2021).

A narrative approach conceptualises that an individual's reality is subjective, and meaning is attached to it via narrative. Stories therefore provide insights into the de facto rules that govern social interactions and reflect the discourses we operate within (Crossley, 2008). Thus, even uniquely personal stories are told from within wider social conditions that make only some stories and identities possible (Silver, 2013). Murray (2009) suggests that, through storytelling, we develop a sense of identity and comprehend our relationship to others and ourselves. Therefore, in keeping with social constructionism, stories are not merely evaluated at face value (Esin et al., 2014; Scheffelaar et al., 2021). Instead, NA requires interpretation of how individual experience is a function of cultural structuration and the social, political, and economic environment rather than mirroring experience (Crossley, 2003; Ponterotto, 2005; Savin-Baden & Niekerk, 2007). There is also acknowledgement that these stories are specific across time and space (Clandinin & Connelly, 2004).

Telling a story is a creative process, and arguably narrating is thus a shared experience with participants changing and creating stories as they relay them (Clandinin & Connelly, 2004; Denzin, 1997). Although individuals explain their actions and behaviour through their stories, using them to exert order is, however, particularly common when there is tension between a person's daily reality and ideal self (Bruner, 1990). NA therefore provides the opportunity to engage with lived realities and the complexities of people's experiences (Neumann, 2009; Rhodes & Brown, 2005). The way in which narratives are structured conveys a particular meaning, and relays who people are and how they should be seen by others (Riessman, 2008). Narrative psychology seeks to explore these and other functions of stories used in interactions (Murray, 2003).

Whether NA was appropriate for use with Māori is also a key consideration in a bi-cultural nation. However, stories are frequently used in Indigenous cultures to pass on knowledge (Bishop, 2008; Ware et al., 2018;). For many Māori, the historical, cultural, and value-based grounding of stories is important to recognise and acknowledge, and NA allows for and accounts for this (Rhodes & Brown, 2005; Ruwhiu, 2008). In ANZ, studies of Māori have used NA as it enables participants to relay information in their own words, honouring both them and their voices (Wirihana, 2012). Although a mainstream Western methodology, NA is

thought to provide the means of cultural legitimation in the interpretation and outcomes of research (Ruwhiu, 2008).

In order to generate data for interpretation, semi-structured interviews (SSI) are commonly used. Although the rich data enabled through the collection of people's stories allow others to draw their own conclusions, the choices made by the researcher will reflect what is noted and discussed and therefore how the report reads (Hickson, 2016; Hosking & McNamee, 2007). The influence of the researcher is thus apparent at every stage prior to and during the interviewing through to identifying and deciding which stories to use in the final analysis (Murray, 2018). However, the choice about which stories are included is contingent primarily on those that answer the research question (Wong & Breheny, 2018).

NA has also developed in a way that encourages flexibility, using methodology that best fits a study. Therefore, it is important to specify precisely what has been done and why. As NA is used by practitioners in various ways, and does not have a definitive method, this became even more relevant (Polkinghorne, 1995; Wong & Breheny, 2018). Nevertheless, it is important to make the analysis process explicit, so the rationale and decision making is clear to the reader. Murray (2000) proposes a structured approach that accounts for the interrelationship between the narrator and the researcher, and how they work together. Neither party is impartial and are therefore influenced by their own values, beliefs, assumptions, and biases (Silver, 2013). In this way stories reflect not just recollections of caregiver's experiences, but also the interview in which data is collected (Neumann, 2009). It is important to be mindful of this both during interviews and subsequently in analysis. To add complexity, the intended audience for the study may impact on what and how stories are told, with them interpreting the data through their own cultural lens (Murray, 2008; Silver, 2013).

Although the knowledge produced is value-laden, it is important to obtain analytical distance. To do this, Murray (2000) proposes four interconnected levels that narrative operates out of (Wong & Breheny, 2018). The levels suggested were personal, interpersonal, positional, and ideological. Analysis at each level enables a better understanding of how stories are located within available social discourses. These levels are therefore not separate,

as ideological discourses determine available narratives for individual expression. Wong and Breheny (2018) however, took Murray's four levels and simplified to three, merging positional and ideological into one. These condensed levels have been used in analysis of the dataset in this study.

It is also important to clarify specific terms, such as what a story is. The word has been used variously, therefore, defining precisely what it refers to in this study was essential. When using the term story, I am referring to the account of an event retold by participants. In the analysis the story will be seen not just in terms of what is said, but what it may mean and in turn its relationship to other stories. Relatedly, when using the word narrative, I am describing the overall discussion of a participant's experience of PE, made up of individual stories. When describing the socio-cultural norms that contextualise information, these will be referred to as discourses since people use commonly available discourses to locate their stories.

Chapter Five: Method of Data Collection

Design

This study was a semi-structured interview design, informed by appreciative inquiry and analysed using narrative analysis. Participants were 11 mothers seeking help for their child's PE.

Recruitment

It was important for the study to be open and accessible to any parent wishing to participate. After extensive consultation, recruitment was therefore designed to appeal directly to Māori, Pacific, and New Zealand European communities, and posters created with these parents in mind were uploaded to social media pages. Physical posters were also distributed to NGOs, health centres, and education facilities catering to parents from various ethnic and socioeconomic communities. I coordinated the placement and spoke to key stakeholders in community groups. Targeted social media advertising was also facilitated through communication with administration teams of parenting sites where families with children with established PE interacted. For examples of recruitment advertising please see Appendix B.

Social media provided the opportunity to rapidly disseminate information at no cost, and posters were widely shared. A significant response came from the large cohort of parents active on the Massey University distance support pages. There was also an issue with what Drysdale et al. (2023) have termed imposter expressions of interest from illegitimate participants, possibly bots. The financial incentive offered to compensate for participants' time produced multiple applications from inauthentic sources. After initial confusion over which requests were genuine, a system was established to exclude imposters and ensure a welcoming response was extended to legitimate participants (for further detail see Appendix C). Prior to acceptance in the study, a series of questions also established the severity of a child's PE to ensure it was more than an age-appropriate transitory stage (Appendix D).

Participants

I recruited 11 mothers who had sought help for a child's PE and experienced a positive interaction with their HCP. The children were all between 2 and 18 years at the time of the affirmative appointment. In addition to PE, many of the children had diagnoses for other challenges (see Table 1 for details).

Although initially I sought to explore appointments with GPs, I included other doctors in the advertisement in case it might capture important HCP–patient interactions relevant to answer the research questions. However, all but one of the participants were recalling experiences with their GP. The other mother had found difficulty accessing supportive primary care. Instead, when coming across a paediatrician who catered to her son's needs the participant used her in many ways instead of a GP and so that is how her doctor is represented in the study.

Table 1

Table of Participants

Participant (pseudonym)	Child (pseudonym)	Age of child at time of positive appointment	Age of child at time of interview	Healthcare provider	Child's diagnoses	Ethnicity
Susan	Max	2	14	GP	ADHD	NZ Euro
Genevieve	Grace	4	5	GP	Referral to paeds	NZ
Katie	Jack	4	12	GP	SPD, ASD, ADHD	NZ Euro
Annie	Alex	5	6	GP		NZ Euro
Angela	Ella	6	8	GP	Dyslexia	NZ Euro

Rhiannon	Olive	6	13	GP		NZ Euro
Tui	Alexander	6	7	Paediatrician	ADHD	Māori
Jasmine	Luffy	7	10	GP	ASD	NZ Euro
Bridget	Henry	10	13	GP	ASD, ADHD, ODD	NZ Euro
Huia	Haeta	12	14	GP	ASD, SAD, additional diagnosis (*)	Māori
Sarah	Thomas	16	19	GP	ADHD, anxiety, depression	NZ Euro

(*) not specified to protect anonymity.

There was diversity among the parents, personally identifying as being from a range of cultural groups. Two identified as Māori, eight as New Zealand European, and one as a non-European New Zealander. Their ages and family composition were also heterogeneous, and the way the mothers discussed their situations suggested a range of socioeconomic backgrounds, although this was not assessed formally. However, they were also all women. Although it is impossible to determine why this is so, a range of hypotheses can be put forward. Perhaps the gendered nature of parenting means mothers were more likely to have the knowledge and interest around both feeding and medical appointments. Similarly, women may be more open to discussing vulnerable topics or engage in a study that has the potential to change a system not always welcoming to parents of picky eaters. Or possibly, women are more likely to participate in studies or respond to a request by a female researcher. Although recruitment design was intended to be gender neutral, the way the study was advertised may also have been more likely to be seen by women or attracted their attention.

Interviews

Semi-structured interviews (SSI) are the most commonly used method of qualitative data collection in healthcare research and therefore a good fit for the study (DeJonckheere & Vaughn, 2019). SSI allow set, open-ended questions to be asked that focus on the topic of interest (Ruslin et al., 2022). However, there is also the flexibility to examine additional avenues raised during the conversation, therefore, considering participants' perspectives on issues, exploring in detail their experiences, thoughts, and beliefs (Kakilla, 2021). The flexible nature of the interview is one of its strengths as is the opportunity to obtain rich data (Bearman, 2019). However, the predetermined base questions provide structure and relevance to the topic (McIntosh & Morse, 2015).

There are also drawbacks to using SSI. First, due to the influence of the researcher, in contrast to naturalistic data collection (Potter & Shaw, 2018). Interviewing therefore introduces the risk of bias through, for example, leading questions posed by the researcher (Coleman, 2022). However, although recognising the advantages of less intervention, within NA those disadvantages are minimal as participants are actively invited to construct a story. Further, although cognisant that interviews are inherently subjective, the validity of my interpretations was a constant concern and is addressed comprehensively in the reflection section. Second, SSI are time consuming and labour-intensive, and flexibility, although a strength, can produce deviation from the main topic and therefore make comparison difficult across participant responses (Fox, 2009). Finally, when there is less coherence, validity of the study may be reduced (Knott et al., 2022). In this study, though, time expended did not pose a challenge and coherence across the stories was evident.

The use of SSI aligns with the principles of AIQ. For this project the interaction between the HCP and the caregiver is of primary importance. Therefore, exploring the encounter using a methodology that reveals the key aspects of the interaction is imperative. Using the best research method is always an important decision (Arnold et al., 2022). Neumann (2009) found ANZ AIQ practitioners saw interviews as the most important phase in the process of identifying what the strengths are in a system. AIQ identifies strengths in large part due to the way in which interviews are conducted.

Open-ended questions and curiosity enables us to learn the stories of people and facilitate reflection in part by allowing individuals to feel heard (Armstrong et al., 2020; Carter & Little, 2007; Neumann, 2009). However, eliciting the right information is contingent on not only asking appropriate questions but also the way those are asked. The quality of the question is gauged by the answer it evokes (Serrat, 2017). A shift in focus from what has gone wrong to what has gone right can produce creative thinking, for example. These are all tenets of AIQ with its focus on the human element within any system. Indeed, when Neumann (2009) interviewed ANZ AIQ practitioners, she discovered they primarily came from backgrounds prioritising humanistic values. Relatedly, Cunliffe et al. (2022) in their study of caregivers of picky eaters found the sequencing of questions supported caregivers to easily recount experiences. Cram (2010) believes AIQ also enables questions and language to be adapted to meet the needs of the whānau participating.

However, Arnold et al. (2022) believe, for an effective AIQ project, a change in perspective and thinking is also necessary, focused on a new way of relating. For example, when encountering difficulties or negative experiences, further exploration of these is a natural way to relate within an interview. However, in AIQ, issues are discussed with a view to seeking the ideal even from within challenges. The AIQ principles need to become the researcher's way of seeing first in order for them to become part of the collaboration with the participants. It is about creating a genuine curiosity about what is meaningful for participants so those are the details that become the core of the conversation (Arnold et al., 2022). Reflecting back the positive strengths of the participant is a way to both build rapport and encourage deeper engagement. It is also helpful for moving them past negative stumbling blocks (Neumann, 2009).

Negative sentiments are, therefore, acknowledged as part of the picture but are frequently reframed as wishes for the future. Instead of dwelling on the negatives, statements help to direct future change (Neumann, 2009). Tensions arise, however, in putting this into practice. For example, Arnold et al. (2022) discuss the difficulty of managing conversations that involve personal challenge. These were handled in two ways. One is to acknowledge difficulties but then reframe with questions that asked how ideally this could be changed. Second, there were situations in which allowing the participant space to express emotion

was the best course of action. Once participants were allowed to communicate their distress, interviews could resume and seemed to encourage a deeper connection between the parties. In AIQ, it is not, therefore, unusual to find that adjustments to interviews and even processes are necessary (Arnold et al., 2022; Arundell et al., 2021). An ongoing iterative process should result in better outcomes for participants, researcher, and the study.

As much of the existing literature focuses on the negative aspects of PE help-seeking, a methodology that specifically explores positive aspects of experiences was ideal to shape the method of data collection. AIQ can be particularly useful as a research framework in certain situations; when the bad is universally seen; there are tensions between groups; a community has assets that are not immediately visible or not being utilised; or creativity is low. Many of these criteria could be applicable to medical encounters by help-seeking caregivers. First, there is a growing body of literature reflecting the issues caregivers face in finding appropriate medical care (Cunliffe et al., 2022; Jackson et al., 2022; Lamm, 2022). Indeed, research that reflects positive medical encounters for caregivers of picky eaters is currently absent. Second, the same studies describe tensions that arise between caregivers and their HCP when their needs are not met, or concerns acknowledged and validated. Relatedly, tension may also be a factor for medical professionals when working with caregivers (Ong et al., 2014). Finally, unrealised assets on both sides of the relationship are made apparent through the study. Caregivers had insights into better ways to support families of picky eaters. Similarly, certain medical professionals were already providing a service valued by caregivers. Bringing together insights from both sides highlights system changes that may support better care.

Interview Procedure

Prior to the interview, all participants received a comprehensive information sheet (see Appendix E). A preliminary video call was then arranged for parents to ask questions and confirm comfort in participating. On this initial call a series of questions also ascertained parental fit for the study. Parents then signed and returned a consent form (see Appendix F). A full interview was scheduled, estimated to take approximately 45 minutes. 50 minutes was the average length across the interviews; however, five interviews were considerably

longer as parent stories were more complex than anticipated and/or participants wanted to explain in detail about their child and experiences. The interviews were conducted via Zoom video conferencing, so it was possible to speak to parents ANZ-wide at times convenient to them. Participants also agreed to have their interviews recorded and from these I was able to transcribe their words. In thanks for their time, a link to a gift voucher was e-mailed upon completion of the main interview.

Interviews were semi-structured to give parents the opportunity to explain in their own words what had happened prior to, during, and after their positive interaction with the doctor. There were some core questions that were part of the interview schedule (for full schedule, see Appendix G) such as, “What made you think of your child as a picky eater?” In line with the collaborative nature of interviews and the constructionist-informed epistemology of both AIQ and NA, participant responses determined how the questions developed. AIQ and NA acknowledge the importance of the relationship and communication between interviewer and respondent. As AIQ also deliberately seeks the positive in any situation, questions are carefully worded to enable this. For example, after asking about the affirmative appointment a follow-up question was “What was most valuable? What sticks in your mind?” Leveraging strategies or factors that are supportive for change is a key focus of AIQ.

However, the first interview conducted still became more focused on the negative than expected. I reflected on why this had occurred in order to align future interviews more with AIQ. Upon rewatching the first interview, I identified how I had inadvertently followed a more standard format for questioning and responding to a participant’s story. I therefore reviewed videos of experienced AIQ researchers and made some changes to the way future conversations were conducted. Subtle shifts enabled both a sensitive navigation of difficult experiences and a focus on positives during the following conversations. After the first two interviews, I also deliberately reduced verbal comments and interjections to enable the participants’ words to be captured without interruptions. I explained this to the nine participants yet to give interviews at the start of the recording. I found this often-facilitated long sections of reflection by participants, which may or may not have occurred otherwise.

I then transcribed the videos and sent them to participants to give them the opportunity to read and comment on the transcripts if they wished. Many requested the copies, but none commented. Participants were also sent a copy of the draft analysis to comment on, if they wished. In this way participants were given the opportunity to help shape the results. However, although half the parents responded, there were no changes requested beyond grammatical tweaks.

Of note is that the majority of the participants were recalling appointments from over a year before. There are advantages and challenges associated with retrospective accounts that span longer periods of time. Some detail may be lost or not recalled as accurately as would be expected if the appointment was more recent. Conversely, for the purposes of the study it provided an excellent overview of outcomes. Not only was it possible to see what had transpired during the positive interaction, but also what had happened as a result. Further, parents could contextualise their recollections by relating them to other experiences both in healthcare and more generally. Although I was not expecting to recruit parents who were discussing experiences that had taken place often many years previously (see Table 1 for details), it felt advantageous for establishing some of the long-term outcomes from positive HCP appointments during analysis.

Chapter Six: Data Analysis Theory and Practice

Data Analysis Theory and Practice

When planning the analysis of SSI in NA, a key decision is whether to use an inductive or deductive approach (Bingham & Witkowsky, 2022). The choice impacts how data is interpreted and the conclusions that can be drawn. An inductive approach uses a data-led methodology. Therefore, information from the interview is used to develop patterns and themes, from a bottom-up perspective, rather than working from a hypothesis or preconceived theory (Bingham & Witkowsky, 2022). As the current project is the first of its kind, a more exploratory and therefore inductive approach appeared appropriate. Analysing in this way enabled interpretation of caregivers' encounters with their HCP.

Analysis conducted inductively is inherently subjective. However, subjectivity is not necessarily a negative component of a project. In fact, it can lend perspective to a topic or bring a unique lens to research (Wang & Geale, 2015). For example, most people relate stories easily and willingly and in turn we are drawn to them (Yamagata-Lynch et al., 2017). Storytelling expresses how participants understand, relate, and retell experiences (Bruce et al., 2016). In so doing, in-depth data is often obtained and meanings uncovered as people are comfortable revealing themselves through stories (Savin-Baden & Niekerk, 2007). Some authors have also suggested better results are achieved when the researcher deeply understands the significance of the stories for the participants and others (Berry, 2016; Wang & Geale, 2015).

However, to acknowledge subjectivity and analyse how it may influence the project is a core objective of reflexive practice and a key requisite of effective NA (Guillemin & Gillam, 2004). It was, therefore, critical I was keenly aware of my own cultural situatedness and how this may affect interpretation (Jens, 2014). My norms and values surfaced in analysis and presentation of data. Negotiating how these impacted upon and should be represented in the study was an ongoing challenge (Savin-Baden & Niekerk, 2007). Culturally driven thought and behaviours may also factor into the initial interview and affect how both parties operate (Jens, 2014). Indeed, I found that the interviews progressed in markedly similar ways and conclude this is in part to due to my background and experience, and also because many of the participants had stories that followed similar patterns. Finding

confluence aligns with the principles of NA and I will engage with this further in the procedure and reflexivity sections below.

Participant stories operate at three different levels: the personal, the interpersonal, and the ideological (Wong & Breheny, 2018). By separating these levels, it was easier to see how the parents' individual stories are located within overarching discourses. It was also important to see how these levels work together and how they helped me view the wider data set collectively (Stephens & Breheny, 2013). Ideas that may seem disparate across individual interviews can often be consolidated into common themes (Carter & Little, 2007) and acted upon.

The personal level of analysis focuses on how individuals tell stories about their experiences and use it to explain and make sense of events, define their identities, and connect themselves to wider society (Murray, 2000; Stephens & Breheny, 2013). At the interpersonal level there is co-construction of the story between narrator and audience (Mishler, 1986; Somers, 1994; Stephens & Breheny, 2013). The third, or ideological level, introduces the importance of understanding how these stories are impacted by and reflect wider society (Wong & Breheny, 2018). Murray (2000) explains how ideological discourses shape social frameworks, understandings, and behaviour. These are core beliefs shared through families, institutions, and wider cultural understandings (Somers, 1994). Positions of moral and social identity for individuals are made available through these discourses (Stephens & Breheny, 2013). However, these levels always work interdependently in the creation of meaning and so the way they work together is important (Stephens & Breheny, 2013).

In this study, although the interpersonal level between interviewer and storyteller was important, it was not a focus of the project. The decision was made on the basis of multiple listenings and readings of the data. The immersion in the stories, located me, as the interviewer, primarily in the role of supporter, a sympathetic and understanding ear. Across the interviews, the mothers appeared to enjoy relating their stories to someone who appreciated their struggles and frustrations, demonstrated by much humour and laughter. However, a detailed analysis of the personal and ideological levels best answered the research question as outlined below and so was the primary focus within the dataset.

While transcribing the interviews, it was possible to begin to engage with the data, checking words carefully against the video/audio recording and inserting hand gestures, expressions and inflections that communicated more than words alone. Once I transcribed the data for each participant, I transferred it into a separate spreadsheet. The spreadsheet enabled me to identify the stories, as suggested by Wong & Breheny (2018). Once the stories in each participants' transcript were determined, I could begin looking at the levels of analysis, beginning with the personal. In this phase I was looking at how the participants described events. The second stage of analysis was locating those stories within Murray's (2000) wider culturally determined discourses. In this phase I was identifying also how participant stories conformed or diverged from those commonly understood social conventions. At the same time, I was noting where stories were similar or different to those of other participants (See Appendix H, for an example).

Further analytic tools are also recommended by Wong and Breheny (2018). These additional means of inquiry develop a more nuanced understanding of the stories told. For this study the additional features of stage and setting, characters, tension in the story, humour, and common refrains were explored and noted during the analysis. The deeper level of analysis focuses on when, where, and by whom the stories are told and where this either conforms to or defies social convention (Wong & Breheny, 2018). These helped foreground additional places where discussion was essential by highlighting the importance of social discourses, particularly those that were gender- and motherhood-based. The process also identified whether certain of the additional categorisations, such as tensions, were particularly relevant to the study.

Once this was completed a summary of each participant's overall narrative was created and a comparison made across the dataset. From this overview it became apparent the narratives followed a similar pattern. Indeed, the similarity across the dataset provided the structure for the analysis. There were three distinct phases all the narratives moved through, termed mini narratives. First, the management stage where participants attempted to resolve PE themselves, followed by a catalyst that precipitated the visit to the HCP. Second, discussion of the positive appointment. Finally, reflection on the outcome of the affirmative visit. Within these mini narratives, there were also clear sub-sections that became apparent. The sub-sections have been used to further explicate the participants' experiences. Across

the narratives, overarching themes such as defining PE, wider social discourses of gender, the primacy of the HCP relationship, and limitations of care, impacted on participants and their behaviour. These were used to order findings for ease of understanding (see Appendix J for list of categories). Naturally, the questions asked led parents to respond in a particular way; however, their stories naturally followed a pattern from first identifying PE through to outcomes from their doctor's appointment.

Writing the analysis was an inductive process with extracts chosen after careful consideration to illustrate the overall narrative, the participants' thoughts and feelings, and how those operated within wider discourses. Interpretations were made with close attention to how stories were part of both the individual's wider narrative and the overarching collective narrative. A paradigmatic analysis such as this seeks relationships between stories not merely categorising data (Polkinghorne, 1995). It was therefore also a recursive process exploring where narratives repeated or were unique and what this may reveal about the individual accounts and the whole dataset. Frequently, participants told similar stories, so I made a decision as to which best represented a particular point in the narrative. In allowing the participants to speak, they were able to communicate their thoughts and feelings directly and a collective voice authentically emerged around key issues. To amplify participant voice "in vivo" quotes are used to describe the narratives.

Across the dataset, I found it necessary to make multiple editing decisions. Some of these are visible, such as adding ellipses "(…)" to indicate speech has been removed as it was not relevant to the experience communicated. The ellipses may also indicate words are from a different part of the interview but brought together to illustrate a point for the reader. Similarly, there were instances where further clarification was needed or where the researcher was part of the story, shown by […] or [JKY]. As all the participants were women and mothers, and gender, especially the mother identity, was highly salient in the interviews, in the analysis I chose to use the terms mother and women, as well as pseudonyms, when discussing the participants.

Ethics

A full ethics review was conducted by the Massey Ethics Committee (approval number OM1 23/09). Parents all volunteered to participate, had the choice whether to answer specific questions, and understood how their information would be used. However,

PE is an emotive subject, and it was important to ensure parents felt comfortable. Their comfort was partly addressed through the AIQ approach, but also through sensitive interviewing that paid attention to participants' emotional states. A comprehensive overview of the interview and subsequent data processing was provided to all participants.

As it was the intention to target various communities, cultural consultation was an important component of ethical approval. As part of this I was privileged to discuss appropriate engagement with the Māori community in relation to research on children's eating with Associate Professor Natasha Tassell-Matamua from Massey University. I also reached out to several Māori contacts who are intimately engaged in community service and work to discuss my plans and request feedback on the forms and advertising used in the study. Further, I was fortunate to have input from a PhD student who had hands-on advice about approaching other communities. Relatedly, as part of my practicum last year, I undertook research regarding picky eating challenges faced by the Māori and Pacific communities, as well as those of NZ European families. The research was done through Whānau Āwhina Plunket who support caregivers from all cultural backgrounds and via cultural consultation with staff at Ora Toa (Māori) and Vaka Atafaga Pacific Nursing Service who also conduct well-child checks. The opportunity to work with Māori and Pacific community nurses developed greater cultural competency that I could comfortably apply to the interviews.

To maintain anonymity, pseudonyms were used for both parents and children and any details that may identify them have either been altered or removed. All participant interviews were transcribed and anonymised and data is stored on a password-protected computer and backup drive with details identifying participants kept separately from the dataset.

Reflexivity

In qualitative research reflexivity is important as it acknowledges the role of the researcher. Since design, language choice, and a researcher's values and aims all affect how data is collected and analysed, part of this reflexivity is also the ability to be self-critical and adapt processes for best outcomes (Arundell et al., 2021; Mortari, 2015). My worldview, experiences, assumptions, and biases affect the research process (Hickson, 2016; Olmos-

Vega et al., 2023). The subjective position informs every stage of the study from design conceptualisation, planning, interviewing, reading, and analysis of data to writing up the research. An ethical responsibility is also placed upon qualitative researchers, particularly in the psychological space, to repeatedly review their approach (Clandinin et al., 2007; Waitoki et al., 2016).

My background and experience featured strongly in choosing the topic of interest, the epistemological stance, and the lens through which I interpreted and filtered information. For example, as a health psychology student in a university where health is always addressed from a critical standpoint, I was drawn to a social constructionist epistemological stance. Within this framework knowledge is produced, evaluated, and appreciated as being part of the socio-cultural environment. A research report is also, in itself, a construction. It is one narrative among possibilities influenced directly by the researcher (Hosking & McNamee, 2007; Neumann, 2009; van der Haar & Hosking, 2004).

Similarly, I looked for research methods that fitted within a social constructionism approach and suited my ethos and the research project. Running a private practice working with parents of picky eaters gave me a unique insight into the area of study, as did several years studying critical health and focusing on topics that related specifically to this area. When designing the research, I was able to bring my experience to bear in the planning stages. I already knew many parents struggled to find validation and support for their children's PE. I was also cognisant of how little research was available in the ANZ context and how a study documenting parents' struggles to find affirmative care would contribute to the literature.

However, one of my core goals was producing a piece of work that may enable positive change. After attending a lecture hosted by a transgender activist working to achieve better outcomes for non-cisgendered patients, I was drawn to the idea of identifying what made certain medical appointments work. From there I hoped it may be possible to recommend system changes. I therefore chose an affirmative approach over documenting challenges when help seeking, despite these being the most prevalent experience for parents (Chilman et al., 2023; Cunliffe et al., 2022; Lamm, 2022).

At the suggestion of my supervisor, I looked at appreciative inquiry (AIQ) as a fit for the study. I was drawn to the methodology and wanted to use it in my study. However, I also

realised that its usual application in organisations made only parts of the methodology suitable for my study. In consultation with my supervisor, I identified that appreciative inquiry would be used for data collection and thus only the first two methodological phases of AIQ were used. However, it was also important for participants to be able to dream and therefore I asked questions around the third phase while appreciating that this would not be actioned. There may be the opportunity, however, to discuss the results with HCPs and therefore seed change.

Participant interviews consisted of two distinct angles of inquiry: first, to establish what went right and, second, to ask for suggestions to improve upon current systems. Front of mind when conducting the interviews was the importance of believing that participants have the answers (Neumann, 2009). As the participant interviews would form the dataset it was important to choose a method of analysis that would represent the stories. NA has frequently been used in medical studies, and pairs well with AIQ. What I was not prepared for was how well NA allowed the participants to speak for themselves. Using their words, I felt, conveyed some of the emotion that was present in the interviews and that was important for the reader to hear.

When interviewing participants, their comfort was critical. I am familiar with conducting appointments with parents of picky eaters, so it was essential to provide a space to facilitate relating often quite confronting episodes or ones tinged with guilt or shame. At the start of the interviews there appeared often reticence and a feeling of wanting to perform correctly. Indeed, many of the parents began the interview with neutral, factual descriptions of events and became more demonstrative and likely to expand upon thoughts as the interview progressed. I felt my role was as someone who appreciated their struggles, contributed to their comfort, and enabled them to become more confident in their opinions. Despite wanting to remain neutral, my opinions were occasionally also foregrounded. There were naturally places where either the emotive content of the story provoked a response and other instances where a reaction to a situation was appropriate.

In the first interview, the nature of the story evoked strong emotions in me, and I found I naturally adopted a more traditional response to hearing a challenging story, rather than seeking the positive as is necessary in AIQ. After the interview it was important for me to reflect on what had led to a deviation from the positive angle and establish how to change

my approach for subsequent interviews. It was interesting to note the interviews were filled with humour and laughter despite often containing emotive and challenging experiences. Also, when touching on the dream phase of AIQ, participants were passionate about providing solutions for other parents (see Appendix I). Making a conscious change to the way I interviewed was important, and while I feel I've grown as an interviewer from this experience, I recognise I am still new to this process. I was also surprised by some of the results of the study, despite being an area I am familiar with.

Indeed, the gendered aspects of the participant's stories and how firmly these were embedded in motherhood roles was unforeseen. Factors associated with the location of the research within its specific socioeconomic, political, and gendered cultural context are important to acknowledge and I was not expecting a focus of the study would be around women's identities as parents and how these shaped many of their actions.

Similarly, it is not my experience in private practice that PE is primarily a problem experienced by families where children have additional challenges. In fact, such a high percentage of neurodiverse children represented in the study was a surprise. However, once this was apparent, I responded flexibly to the needs of the research project by accounting for neurodiversity in the design, such as altering the interview schedule. I was, therefore, able to ask specific questions to establish whether there was a difference between neurodiverse and neurotypical children in terms of medical appointments. I wanted to consider whether being neurodiverse impacted on the quality of the service, for example, or the relationship with the HCP. During the study it was interesting to find many of the parents had a HCP they saw regularly and I was left reflecting whether the primary reason for this was due to neurodiversity, a point I return to in the discussion chapter when considering future research.

I was also cognisant that knowledge is a co-production with my role affecting what and how things are said, once I moved to the analysis phase of the study (Orr & Bennett, 2009). Working through the data using Breheny and Wong's (2018) interpretation of Murray's (2000) levels and their additional tools enabled me, however, to analyse methodically. Despite this, my experience in the PE area surfaced consistently and I was forced to continually reflect on what the data was saying. Producing an overall summary of the stories was a way to do this from a global perspective. Similarly, when choosing extracts and key

refrains from within the data, I considered which most accurately portrayed what participants had said and those things that were important to them. I consciously sought not to let my views on picky eating colour the results and part of doing this as effectively as possible was continually returning to the data alongside active engagement with my supervisor.

Quality Criteria

The validity of a qualitative research project is contingent on whether it is seen as legitimate, trustworthy, authoritative, useful, and sound by those who wish to use the study, such as other researchers, examiners, funders, and the public (Yardley, 2015). There are specific criteria used to assess the quality of a qualitative research project (Lincoln & Guba, 1985; Ravenek & Rudman, 2013; Yardley, 2015). However, it is also important to recognise that each study must be judged against criteria that are relevant to the specific project and its methodology. Further, following guidelines does not ensure research is good or that departure from usual procedure is necessarily a negative as long as the rationale is justified (LaMarre & Chamberlain, 2022). Despite this, Yardley (2015) outlines some general factors that can be used to gauge the quality of a study. I will discuss those applicable to the study: generalisability, participant feedback, disconfirming case analysis, an audit trail, sensitivity to context, coherence, and transparency.

Generalisability, when applied to a qualitative study, suggests insights derived from one study may help understanding of a phenomenon in another context where there are similarities. In this study there was heterogeneity across both participants and their children in age, geographic location, diagnoses, and feeding challenges. Despite this, there was also a surprising homogeneity to the narratives, a comment made by more than one participant remarking on the draft analysis section. Given the similarities it is reasonable to assume other caregivers in ANZ may have similar experiences. However, it may also be important to establish whether neurodiversity has impacted on the results, particularly as those caregivers may be more likely to have a long-standing HCP.

Participant feedback or respondent validation engages parents in the research by asking for input (Yardley, 2015). As my stated aim was not only to establish what constituted a positive medical appointment but also to use that information to inform potential change, it was

important participants were comfortable with the study and the way they were represented. Three factors potentially increased the interest of the participants themselves. First, the AIQ component where ideas were welcomed. Second, the uniqueness of the study and the potential longer-term usefulness of participating. Finally, that many of the participants were interested in research. Although there are potential drawbacks to making research available to participants for feedback, for example, an inability to relate to the analysis, it was important for me to do so. I was also confident participants would read the draft analysis comfortably, and that was the case.

Although there was congruity across the stories, it was also important to note where there were instances of disconfirming cases, or data that did not fit the general patterns. Identifying deviant cases reassures a reader that all data has been included, not merely ones that fit patterns that confirm points made. Doing this was far more difficult than I anticipated as each story and situation is unique, and so identifying where there were matches and conversely which discrete experiences or factors were important to report was not straightforward. Both for ease of analysis and for transparency I have created detailed spreadsheets that can be used to understand precisely how the interviews and dataset were used to produce the final report. An audit trail such as this enables others to understand how the analysis developed from the raw data. It is also indicative of an inductive study where patterns are derived from the dataset.

Part of validity for a qualitative study is that it explores new topics and identifies or describes new phenomena. Moreover, that there is a self-critical accounting and declaration of why a researcher is pursuing the project as self-awareness influences values and practices (Clandinin et al., 2007; Hickson, 2016; Tracy, 2010). As the study is the first of its kind globally it has engaged with parents of picky eaters in a way that sheds new light on an understudied area internationally and adds more research in the ANZ context. In this way it demonstrates relevance and potentially impacts on how PE and help-seeking is viewed.

It is also important to show sensitivity to context, which can be done in a variety of ways. Using the existing literature enables the study to be compared against previous research (Finlay & Ballinger, 2006; Ruwhiu, 2008). Interpretation of the findings can therefore be

contextualised and understood in light of research on similar topics. Therefore, as the study is novel, I spent considerable time becoming familiar with studies that may be of use in better understanding and interpreting the dataset.

Sensitivity to context also refers to participants and how comfortable they are participating and sharing their views. Given my background I was focused on ensuring parents were able to speak freely without fear of judgement and were able to communicate what was important to them (Wilkinson et al., 2004). Similarly, it is important to consider why certain views are communicated or not, and the ways in which this is done while giving the data primacy. It is also important to engage with the complexities in participants' stories. Using Wong and Breheny's (2018) levels of analysis and additional tools for exploring the data was a useful way to rise to these challenges. Understanding the participant perspectives and attending carefully to their stories both during the interview and in analysis was important. The time taken across these processes demonstrates my commitment and the study's rigour.

A qualitative study's coherence, transparency, reflexivity, and ethical stance also improve the quality. Coherence is ensuring there is consistency across the study in terms of theoretical approach, method, analysis, and the research question (Yardley 2015). Transparency requires the reader to be able to see and understand what has been done and why, and reflexivity is consideration of the influence of the researcher. In this study I sought to ensure methodological coherence, and that methods and procedures were clearly reported. A substantial reflexivity section has addressed my influence, alongside other issues in need of discussion. Similarly, ethical considerations were front of mind from the outset and were considered at every step of the study (Ravenek & Rudman, 2013).

Chapter Seven: Analysis/Findings

Introduction

Although complex and heterogenous, the mothers' stories followed a similar trajectory, allowing me to produce an analysis with participant stories considered as a set analytically. Many of the stories spanned multiple years, which enabled both an overview of the participant help-seeking journey and how that positive visit impacted upon them and the lives of their children. Although these are personal and unique stories, it is also important to locate them within dominant, socially mandated norms around motherhood and particularly eating and health. The study reflects how childrearing and feeding are still primarily gendered and how powerful discourses on raising children can be. In considering the mothers' stories, the analysis that follows showed how these women operated within those overarching tenets and how they embrace or resist social pressures through their experiences of help-seeking.

There were three distinct but interlinked parts within the overall narratives that reflected how the parents described their experiences. The stories began with the mothers' determination to resolve PE independently; as Bridget said in relation to her and her partner, "we tried to manage it ourselves for quite a while." All the parents felt it was their responsibility to feed their child in a particular way and they researched, sought advice, and experimented, to do this to the best of their ability. However, these solutions were not successful and problems continued. At some point there was a catalyst that motivated parents to (further) seek external medical help, culminating in a positive experience with a GP or paediatrician. The second part of the narrative analysis focuses on that positive healthcare practitioner interaction and the factors making that visit positive. Finally, the third part of the narrative considers the outcomes for both parent and child of an affirmative experience with a doctor. These three mini narratives are discussed in parts 1, 2, and 3, collectively forming the overall narrative.

Part 1: Before the Positive Experience

Participants described events that occurred prior to the affirmative meeting with the doctor, forming the first of the three mini narratives. There are several subsections to this mini narrative the mothers described: managing PE themselves; the catalyst for visiting the doctor; failure and guilt.

"We Tried to Manage it Ourselves for Quite a While"

As in Bridget's extract above, all participants described attempting to manage PE within the family. They felt responsibility to resolve the PE, although the emphasis varied in terms of how it was prioritised. For example, some parents carefully considered each food they offered, and included those likely to be rejected, meaning the PE was always front of mind. Others took a more relaxed approach, with the expectation things would get better in time. Indeed, many parents didn't feel PE was either urgent or a major problem to begin with. Angela summarised that attitude as "we'll get through this because no one ever really died from not eating vegetables."

The reference, in jest, of not dying from lack of vegetable intake was echoed by more than one parent across the conversations, and perhaps reflects their resistance to widely disseminated discourses about the importance of children consuming vegetables. The inability to eat according to normative benchmarks was viewed by most of the parents as a normal phase children went through. Katie explained her situation:

> So, we were having a lot of feedback from um, you know Plunket [children's health NGO] and friends and all that kind of stuff that aw, it's just you know, he'll grow out of it just keep offering, which we were doing.

Even at the Child Development Centre (governmental child service for developmental disorders) Katie reported being told "he's highly sensitive and a bit fussy, but he'll outgrow it." However, although being assured Jack's eating was a normal childhood phase, Katie, along with a few of the other parents, strongly felt their child's diet may have been negatively impacting health despite being deemed transitory. Tension between the two opposing positions caused discomfort. Moreover, safeguarding a child's healthy development is presumed a parent's responsibility. Once fears they were potentially not supporting optimal development were realised, and this occurred at different points for the participants, the mothers set out to rectify this.

Prior to booking an appointment with the doctor, however, the participants experimented with a range of strategies. For most, this was something to be handled internally. Indeed, for parents such as Angela or Rhiannon, introducing more "noise" was deemed unhelpful. Other parents sought external advice, as they knew they had reached a point where their own

strategies were ineffective. Katie, for example, found social media forums dedicated to parenting sensitive children aligned with her views on parenting Jack. Similarly, she turned to her mother, a nurse, for support. Ultimately, nothing was successful and so Katie in desperation tried something that inadvertently caused harm. She tells with enormous shame that:

> [W]e even tried that awful [laughs in horror], you can't have anything else if you don't eat it. Only because other people told us to do it. And it was horrific. He didn't eat for like, he just refused for days (...) I feel like I traumatised him. I think we lost three foods [laughs in sort of despair], so it was awful.

Katie believed this incident both set Jack's eating back and "traumatised him". Her decision to use an extreme measure, which even at the time she was not sure was advisable, speaks to the responsibility she was feeling to enable Jack to eat better and the desperation to resolve it at all costs. The difference in how the mothers sought and received advice was partially contingent on how important it was to them their child was able to eat normatively, with an emphasis on healthy foods such as vegetables. For example, although Tui wanted Alexander to eat nutritious foods, she resisted the advice of a paediatrician to starve him, refusing to return to that doctor, as she deemed it "horrible".

For most parents, believing PE was a temporary phase, or not contra to their child's healthy development, enabled them to defer medical intervention. However, even though believing it was a transitory problem, PE often caused difficulties for both child and family. Annie summarises, "Um, but yeah there were lots of dinners with crying on the floor." Despite accepting inconvenience and frequent upset often over many years, for the majority of the mothers there was a turning point or catalyst where in-home strategies and support was no longer tenable and medical care was essential.

"And that was the Point When we Thought Aw Look" (Bridget)

Although all parents described a turning point where they decided they needed external help, what motivated participants to visit the doctor varied. For some it was a realisation their child was missing out on core nutrients, as Annie explained, "not a single fruit or vegetable". Four of the mothers, Annie, Angela, Bridget, and Rhiannon, had been quite relaxed initially. While Rhiannon had a growing sense of unease, the other three

mothers, described reaching a point where PE was potentially impacting their child's health or development and feeling compelled to seek support. Bridget, for example, talked about Henry losing weight and recognising how problematic at his stage of development that "he had lost weight, which is not what you want to see for a young, a young child (…). And that was the point when we thought aw look, we're not (…) managing this on our own."

However, it did not need to be a physical signifier of health to act as a turning point. Indeed, the primary reason parents took their child to the doctor was lack of fruit and vegetable intake, in the context that consumption of these was understood as a marker of health in general or specifically in relation to nutritional deficiency. In fact, which foods their child ate precipitated the visit to the doctor for almost all. As Annie recalls, as her child was not eating fruit or vegetables:

> Pretty much my priority was around um, making sure he wasn't lacking in nutrients and actually was okay. And so, because he was a normal (…), weight and height and hardly ever got sick, I figured he probably was, but it was at the point we needed to check.

Several parents expressed similar thoughts, whereby their child seemed outwardly healthy with no obvious physical signs that anything was amiss; however, there was concern lack of nutrients would have a detrimental effect. For example, Angela, who works in health, oriented to future wellbeing risks when she realised her daughter had virtually no calcium in her diet as she was dairy free and eating no substitutes:

> [I]t's not affecting her growing now, she's like 90th centile (…) she's a healthy, strong girl. It's not there for all to see at the moment but later down the line, if we don't do something she'll be, you know, she'll be the one that fractures.

For Angela it was the specific concern related to calcium deficiency, perhaps elicited by her professional status in health. But for most participants, it was lack of a rounded diet that was the problem, reflecting the pervasive marketing of eating 5 a Day.

Although their motivations for seeking external help were similar, the participants' rationales for seeing a doctor also differed. For Annie and Angela, it was the doctor's position as gatekeeper to specialist services. As Angela explains, "So I knew to access the hospital dietician we would need to see the GP." Whereas Bridget and Rhiannon were not sure

precisely what the GP could do but knew it was important to seek expert advice. As Rhiannon recalls, "I thought, well, probably a doctor will give me the best advice about what a healthy diet looks like for a six year old", therefore describing how she visited her GP primarily for reassurance. Rhiannon wanted confirmation Olive's diet was not detrimental to her development. There was not, therefore, a definitive moment when she knew it was imperative to act. She had also possibly not got to the point of desperation that is reflected in the narratives of Genevieve, Katie, and Jasmine, whose child's eating had become concerningly restrictive or related to other health problems, as in Genevieve's story and her concern for Grace's eczema:

> And as I was giving her rice pretty much three meals a day, her eczema went absolutely out of control (…) and she wasn't sleeping well at this stage. Because if you're not well nutritioned in your belly (…) you also lose weight, but you don't sleep well. So now we were battling eczema, picky eating and not sleeping.

Grace's sleep was so disrupted by lack of food and the irritation from the eczema that she was not coping. Genevieve believed the solution was a prescription for melatonin, to improve the sleep and give her time to better support the PE. Interestingly, despite desperately needing help, as Grace's diet and intake volume was so limited, she did not feel the solution to the PE lay with the GP. The doctor was engaged as the prescriber of medication for sleep. Similarly, for Annie and Angela, a clinical need rather than the perception a GP could help resolve PE drove the visit to the doctor. Angela felt PE was something you could research online and more an issue to be dealt with personally, rather than a discussion for the GP. Sarah had similar thoughts. Katie and Jasmine, however, felt their GP was the best place to find PE support. As Jasmine explained:

> [I]t got to a point where I was kind of struggling because I didn't know if it was what I was doing, or if it was connected to the autism, or if it was trauma from um, his earlier years [her ex-husband made food uncomfortable]. So hence the visit to the GP.

For both Jasmine and Katie, who described Jack's extreme reaction to foods, it is a logical decision. They are having problems patently outside the norm when compared to peers, such as their child not being able to sit at the table without distress and, unable to resolve the PE independently, the GP is the obvious next step. Huia too had wanted to get medical

support for Haeta's PE, and her story involved numerous attempts to get expert help and several HCPs over the years. Unfortunately, her requests for help were consistently rebuffed: "So, I did talk to quite a few people. Um, past GP's and I'd brought it up with other people counsellors and psychologists and social workers and psychiatrists [who she had seen for her daughter's other challenges]." Despite numerous appointments in both primary care and specialist services, PE was not an issue that was taken seriously, was seen as less important than other issues, or was discounted as a function of Haeta's anxiety.

Huia's catalyst for seeking further support was an ongoing discomfort with how her daughter's PE was affecting her, particularly as she was cognisant of the link between diet and auto-immune diseases, one of Haeta's conditions. While Huia's story was one of standout difficulties in getting support, she was, alongside Annie, one of only two participants whose doctors acknowledged the quality of their children's diets was a potential problem. For Huia this was also only after countless other appointments where her concerns were dismissed, as she explained:

> [I]t's important to be healthy eating, it's such an important part of life, but it was always kind of like (…) no she's gaining weight, don't worry about it. (…) I would be concerned about (…) her digestive system (…) they'd say to me just don't worry about it. [Then the GP] agreed with me, she saw the common sense.

Huia's extract above, summarised one of the themes of her story, raising multiple concerns with healthcare professionals, drawing on normative understandings of healthy eating ("it's such an important part of life") to do so, and, yet, these concerns were dismissed as unfounded. It was therefore, an unusual healthcare professional that Huia meets, who shared an understanding of the centrality of healthy eating to health, thereby finally meeting a HCP who sees "common sense".

Similarly, Tui saw a range of professionals for Alexander and had consistently brought up the PE challenges, but not had them addressed in supportive ways. In fact, she was dismissed as an anxious mother and referred for parenting courses to address potential gaps in her competence, as shown when she visited a pediatrician:

> Um, I found there was quite a bit of gaslighting. (…) you're just being anxious, there's nothing wrong with him. I said, look, he can go all day without eating. He'll eat like one

> cracker and it's, I can see, you know, he's, he's getting pale, withdrawn, his behaviour, everything [with the response being] No, you're just anxious.

Tui presented a list of issues that created an overall sense of unhealthiness, but that were reinterpreted as a problem with her. The outcome was a feeling of being “gaslighted”, a term that intuits a sense of abuse in her relationship with her HCP. Tui attempted to make sense of this behaviour and wondered whether it was due to her ethnicity, as a minority, and her age as a young mother, positionalities that are vulnerable to stereotyping. Although not given the support she needed, she created a turning point in this narrative, when opportunistically using a consultation for Alexander’s sibling with his paediatrician to secure her own medical counsel: “I said, hey, um, this is a bit cheeky, but, you know, (…) I’ve been having problems, I haven’t had supportive paediatricians, um, no one’s listening to me. Do you think you could see him?”

Similarly, Sarah did not decide to see the GP on her son’s behalf. In fact she recalls she was merely the chauffeur for Thomas who at 16 was visiting the doctor for an unrelated matter that led to discussions of PE, “so the decision, it wasn’t really a decision, I would never have made that appointment, because I wouldn’t have identified it as something I should talk to her about, it was just something we were dealing with.” Sarah did not think to speak to the GP about Thomas’s struggles to eat and it was the hand on the door question by the doctor “is there anything else?” that brought about Thomas’s comment, “And he said yes, I’m, struggling to eat.”

Sarah identified PE as a familial rather than a medical issue, although, later in the interview, with the benefit of hindsight, Sarah laments PE is something she should have raised with the GP:

> It’s been interesting to have this conversation with you because I hadn’t realised that I didn’t actively do anything about it. [Explaining] it’s just something you get used to. It’s like boiling a frog, you’re just like well that’s just the way it is.

Sarah acknowledges PE was something that had become their normal, so the experience of looking back at photographs of her children creates a sense of shock: “why did I not notice?” Sarah’s reference to a new (problematic) norm was echoed by Bridget who found Henry’s weight loss was not as evident to them as it was for people who had not seen him for a

while. She was shocked seeing photos on Facebook that showed weight loss over time. Therefore, many of the parents expressed regrets they hadn't sought, or received, help earlier. Also, during this part of the narrative, participants discussed how their child's PE had impacted on their sense of identity as parents, but particularly as mothers. Their perceptions of themselves also had consequences for decision-making.

"You Feel Like a Failure" (Rhiannon)

Making the decision to speak to a healthcare professional about their child's PE was often dilemmatic for participants. For parents like Huia, previous attempts had been unsuccessful, reducing her expectations for future help. Whereas for other participants, like Rhiannon, the dilemma revolved around trusting her own judgement, within a wider discourse of overly anxious mothers who positioned her concern as unjustified. As Rhiannon explained about her initial hesitancy in seeking help for Olive's PE, "I was feeling like I was a silly, paranoid mum, you know." Rhiannon's thoughts were echoed by other parents who felt conflicted. On the one hand they were aware eating was not going well, and they were struggling to make headway resolving it independently. On the other hand, as Sarah described, "I basically gaslighting myself and saying don't be ridiculous, calm down (…). And it was a feeling of probably shame or just not wanting to appear like a crazy helicopter parent (…). There's people with bigger problems than that."

The tension between needing help but not wanting to appear either overprotective and/or wasting valuable healthcare professional time with a triviality was apparent across several stories. However, more evident was a sense of shame or failure. As Rhiannon explains:

> [I]t's a little bit taboo, I feel like because you feel like a failure if you've got a picky eater (…) you don't share with too many people that you've got a problem as because you don't want to look like a failure.

Many of the parents expressed a sense of guilt about the inability to feed their child widely and well, and also that they may be judged. As Angela conveyed:

> I think as a parent you, you think that picky eating is um, some kind of reflection on your parenting (…). I don't think I would have sought help earlier, to be honest, because (…) you feel like what's happening (…) is because of your influence as parents.

Angela situated the PE problem as one of parenting competence, challenging her self-identity as a good mother. She also recounts a visit to a dietician for her other child that influenced how likely she was to seek help in the food sphere:

> We had quite a bad experience with a dietician who was quite judgemental about us as parents (…) it wasn't on the forefront of my mind that I was going to ask for any support over my daughter because I didn't want that judgement again.

The prior experience reinforced Angela's perception that a HCP visit potentially revealed negative aspects of her parenting. The word "judged" and being unwilling to advertise they felt they were not parenting well in the feeding domain was echoed by many participants. Despite some of the mothers with neuro diverse children having tangible evidence that additional challenges made eating particularly difficult for their child, nevertheless the spectre of failure loomed large. For example, Jasmine felt strongly about her role in Luffy's PE: "I'm failing as a mum." For her the guilt was almost paralysing and prevented her from effectively supporting Luffy:

> So because mum guilt is a powerful weapon [laughing] [JKY: Oh yes, it is isn't it] [both laughing]. There is nothing you can do. As soon as that kicks in you're stuffed. Like all of your logical thinking goes out of the window because you're like I'm failing as a mum, I'm not doing what I'm supposed to be doing.

"Supposed to" reflects the social pressure to perform parenting in a particular way, and the internalised guilt Jasmine feels. The "mum guilt" is experienced as overwhelming, a weapon that's activated within her, stripping her agency; she is "stuffed" and loses "logical thinking". Guilt was pervasive and disempowering for many of the mothers, and this potentially overwhelming and paralysing framework connects to wider, social discourses of parental responsibility as it intersects with health. It was a clear agent in some of the participants' narratives, for example, as Annie described, "because socially and in society, you read these articles about picky eating and behaviour, and you associate behaviour with parenting and parenting skills."

Further, although many of the parents faced consistent knock-backs when seeking support for their children's challenges they were primarily rejected on the basis of diagnostic criteria, age, or other tangible factors. Tui and Susan, however, recall being challenged about the

quality of their parenting. Indeed, Susan explains emotively what happened on referral to the hospital after Max had continued to lose weight: “the paediatric doctors (…) they were concerned that he had um, failure to thrive and that there was something that we were doing wrong as parents when there wasn't.” Both Tui and Susan lament the quick judgement of an expert who does not have the intimate knowledge to make this assessment of parenting competence. These mothers’ narratives communicate the emotional load that is borne via the label of poor parent and are examples of how difficult it can be to seek help within a judgmental health-care culture.

Whether censure, or just less comfortable interactions, prior experience impacted how likely or how quickly a parent was inclined to ask for help for PE. It is probable this was also influenced by the discourses surrounding PE, combined with the lack of concrete definition that colours how it is framed. Moreover, as discussed in Chapter 2, a dominant discourse circulates constructing feeding as a critical part of health and therefore ensuring a child is able to eat enough to grow, to have energy, and to develop optimally as a key part of parenting responsibly. Many of the parents used humour or exaggerated analogy to describe how they felt about their inability to feed normatively. As Jasmine recounts, “because in my mind (…) I’ve broken him”. It is a statement that captures the depth of feeling surrounding PE conveyed by many of the parents.

Regardless of how uncomfortable the participants felt, however, they all came to the point where discussing their child’s PE with a doctor was essential. They arrived at this decision for different reasons and at different points. However, all deemed their appointment with the medical professional to have been positive.

Part 2: A Positive Appointment

In this part of the analysis, I focus on participants’ accounts of what made their doctor’s visit positive. However, it is also important to contextualise affirmative factors against experiences that were less positive, which are included in this section, because without contrast some of the nuance may be lost. Subsections to this second mini narrative describe discrete but overlapping themes: validation of parent concerns; continuity of care; the relationship with the HCP; advocacy; how the HCP relates to the child; and discussing PE in front of a child. Throughout the stories parents also discussed how they presented

themselves and their challenges in ways that were a fit for the HCP provider and, therefore, success was partially contingent on participant actions.

"I Felt Validated That my Concerns Were Being Taken Seriously" (Angela)

Not all participants had expectations that a visit to their HCP would be fruitful. Prior experiences and/or their perception of the role or capability of doctors determined how likely they were to assume the interaction would go well. Expectations were also mediated by more positive assumptions for those with an existing relationship with the HCP. However, for all participants, a core element of a positive HCP interaction related to a sense of relief they were listened to, and their concerns acknowledged. As summarised by Annie, "I felt affirmed that actually this was worth investigating further, and that there could be some help out there (…) he definitely took it seriously." As Annie was not visiting a GP with whom she was well acquainted, this was a great, but not guaranteed outcome.

Similarly, Rhiannon had spoken to the GP in the hope that he could help, but having no clear idea of what this may entail: "I was surprised that I got the amount of attention on that issue and area." Huia in contrast, had a long history of help-seeking and having her concerns dismissed:

> [I]t wasn't like I had to convince her (…) um, so, yeah, it was pretty straightforward with that GP. [JKY: And, and was that what you expected?]. No [both laugh]. No, because that hadn't been my experience up until that point. I thought she might say what other people had said, oh she's gaining weight don't worry about it. Or we can do some blood tests (…). I just felt that she believed what I was saying, and that she took it seriously and that she acted on what she was able to do.

Despite Huia having a longer-term relationship with her GP, her expectations were tempered by her ongoing experience of having Haeta's PE challenges minimised. However, in this instance she was taken seriously. Being taken seriously was a common refrain across the stories, as was having their concerns validated. As Susan describes, "there was lots of kindness and compassion and and validating that this was a worry for us." However, perhaps that respect is accorded more easily to some than others, as Annie articulates: "I've got health privilege. I'm a white, educated woman who can speak clearly and knew what outcomes I wanted going in and was able to advocate for those." The contrast is shown for

Tui: “I had to learn to advocate for myself and for him and be very assertive because, especially because I was a teenage mum (…) I was pregnant at 18. Um, people just looked over me.” Tui goes on to explain how “society they think (…) it’s your parenting” when discussing Alexander’s neurodivergent behaviour.

Judgement is also apparent in the context of feeding. Tension was evident for some parents between conforming to normative feeding practices and therefore not being the object of censure, and what was possible for their child. It also meant the way the doctor responded to their help-seeking was critical. Deeming the interaction positive, was, for some, in large part finding absolution. Katie summarises, “And so I really felt heard that I wasn’t doing anything wrong to make him like that. And that also some kids are like this and that’s okay.” Katie and Jasmine both have neurodiverse boys they have needed to advocate for over the years. Prior to the GP visit they also expressed guilt that they had not been able to feed them according to normative standards. These factors mediate how they received the remarkably similar information relayed by their respective GPs. Katie explains how she was feeling and what the doctor said:

> I did feel less like a shitty parent [both laughing]. (…) It’s okay if he’s only eating peanut butter on toast, give him peanut butter on toast, it’s better than him having nothing [said in a sing song voice] (…) And he had this big cup of milk [infant formula] which gave him all the fortified iron and you know all that stuff that he was otherwise just not getting. Um and she was like keep doing that, that’s fine. Um, get the nutrients in any way you can. Here’s some vitamin options if you’re worried. (…) [then] She kind of was like forget about the food.

Katie communicates both her desperation and the change in perspective offered by the GP. The doctor was not concerned about what Jack was eating, she felt it was more important the volume was sufficient. Although agreeing to a referral (rejected) and offering some recommendations around the PE, as did Jasmine’s GP, the focus of the advice was on minimising the mother’s concerns and this was readily accomplished. The doctor also felt that finding easy ways to cover potential gaps in nutrition was sensible. Jasmine was offered similar advice and, as both mothers explain, this was crucial for their wellbeing on multiple levels. Katie reflects:

> [I]t was quite nice to hear someone say because you're drilled in about this food pyramid (…). And that was quite good to hear. Because you constantly try and follow all these rules when you're a parent and she just kind of said (…) you don't have to do those rules to be raising your child well (…) quite a good circuit breaker for my like underlying beliefs around what I had to do.

Both Katie and Jasmine were given permission to relax about their son's eating. Not only does the GP absolve them from the burden of guilt they have been carrying, but despite not able to eat in accordance with the food pyramid both boys are deemed healthy and supplementing gaps with vitamins or formula advised to be sufficient. These positive experiences relate directly to parenting identity. Not being able to feed normatively situates the mothers as failing. Conversely, the doctors' advice to minimise the importance of food and defer to supplements if necessary facilitates acceptance of the advice. The mothers welcome the doctors' recommendation as it resituates them as competent parents.

Katie and Jasmine explained how critical this was both for their mental health and for the long-term support of their children. As Katie recalls:

> I remember leaving (…) ringing my mum and being quite happy [laughing] that it was okay that my kid had some hot chips and bread (…). It's okay if it's a chocolate muffin not a blueberry muffin, like it doesn't matter [laughing throughout]. And it doesn't matter. But it did, but then I needed, needed it not to matter for us to be able to make a positive change for him.

Similarly, Jasmine explained what the doctor said:

> So for a start, stop beating yourself up about it. Because it's not something that you can just fix overnight. (…) sometimes it's not something that can be fixed (…) so that first step, I think was really good for me because it just helped me change my mindset.

Listening to these accounts, it is easy to appreciate why both mothers found their GP appointments to be positive, removing as it did the crippling burden of stress and pressure. Therefore, their affirmative experience also hinged on how the mothers viewed their parenting and possible culpability prior to the appointment. Rhiannon too, found her GP's advice to be very similar to that of Katie and Jasmine's, although Olive's outcomes were

different. Possibly this is in part due to the relative severity of Katie and Jasmine's son's PE and the additional complexity introduced by neurodiversity, despite Jasmine's GP disputing the PE was connected to Luffy's autism. Also, Rhiannon specifically sought input from her GP: "I wanted the doctor to say something to her as the expert [quote marks] because he's a he's a doctor. [Then] it had been quite obvious that I was there to include her." The GP was obliging and spoke to Olive directly while also explaining PE was quite normal and not something to be so worried about.

"Over the Week was Enough" (Rhiannon)

Rhiannon explained her GP reframed Olive's inability to eat fruit, vegetables, or animal protein when he said:

> [M]aybe she's going through a growth phase and needs lots of carbs at that point. [Then continues] five a day (…) you know we talked about that and how it can go over a week or even two weeks (…) if she didn't want animal protein, maybe she didn't need it (…) and it just shifted my um, whole attitude towards her eating from that point (…) not worrying so much about sugar.

Above, Rhiannon described how the GP explained the 5 a Day principle was a suggestion and not necessarily per day but could be eaten across a much longer period of time. Also, that sugar and carbohydrates may be appropriate for Olive at that stage. Rhiannon explained that, similar to Katie and Jasmine, in this consultation she found absolution from the enormous guilt she was feeling. Moreover, she was able to reframe Olive's eating as normal, thus aligning with competent parenting, and felt if she was able to relax it would probably resolve itself organically. Rhiannon was delighted by the support given, particularly as she was not expecting to find such relief.

"I was Very Familiar With Her" (Jasmine)

For all participants, the affirmative appointment appeared to be mediated in large part by their relationship with the HCP. The majority of participants had one or sometimes two doctors they saw regularly. Indeed, continuity of care was actively sought by most parents. As Jasmine explains:

> I was very familiar with her [one of two doctors] (…) have known Luffy since he was a baby so um, and that's been really important for me is having that ongoing care (…) [and

later] I would travel to see her, it's like finding a good hairdresser you know, you would just go to them, you follow them. It's what you do.

Other participants used similar language to Jasmine, communicating their luck and privilege to have a doctor who knows them, as they were aware it was not the norm. In fact, many of the parents followed their GP from surgery to surgery or drove significant distances to maintain the relationship.

Those participants without continuity of care were cognisant of the importance of a good relationship with the doctor. Therefore, where possible they sought a HCP who was likely to be sympathetic to their needs to increase the likelihood of a good experience. As Angela explained, "So I booked in with the one I have the best rapport with (…) hoped because he'd been, we'd had good experiences with him before (…) that he would be accommodating to those requests." Continuity of care with a GP deemed good was of importance to all, however, not always possible. For example, Annie's healthcare surgery did not allow patients to choose a specific GP, so when she tried to follow up her positive experience, she was given a new GP, who questioned the referral, and severity and importance of the PE. Sending her back to square one, Annie's experience demonstrated how critical validation of parental concerns is and how this demonstrates the importance of continuity of care and patient agency in this context.

"I've had Two GPs With Jack, and They've Both Been Diamonds" (Katie)

For those participants with a regular HCP there appeared to be a different dynamic than for those without an ongoing care arrangement. What stood out in the stories was how these parents described their HCP using superlatives. As Katie enthuses, "I've had two GPs with Jack, and they've both been diamonds." A diamond is both precious and rare and shows the depth of feeling parents have for a HCP who is attentive to their needs and those of their child. The words used demonstrate the quality of the relationship appeared paramount over the professional/pragmatic attributes of the HCP for those with continuity of care, which included all parents except Rhiannon, Angela, and Annie.

"I Feel Good When we go to See Her" (Sarah)

A common thread across participant stories for those with continuity of care was how the HCP made them feel. As Tui explains, "I've only had good experiences with her (…)

she's leaning in, she's active listening, giving feedback so I felt safe to talk with her." Feeling safe was important to Tui as this had not been her previous experience. Similarly, Sarah, summarised the feelings of many of the other parents who were fortunate to find a GP they could see on a regular basis: "I feel good when we go to see her because I trust her (…) it's a great relationship." In fact, Sarah went on to explain, "I felt like cared for, and like he [Thomas] was being cared for appropriately."

Sarah communicated the depth of feeling expressed at the care received. Care is another common word used across the stories. In some ways this is not unexpected, as it is the language of the medical professions. However, it is not a word used either by the participants without a usual GP, or common in the PE research literature. Empathetic, listening, and other such words summarising a good relationship with a person repeat through the stories. Genevieve said as she specified how the GP supported them, "we felt like she was on our page, and she was the advocate too, you know."

"Because I Have Worked Advocating for Him" (Bridget)

Many participants responded to a question on the interview schedule about whether parents had strengths that led to better encounters by explaining how they advocate for their child. Indeed, the mothers, aside from Genevieve, were quick to explain how they were an important factor in positive appointments. Genevieve did not initially list her strengths as she felt the information presented was what was important: "I don't believe any of my, my personality, my strengths or what I said, it was very factual the facts spoke for themselves." However, despite not acknowledging this was important, it was clear in her story she had engaged in significant research in order to support Grace's PE. Genevieve relayed what the doctor said: "whoa, you waited, you know, three, four months before you came to see me (…) I know you would have done so much during that time."

Genevieve's statement reflects how invested parents were in researching PE, its aetiology and remediation, and these were common themes across the stories. As Angela explained, "I'm someone who researches the hell out everything [both laugh]. And come completely prepared to any appointment." Angela, alongside many of the other parents, discussed how important it is to have facts at your fingertips, and research into problems prior to an appointment. Research was frequently framed in terms of advocacy. Parents, particularly

those with children with additional challenges, had often faced roadblocks for assessments and treatments and thus become adept at navigating the health system. Huia explains:

> [Y]ou kind of have to be willing to go into bat for your child when it comes to public health service in New Zealand (…) people can be quite dismissive (…) you have to be er, persistent without being rude (…) just being strong and communicating what you think your child needs.

Huia explained it may not be merely a case of attending appointments in order to have a child's needs met, but the value in being assertive. She also demonstrates the importance of meeting the needs of the HCP, and thus facilitating an affirmative appointment, a theme many of the participants wove through their stories. Bridget expands on this:

> [B]ecause I have worked advocating for him, I'm less likely to just kind of accept a solution (…) earlier on with Henry, I may not have gone to the GP or I may not have known the questions to ask or I may have accepted, oh, that's just what kids do.

Bridget demonstrates the progression of knowledge, confidence, and ability to advocate for a child that develops with time and experience. As all the parents had been either help-seeking for a considerable time or had consciously prepared for their appointments based on prior experiences, it is perhaps unsurprising that their encounters were deemed positive. There appears to be a general feeling this also leads to respect for the parent. Huia explains a conscious decision to situate herself as part of the team in order to be treated as such: "she [Haeta] was in hospital when she was born for a couple of weeks, and you have to learn their lingo and their way of doing things there." Perhaps the actions of the parents thus enable further support and a more team-oriented approach. Indeed, Tui reported her current paediatrician felt her unique understanding of her son and his needs was an asset: "you know him best. You're with him all the time."

Knowing their child well was a theme replicated across all the stories in one way or another. Jasmine explains, "I'm a very involved parent (…) because if I don't understand him he won't have a chance of figuring it out himself." Sarah extends this as she explains that the relationship she has with Thomas is one of the key elements that ensures a positive encounter with the GP. During the interviews many of the parents repeatedly highlighted the importance of relationships as a determining factor in good appointments.

“It was Awesome to be Able to Give Him a Voice” (Jasmine)

The centrality of the relationship also extended to the children. All participants felt the HCP acknowledged their child. As Annie sums up with humour, “it wasn't one of those appointments, where I felt like my child was invisible.” The parents place a high premium on the doctor–child relationship both as part of the family and in cases of continuity of care, independently. Even with the younger children, direct communication, where appropriate, was appreciated. Jasmine was delighted the GP involved Luffy, aged seven, even though this was unexpected: “I think it was awesome to be able to give him a voice. I think you (…) choose to be your child's voice (…) when sometimes they can actually talk for themselves.”

Thinking ahead is part of planning for parents, particularly when children have additional challenges. Both Katie and Huia appreciate the importance of ongoing care offered by the family GP as their children become teenagers. Katie explains, “as he hits puberty, um, I’d like to see her as someone Jack can trust to go to himself (…) she does have a relationship with him.” Huia is consciously nurturing this independent relationship: “she’s [the doctor] trying to involve Haeta in the decision making (…) and Haeta’s just becoming more comfortable with her. So, yeah, I kind of see it like as a long-term [laughing] investment.” In fact, Huia’s GP is supporting this “investment” by requesting periodic longer appointments so she can ensure she does not miss anything in the complexity of Haeta’s needs and be more thorough in her assessments. The actions of the GP build confidence for Huia. Similarly reassuring for parents was finding a HCP who is able to speak appropriately in front of their child.

“I Don’t Like Him Hearing it” (Tui)

How to communicate about PE both to and from the parent was a common thread across the stories. Although there were questions in the interview around whether the HCP spoke to the child, there was nothing that prompted a conversation about how to discuss issues in front of them. However, quite a few of the parents unbidden remarked on how important it was how PE was framed. As Tui explains, “I’m a bit wary in how I talked to her because when my sons in the appointment (…) I don’t like him hearing it (…) I try to frame them in not such a negative way.” Not speaking in deficits was a concern echoed by Bridget. However, there is the ongoing paradox that it is important to speak clearly and openly about issues in order to obtain the help necessary, and yet it can be difficult to do so.

Common narratives of ’’casual”, “calmly”, “matter of fact” were used to describe how HCPs discussed issues in front of children, who were all present at the appointments. How the doctors communicated both specifics and in general was a topic raised by all the parents. Further, speaking about eating in front of children introduces complexities the parents are keenly aware of particularly as they age, and the spectre of eating disorders is brought to the fore. Sarah discussed this, as Thomas was 16 at the time of his appointment: “she didn’t mention any of those trigger words.” Sarah is referring to calories and weight loss, which in her eyes were potentially unwise ways to frame eating solutions. The tension between achieving outcomes through robust communication with the GP, and not inadvertently exacerbating the situation is one parents were keenly aware of. Once again, the parents demonstrate that relationships are a critical part of a positive interaction.

However, despite the participants discussing their affirmative appointments with enthusiasm, there was still evidence of ambivalence. For example, near the end of her interview Rhiannon remarked, “but then do you trust your GP?” Although she acknowledges the doctor’s advice did over time help her to better support Olive’s eating, there was still some uncertainty. Rhiannon felt some conflict as to whether the input she got was indeed the best advice and wondered whether further intervention could have helped.

Part 3: Outcomes of Affirmative Appointment

In part 3 participants summarise what has happened since the affirmative appointment with the doctor. The stories, although unique, conclude with a similar point: the children are still challenged by PE. In some cases, there has been marked improvement of the PE, and in others the intervention has potentially led to worse long-term outcomes. Within this mini narrative these complexities are discussed, and a conclusion drawn.

Although Katie, Jasmine, and Rhiannon were enthusiastic in recounting how helpful the GP was, ambivalence is evident. Towards the end of the interview Katie reflects:

> I do wonder if (…) this kind of stuff was caught when he was between 2 and 4 it could quite possibly been more helpful than the advice I was given (…) which I think probably made it worse, not better. [Then the new age-related challenges] we have noticed (…) now that he’s 12 he’s starting to find the food thing (…) with his peers (…) he knows that he’s different (…) school camp he doesn’t want to go and one of the big barriers is food

> (…). And he's quite conflicted so he gets really upset. And that's something that the GP's can't do a lot with either because um, they also push away, and they don't want their help.

Katie and Jasmine both acknowledged that, despite some small steps forwards, the PE is still apparent. Katie is now facing a new challenge as Jack enters his teens and PE impacts on him socially. Resolving the problem is now also harder due to his age and natural inclination to shy away from support. She also reflects that if the PE had been addressed earlier possibly the longer-term outcome would have been better. Perhaps the positive interactions with the GP in these cases were paradoxically good for the mothers but inadvertently prevented further help-seeking or a determined focus on resolving the PE.

Susan, too, had complicated and ambivalent thoughts around Max's treatment journey and even remarked at one point she almost wishes she had never seen the GP. Overall, Susan's help-seeking story mirrors Rhiannon's in many ways, although the outcome differs. She too sought help from the GP as Max was eating a narrow range of foods. The GP was similarly unconcerned about what Max was eating:

> [T]hey minimised it being a problem and they just kind of said look, this is really normal for kids to be fussy [JKY: Yep]. Um, and it should resolve by itself, but actually we are really concerned about the weight issue.

The GP was empathetic about the PE and unconcerned about Max's diet until he weighed him, and realised weight gain was low. Susan argued, "but he's he's healthy, he's happy, he doesn't get sick regularly, um, we have no concerns about his development." Nevertheless, the GP was adamant the weight gain was an issue and advised:

> [G]ive him lots of ice cream um, give him extra chunks of chocolate in the evening, um, give him all kinds of things to try and try and fatten up because we really don't want him to get to the point where he's not gaining weight and he's got to be assessed by paediatrics. [Susan explains her discomfort] Um, I don't quite agree with the deep fry everything er er that conflicts a bit with my values of being a healthy parent (…) then he ended up living on fish fingers and chicken nuggets for [JKY: Right – Laughs] A long time [laughs].

The advice from the GP follows similar patterns to those of Katie and Jasmine, and while alleviating one problem, created others. Using fried foods contradicted Susan's parenting values, undermining her ability to meet normative ideas of a healthy diet. The recommendation caused both ongoing conflict as it did not feel right and longer-term issues where Max's diet did not improve. She reflects that "actually doing this [referring to the interview] has made me realise (…) because if he ate more variety, we would have more opportunity to give him healthy fats. Instead of (…) all these blooming oils and stuff."

"He's Definitely Tracking Down on his Growth Chart" (Bridget)

Max's current HCP has given similar advice, which is that fat is fat, and sugar is sugar, so do whatever works, as weight gain is essential. Max is also under a dietician who prescribes Ensure (a supplement drink), which is specifically for weight gain. Susan uses humour to discuss her frustration that none of the advice has been focused on supporting Max to eat more widely, and the sole focus has been weight gain, going on to reflect:

> [T]here's almost this need sometimes to educate the doctors of actually can we get this fixed before it becomes a weight issue and that's all you really care about? Um, because their attempt to fix the weight issue, um, worsened the picky eating by like 100-fold.

Susan is referring to the distressing experience when Max was forced into hospital against parental wishes and threatened with a peg feeding tube. When revisiting this incident Susan reflected on how the hospitalisation ironically resulted in more weight loss due to the methods used. The incident was traumatic, placing enormous stress on the parents. Susan is adamant a fixation on weight was misguided and solutions were temporary fixes, which perhaps long term caused greater harm.

Both Sarah and Bridget also shared stories in which weight was an issue for their boys. Bridget had gone to the GP specifically about Henry losing weight:

> So then she weighed him, measured his height, confirmed that oh yes, he's definitely tracking down on his growth curve (…). She contacted his pediatrician. Um, together they suggested Pediasure [supplement drink for children] (…) um, as a supplement just to kind of boost everything. Which kind of comes in a tray, and they're all plastic bottles, artificial, you know, [laughs] [JKY: Nodding in agreement]. Um, took a while to get a flavour that was palatable [laughs]. [Then explains] and while in hindsight maybe Pediasure wasn't

> the best choice it was certainly able to put on weight rapidly. [Reflecting] we just kind of blindly trust that a medical professional knows what they are talking about, and they may not.

"Together They Suggested Pediasure" (Bridget)

Bridget felt conflicted about Pediasure. When asked later what she would like in an ideal world she responded, a more natural alternative. She also questioned decisions made by HCP, despite her obvious positive appraisal of her GP, justifying, "I think they're really, they're stuck, because they don't have (…) a really broad range of knowledge." Bridget was therefore delighted supplements were prescribed in conjunction with the paediatrician, increasing confidence it was not an ad hoc decision. She also appreciated at the time that Pediasure resolved Henry's immediate problem, which was weight loss. Currently, although Henry is not eating as well as his peers, Bridget is comfortable with how far he has come since her GP visit and is no longer concerned about his PE.

Similar to Bridget, Sarah reflects on how much of a difference a supplement/rapid weight gain drink made to both Thomas and herself:

> [A]fter the fact, I realised how underlyingly anxious, I'm always worried about it, you know, like we want our kids to eat and be healthy (…) but it was only when we had that tin of powder, I loved making him those smoothies and taking them to him because I knew that he had a nutritional sort of broad blend.

Sarah acknowledges she had not realised the extent of her concern until she had the supplements. She relays her delight at finally having a solution that ensured Thomas was both eating and had a spread of nutrients to support him. Without being consciously aware Sarah felt she had not upheld her social responsibility as a mother to feed Thomas sufficient food and nutrients. Sarah was, therefore, quite strident in her advice to other parents to take note of the PE and seek outside help. She was also cognisant that both Thomas and his older brother, despite now living away from home, still have issues around eating.

Similarly, Tui reflected that Alexander's eating has not improved much: "So he has his normal safe foods which is about five or six different foods." Although Tui was happy under the care of the paediatrician, she was also concerned Alexander's limited diet may result in nutrient deficiencies. To address this, she requested Pediasure, as Alexander will no longer take the

multivitamins, which initially gave her some reassurance. However, when referred to a dietician in charge of prescribing supplements, what was deemed critical was whether Alexander's weight was appropriate. Currently, his weight is monitored but unless that drops Pediasure will not be prescribed. Annie's son, Alex, on the other hand, through a dietician assigned privately has been given Pediasure to cover gaps in his nutrition not covered by his diet.

"She Would Have Supplements" (Genevieve)

During Genevieve's affirmative GP meeting, supplements, in the form of prescription melatonin, were offered as the solution to sleep problems generated by PE. Similar to many of the other parents, Genevieve was not seeking a solution to the PE when she visited the GP; she sought a specific outcome. Genevieve believed resolving Grace's sleeping was the priority and in turn that would give her the ability to focus on the PE. However, of note, prior to and after the GP visit, Genevieve was giving Grace multiple high-quality supplements. Supplements provided assurance that, despite Grace's narrow diet, her health was not compromised in the short term. Since visiting the GP, Grace's sleeping has indeed improved, as has her eating; however, this does not extend to vegetables, for example. Therefore, although the immediate problem is addressed, creating a positive interaction, the long-term issue of restricted eating, particularly in relation to a whole group considered essential for healthy eating continues.

"We Can Get You Someone to Talk to" (Huia)

There are clearly multiple instances where what a child eats is not prioritised by the HCP. Despite all participants acknowledging they were unable to fix the PE themselves and, therefore, required help, the advice or support from the HCP was rarely focused on resolving the feeding problem. Instead, help primarily revolved around ameliorating symptoms, minimising the scope of the problem, or ordering specific tests, not on improving a child's ability to eat.

Huia's positive experience at the doctors, however, was recognition that what her daughter ate was important and that the GP could access specialist help through Haeta's existing supports. In this way Huia's situation was unusual as the GP actively looked for a way to resolve Haeta's PE: "this GP had said (…) we can get you someone to talk to you about that,

so who's actually trained in that area." Huia reflects that although her daughter is still a PE, the specialist support from the dietician was helpful.

"I Think We Should Ask a Dietician" (Angela)

Angela's doctor did refer her to a dietician, but this was specific to receiving calcium, not a general concern about nutrition. When Angela requested calcium tablets, the GP responded, "aw, I think we really should um, ask a dietician." He was either unwilling or unable to prescribe supplements and so deferred to a dietician to make the decision. Angela was delighted, as not only did the dietician provide calcium tablets, but also offered advice that was helpful and went some way to resolving Ella's PE. For Angela it was an unexpected but most welcome side-effect she reflected should be an integral part of supporting parents of PE.

Annie visited the GP to request blood tests for potential nutrient deficiency but also for a referral to a dietician. The GP ordered an iron test, showing Alex was indeed deficient. A food diary demonstrating how narrow Alex's diet had become supported Annie's request for the dietician referral. However, similar to Tui, Annie's locale has a procedure for PE the GP was unaware of. Rather than be seen by a dietician, all parents must first attend a course for picky eaters. However, although both Annie and Tui have attended the course, neither found it beneficial. Therefore, even with an affirmative GP visit, there remains this broader context they have to negotiate. For example, Annie thought the PE course content was great, but the ability to translate into results would be difficult:

> [T]hey gave so much incredible information and it's like how do I even action this like I'm someone who should be able to, I'm used to attending workshops, I'm used to that kind of way of learning. But without someone one-on-one coaching or specific support, it's not set up to be successful.

Annie explains that despite educational privilege she was still left navigating Alex's PE without adequate support. Annie was also concerned the course introduced an element of "gatekeeping". If you do not attend, your child cannot get further help nor see a dietician.

"Really Big System That's Broken" (Katie)

A serious accident has seen Alex assigned help for his PE through the Accident Compensation Corporation (ACC). Annie was delighted as "they recognize that his picky

eating is a barrier to him healing." Rather than dismiss the PE, the assigned dietician specified PE was impeding recovery and requested follow-up tests to ensure Alex's iron levels were now sufficient, plus a range of tests for other potential deficiencies. Annie feels "We're getting a really surface-level public health support that is kind of just ticking the boxes but when we go privately, we're getting decent help." Paradoxically, due to Alex's injury, Annie has found support for his PE.

Perhaps Katie's words responding to a question about what her GP could have done better summarises the conclusions many of the parents draw after years in the public health system:

> [A]t the end of the day, they're really restricted too with what they have access to. Like I, I think back when he was 4 or 5, I would have said yes, they should have tried harder and this and that. But I think the reality is is, that they're also a really small stepping stone in a really big system that's broken.

Perhaps indicative of this general feeling is that less than half the doctors followed up on the PE after the appointment even if the parents went back to see them in the short term.

Part 3, therefore, summarises outcomes of the affirmative visit to the doctor. Within this mini narrative there is positivity; however, that is limited in a number of ways. First, the general focus on symptoms, not the core problem of a limited diet, is seen across the stories and the narratives show long-term nutrient deficiency is still a consideration. In fact, this is the case for the majority of children discussed in the study, as only three are currently managing to consume sufficient nutrients for optimal development through their diet. PE is not, in the majority of stories, seen as a problem in itself by the doctor, which creates the second limitation: lack of ongoing care. Despite most participants having an ongoing relationship with their doctor, there is both little follow up and a healthcare system limited in its resources and procedures for PE, thereby reducing potential avenues for treatment. Finally, the stories convey how participants are still part of a system where judgement is a factor, and solutions offered do not always align with parent values.

Chapter Eight: Discussion

This study aimed to understand the stories parents of PE tell of positive experiences between themselves and their HCP and what the consequences of these affirmative interactions were. The main finding was their stories followed a clear three-part structure. Part 1, in which concerns about PE became increasingly acute, was a stage characterised by inefficacious remediation strategies and/or help seeking, until a crisis/turning point occurred, even then, sometimes taking time to get a positive experience after seeking medical help. Part 2 described the positive experience with a GP or paediatrician, who confirmed the mother's concerns and offered solutions in the context of relationship-building between mother, child, and HCP. Combined, parts 1 and 2 address research question one with its focus on identifying the stories told about an affirmative appointment. Part 3 answers the second research question, showing initial relief for participants, but subsequent barriers and ambiguity to effective treatment. The implication is, therefore, that some of the characteristics of the positive experience, for example, using food substitutions, rather than evidence-based change to facilitate wider eating, failed to address the problem in the long term.

Adding to this main finding is understanding that these experiences were shaped by gender. The importance of gender and motherhood was apparent both in how participants talked about their experiences and the outcome of recruitment, attracting only females. Gender also shaped why the appointment was positive as an antidote to judgemental criticism of mothers, for some, a large contribution to the affirmative experience. Recruitment also highlighted another factor that may be contributing to positive experiences, in the context where research suggests these are infrequent, neurodiversity. Neurodiversity, therefore, may have made doctors more primed to accept PE as a problem and/or that the mothers had opportunities to develop relationships with the HCP.

Therefore, this is the first study of its kind on a number of levels. First, to focus entirely on PE in an ANZ context, except one other exploring ARFID from a HCP perspective, Jackson et al. (2022). Second, there has been no research, either locally or internationally, exclusively focused on the experience of interactions between help-seeking parents of children with PE and primary care physicians. Further, no study has sought out positive doctor's appointments for PE, exploring what makes them so, and considered whether those good

encounters lead to productive outcomes. This research sits with literature that is part of a growing body of research exploring part 1, how parents manage PE. Parts 2 and 3 have only been touched on in prior studies. Seven recent qualitative studies were found that explored PE. Three of those studies focused only on clinically diagnosed presentations of PE: Estrem et al. (2018), Lamm (2022), and Simione et al. (2020). Two studies researched extreme PE, which more accurately reflects the experiences of the majority of participants in this study: Chilman et al. (2023) and Cunliffe et al. (2022); and two papers looked at various presentations of PE: Trofholz et al. (2017) and Rubio and Rigal (2017). My findings support and develop this research significantly.

Findings focus on the three-part narrative structures, but within these, there were several themes that provided further insight into the research questions: definition of PE; wider discourses of gender; the primacy of the HCP relationship; and the limitations of care. These are discussed below in dialogue with relevant literature.

Definition of PE

Several key sub-sections were apparent in part one of the narrative: how parents framed the PE; their acceptance of non-normative feeding; and focus on eating within public health guidelines. The first of these concerns how PE was conceptualised. In lieu of a widely recognised universal definition, what constituted PE and associated issues was open to interpretation and that was evident in the stories of the parents and mirrored the literature (Goday et al., 2019; Rubio & Rigal, 2017; Trofholz et al., 2017; Wolstenholme et al., 2020). Due to complications introduced by normative food neophobia and imprecise definition, a lack of common understanding generally, medically, and scientifically has led to much frustration among researchers and challenge comparing between studies (Taylor & Emmett, 2019; Wolstenholme et al., 2020). Therefore, in this study, although referencing other research, I was cognisant of the difficulty generated by lack of agreed definition and was attentive to how PE was conceptualised by the participants.

Varying levels of acceptance of feeding that was non-normative in terms of public health advice was also communicated by the participants, a pattern likewise apparent in previous studies (Chilman et al., 2023; Cunliffe et al., 2022; Trofholz et al., 2017). How PE was conceptualised, and the prioritisation of eating challenges within this, meant participants tolerated PE, obvious inconvenience, and often upset for varying amounts of time.

Participant beliefs around PE determined what was acceptable in terms of feeding problems, with the concept of PE as a phase a dominant narrative.

The majority of participants believed, at least initially, their child's PE was part of a normal development stage in which foods are likely to be rejected. Despite upset to family dynamics, their assumption that eating would improve given time dictated their relaxed approach to the PE. Some parents, although asking for help sooner, still believed PE was normative. The participant beliefs align with the literature, where a historically protective food neophobic trait in young children has been well documented (Hazley et al., 2022; Rozin & Todd, 2015; Torres et al., 2020). PE was therefore frequently situated by both participants and HCPs as a normative phase (Cunliffe et al., 2022; Wolstenholme et al., 2020). Further, widely held societal understanding that PE is transient was shown across the stories, for example, agencies such as the child development centre also framed eating challenges as a phase.

Parents were aware of this wider community belief about a PE phase. However, there were strong competing narratives to contend with. For example, the compromise of limited nutrition while a child worked through this stage and the awareness of eating competence among their children's peers and siblings (Estrem et al., 2018). However, navigating contradictory information, with a PE phase as acceptable versus awareness of unpalatable aspects of limited diets, and deciding which takes precedence, created uncertainty. Indeed, one of the parents even visited the GP with the desire to establish from an expert which information was correct. The study demonstrated how distinguishing between problematic feeding and normative food refusal, a phase, introduces confusion for both parents and HCPs, an issue also discussed by Chilman et al. (2023) in their research.

Therefore, some participants in this study did not become alarmed despite years of PE, as feeding normatively was not felt to be potentially detrimental to health. When PE was seen as not medically urgent by parents in prior studies, a similar position was adopted (Trofholz et al., 2017). In this study, for these parents, ensuring their child was fed, rather than dietary composition, took primacy and was, understandably, a key factor in participant decision making. Similar findings of calorific intake as priority are evident in studies where clinically extreme PE is evident (Lamm, 2022). In this study, when fed is best became the only viable philosophy, participant stories roughly divided into two equal camps.

For one group, it was a necessary action and because eating non-normatively was not believed to automatically lead to negative long-term repercussions participants were relatively comfortable with the decision. The other group, characterised by an emphasis on the importance of nutrition, acknowledged their lack of choice, as their efforts to improve their child's diet had failed. Therefore, acceptance of calories over content was done only with reluctance and a sense of ongoing discomfort. Chilman et al. (2023) and Simione et al. (2020) both touch on this dilemma, and, here, I provide further evidence that this shapes patient interactions with HCPs. I also show how it held implications for the help-seeking trajectory.

Indeed, the length of time participants waited before help-seeking was mediated by how damaging PE was deemed. Therefore, the turning point in the narratives at which external help was sought occurred at different points and is detail that has previously not been considered in depth. What was evident across the stories was that once parents acknowledged PE was affecting their child's health and development all parents acted. For some this realisation was retrospective as they had not appreciated the depth of the problem until finding a solution. Prior research also shows that evidence of medical necessity prompts action, and in studies where diagnoses are obtained early help-seeking begins immediately (Estrem et al., 2018; Lamm, 2022; Simione et al., 2020).

However, this study further contributes to the wider literature by demonstrating how parents of children with a range of presentations of PE determine what is problematic and decide when intervention is necessary. The study's findings are novel in the ANZ context where there is no research on patient experiences of help-seeking for PE and other studies are limited. Galloway et al.'s (2018) research looked into the impact of socioeconomics and PE on weight gain in infants, and Jackson et al. (2022) focused on doctors' understanding of the specific manifestation of an ARFID diagnosis. Uniquely, therefore, this study's findings show the presence of mother-led actions often with significant barriers to getting the help they seek and need. Further, their level of concern was also in part contingent on gendered roles and obligations, prominent across the stories.

Wider Discourses of Gender

The importance of gender was evident in the stories participants told. The mothers revealed in all three parts of the narrative how gender explicit some aspects of their

behaviour were in terms of managing PE, seeking help, and accepting solutions. In part 1 of the narrative, discussion centred on the mother's personal responsibility around feeding and how that was inextricably bound up in normative ideals about parenting and following public health guidelines. It also demonstrated how feelings of guilt and shame influenced participants' behaviour once help was sought.

The gendered nature of feeding was made apparent in the study in a number of ways, most obviously through an exclusively female cohort. The dominance of females within a feeding study aligns with the substantial body of literature that demonstrates how childrearing and feeding are primarily gendered (Faircloth, 2021; Lupton 2009; Maher et al., 2013, Riley et al., 2019; Watson-Mackie et al., 2022). In other recent qualitative studies where parents of PE have been studied, male caregivers have also been part of the research. However, even in that research, participants were primarily women, so that while fathers were represented they either provided a minor voice, were part of a two-parent dyad, or researchers did not differentiate findings by gender (Chilman et al., 2023; Cunliffe et al., 2022; Estrem et al., 2018; Lamm, 2022; Rubio & Rigal, 2017; Simione et al., 2020; Trofholz et al., 2017). As this study only interviewed women, the gendered aspects of parenting may be particularly noticeable and perhaps provide a unique insight into the influence of expectations placed upon mothers.

Hays's (1996) concept of intensive mothering offered a useful conceptual lens for exploring gendered expectations on mothers. Within Hays's framework, the child is centred, and no efforts are to be spared emotionally, practically, or financially in ensuring the child is raised to exacting standards. Research suggests a focus on children's health has contemporarily become one of expected obligation rather than the more organic process of previous generations, particularly in a neoliberal political climate (Barnett & Bagshaw, 2020; Hays, 1996; Lupton, 2009; Riley et al., 2019). Social pressure to feed in accordance with this was apparent across all the narratives and indeed, in some, was a key factor influencing behaviour in parent stories. Although lightly touched upon in previous PE studies this aspect of feeding has been more widely addressed in general studies pertaining to children's food (Maher et al., 2013; Watson-Mackie et al., 2022).

The contemporary importance placed on intensive mothering practices produces additional pressure upon women to perform motherhood in a particular way (Wolf, 2011). Within this

ideology, mothers are burdened with what Daminger (2019) terms cognitive labour, the project management of a household ensuring all things run optimally. Cognitive labour was evident through participants' discussions of the dominant role they played in coordinating their child's life. One such example is that, despite all but one participant living in a dual-parent family, fathers were noticeably absent from discussions. In fact, only one mother routinely used the word we, including her husband. The participants were clearly taking on primary responsibility for both feeding and support of the PE.

They were also cognisant of normative ideals for parenting and to varying degrees accepted that public health guidelines represent ideal feeding practices. Nowhere are these feeding obligations more apparent than in the ubiquitous focus on consumption of fruit and vegetables (Watson-Mackie et al., 2022). The importance of 5 a Day and eating according to the food pyramid are widely engrained public health messages and a key aspect of the good motherhood discourse in contemporary culture (Henderson et al., 2016). These directives are overwhelmingly aimed at women (Lupton, 2011; Sattar & Forouhi, 2021). Therefore, in line with prior research, some participant stories reflected understanding of how they were located within a wider discourse of ideal parenting and, particularly, motherhood (Chilman et al., 2023; Cunliffe et al., 2022).

Unfortunately, this discourse of idealised feeding is often experienced as pressure for perfection by mothers (Lupton, 2009; Maher et al., 2013; Riley et al., 2019). How invested participants were in seeking perfection also had implications for how they both sought and accepted help. For some participants, although they acknowledged they would prefer their child to eat normatively, they resisted the pressure of ideals. For others the burden of attempting to squeeze their child into feeding norms was a key part of their narrative, generating guilt for not living up to ideals. For example, that the consumption of specific amounts of certain foods is essential for children to be healthy. Stories across the narratives provide an in-depth representation of parental obligation and conflict. The desperation felt at the inability to feed a child in line with public health recommendations is a level of detail not addressed in previous research. Although other studies touch on children not eating vegetables and the worry about nutritional intake, there has been little qualitative attention paid to this aspect of parental concern (Chilman et al., 2023; Rubio & Rigal, 2017; Trofholz et al., 2017).

Conversely, in this project not eating according to the 5 a Day directive was a main theme repeated across the narratives. Indeed, although help-seeking was, for some, precipitated by a child's weight loss or not eating enough, for most it was lack of consumption of foods deemed healthy and/or missing out on specific nutrients due to their restricted diet. The study clearly shows how important it was to participants their child was eating foods believed to be critical for optimal development and therefore aligning with general understandings of normative feeding. For some participants the depth of feeling over the concern of potential damage from a limited diet was reflected by the adoption of extreme measures such as starving their child for compliance.

For those mothers with a neurodiverse child, feeding challenges were often more complex. As Maher et al. (2013) found, there is little nuance within public health messaging. Given the simplicity of the normative directive that does not account for differences in capability, there is significant potential for harm in this messaging for mothers with neurodiverse children, as I outline below. Although some participants in this study recognised that additional challenges such as sensory differences affected their child's eating, nevertheless, an overwhelming pressure to feed according to widely accepted norms was felt. Some participants were therefore stressed and uncomfortable about attempting to perform what may, for them, have been the impossible. Eating in accordance with healthy guidelines has proven difficult for certain children, and is well documented in studies (Chilman et al., 2023; Cunliffe et al., 2022; Lamm, 2022; Simione et al., 2020).

One of the features of interviews in this study was, therefore, how parents were often mired within expectations, some even contradictory, and how they accepted or resisted these. For example, refusal to concede to the recommendation of a paediatrician, as deemed detrimental by the parent for her child, but thus also contradicting medical advice and a possible PE solution. The ability to refuse advice, despite cognisance of normative dictates aligns with Lindsay et al.'s (2021) proposal that dogmatic adherence to guidelines may not be in the best interests of a child. However, the pressure to conform was apparent across the narratives. Both Maher et al.'s (2013) and Watson-Mackie et al.'s (2022) studies in Australia echo this in their exploration of how mothers navigated multiple and often competing messages when feeding their children.

Participants were also aware of wider social discourses that position PE as parental failure. These feelings of inadequacy are represented in the literature, with acknowledgment of feeding well as evidence of good parenting and poor eating as a reflection on how a child is being raised (Cunliffe et al., 2022; Rubio & Rigal, 2017; Silverman, 2010). Despite not being a question on the interview schedule, deliberately crafted in line with AIQ to elicit positive stories, several participants discussed explicitly how PE connotes failure. To not perform competently something deemed a core responsibility for mothers was seen as a challenge to their parenting. The words used to describe feelings were often ones of both defeat and shame, such as “broken” and “taboo”.

Therefore, many of the participants were reluctant to seek help and discuss their child’s PE, feeling it reflected badly upon them. It also meant other potential avenues for help may not have been possible, as parents were unwilling to acknowledge PE was affecting their families. Participants avoided conversations that potentially introduced both “noise” and possible social censure. Other studies touch on this; for example, Rubio and Rigal (2017) found parents experienced criticism from family members and Lamm (2022) found that participants preferred not to engage with those who did not appreciate the extent of their difficulties. In this study, some parents were prevented from help-seeking as they were attuned to wider considerations. For example, not wanting to be seen a helicopter parent seeking help for something minor, with the confusion around what constitutes problematic PE obviously contributing to participant perception of potentially wasting the time of a HCP.

A feeling of failure is not a place of strength from which to operate. Unfortunately, this may also be detrimental to the way that parents feed, producing a negative spiral. Research shows the relational nature of the feeding dyad means parenting practices can have large effects (Walton et al., 2017; Wiggins, 2001). Indeed, some of the participants were able to reflect on how unhelpful negative feelings were. Unfortunately, unfavourable assumptions about parenting competence have negative ramifications, particularly when judgements come from those expected to be supportive (Cunliffe et al., 2022; Galloway et al., 2005; Lamm, 2022).

Judgement has been shown by HCP providers (Chilman et al., 2023; Cunliffe et al., 2022; Lamm, 2022). The present study supports these existing findings. Despite the study focusing on positive experiences with HCP, many parents also spoke of less supportive appointments

they had attended previously, to the extent that the positive experience was often framed as unusual. Participants were often surprised even retrospectively that they had been able to find support. The delight in finding a doctor who met expectations in regard to PE is, therefore, for many participants, best understood in relation to their prior experiences. Lamm (2022) found that parents of PE in her study reported a similar delight when support was found for their child's eating after often numerous rejections or non-positive appointments.

Primacy of HCP Relationship

This study is the first to exclusively explore interactions with doctors when seeking support for PE, both locally and internationally. Other studies have touched on appointments with a HCP in the PE context, but none have looked in detail (Chilman et al., 2023; Cunliffe et al., 2022; Estrem et al., 2018; Lamm, 2022; Simione et al., 2020). Simione et al. (2020) list the characteristics of HCP that are most important to parents; however, beyond this, there was little focus on why appointments were deemed good.

In this study, findings concentrate on participant narratives from part 2, where across the stories there were key commonalities, many of which hinged around the relationship with the HCP. Positive aspects of this relationship included the doctor's acknowledgement of participant concerns around PE, the validation of mothers' mothering, and the HCP creating a relationship with the child. Although doctor–patient and doctor–child relationships have been widely researched in general medical appointments, the complexity that arises when specific to PE is important, and unique to this study. There are also further interpersonal dynamics that contributed to positive doctor–patient relationships apparent across the narratives. For example, the importance of parental advocacy in facilitating success in the appointment and how continuity of care conferred benefits that may be a key factor in providing positive support. As caregiver experiences of shame and guilt also influenced perception of medical interactions, how parents perceived their child's eating in general, and their experiences of PE prior to the doctor's visit also impacted greatly on their stories and will be discussed.

All participants found the manner of their HCP underpinned their affirmative appointment, with the trait of being "personable" effectively conceptualising that key characteristic. Without this core interpersonal relationship factor, regardless of the outcome of the

interaction, it may not have been viewed in the same light. The finding that being personable is of primary importance aligns with Simione et al.'s (2020) study in which parents of picky eaters listed the most important attributes of a HCP. These, in order of importance, were personable, knowledgeable, and experienced.

The findings in this study, however, then appear to contradict Simione et al.'s (2020) results. Although medical competence can be accepted as a given, none of the narratives emphasised either knowledgeable or experienced in their summary of why the appointment was positive. Perhaps to a degree this divergence reflects the severity of the feeding problems and the length of time parents had been seeking support prior to receiving adequate help. In this thesis, although some of the children had reached a point where medical intervention was essential due to extreme calorific deprivation, nutritional gaps experienced by the majority are not framed as urgent. Similarly, although some of the participants had been seeking help for their child's PE for some time, it was not prioritised in the same way as for children needing immediate medical intervention, as was the case in other studies (Estrem et al., 2018; Lamm, 2022; Simione et al., 2022). Again, the lack of clear parameters around what constitutes problematic PE introduces complexity to discussions. However, in the stories of the participants, it is clear the relational aspects of the appointment were of primary importance.

The participant stories also reveal complexity even within interpersonal attributes about why experiences were deemed positive and factors that made this more likely to occur. What on the surface appears fairly straightforward is perhaps more nuanced when explored in depth. For example, if prior experiences led to low expectations, then meeting minimum standards of interpersonal care perhaps provokes a positive response. In fact, many of the factors that were deemed positive appear to be essential components of a good relational interaction, whether medical or otherwise.

Indeed, a core component of the positive appointment for all parents was being listened to and having their concerns validated. These are well documented in the literature as being essential for any patient (Dorr Goold & Lipkin, 1999; Lamm, 2022). For example, validation that mothers' concerns were warranted and reassurance the participants were competent parents despite feeding problems was common across the narratives. Similar relief that PE problems are acknowledged by HCPs is evident in prior research where doctors' visits are

discussed (Chilman et al., 2023; Cunliffe et al., 2022; Lamm, 2022). For some parents this validation was contrasted with a history of having their child's PE dismissed or feeling they themselves were unheard. Poor communication has been linked to unsatisfactory outcomes and that is reflected by how important active listening was deemed to be by the participants (Matthys et al., 2009). Beitat (2015) also believes feeling heard may contribute to better decision making as communication is more open, responsive, and reciprocal. Moreover, as research shows that the best diagnostic tool for physicians is a patient-centred medical appointment, the importance of this is clear (Kennerly et al., 2012; Khawaja, 2021; Lin et al., 2005). It is also reflected in the study where additional feelings of satisfaction were expressed if the HCP acknowledged the PE was a problem for the mothers, thereby appreciating parental needs.

However, acknowledging a parent's belief there is a problem may not go far enough. Many participants knew instinctively PE was more than a passing phase but had struggled to have this recognised. Estrem et al. (2018) found having concerns dismissed can also challenge a parent's confidence in their own judgement despite unique knowledge of their own child. In this study narratives demonstrated this, for example, showing participants had previously received advice that PE was a function of either parental or childhood anxiety. Parents then doubted their judgement, even when it was clear to them the PE problem was greater than acknowledged by a HCP. The participants' challenge is echoed in the literature as both Lamm (2022) and Glynn (2014) discuss the importance of a doctor trusting caregiver intuition that something is wrong.

Participants were also often feeling vulnerable, so the reception they received was critical. Despite the appointment focusing on the child's PE, a recurrent theme across many of the stories was HCPs prioritising the wellbeing of the parent, with concern shown for the mother as important if not more than for that of the child. Stress felt by participants was clearly communicated, alerting HCP to the importance of parental mental health. Indeed, for several parents, what made the appointment positive was a focus on them, with doctors seemingly seeking to absolve guilt over the PE, the driver of stress. Two of the participants discussed specifically how the appointment was important for their mental health, and several others alluded to it. Not only were they absolved of guilt, but this reset participant perception of their own parenting competence, reinstating the identity of the good mother,

and demonstrating the sensitivity of this by the doctor (Lupton, 2009; Riley et al., 2019). Indeed, the relief shown by several participants was palpable once that burden of failure was removed.

Therefore, how the participants were feeling prior to the appointment determined to a degree how they responded to the HCP. When at a point of desperation about PE and casting doubt on their parenting competence, experiencing absolution from failure was of primary importance. Conversely, other parents were not at the same breakpoint and so reassurance by the HCP that PE was not a concern was received with more ambivalence. Being reassured that parents were not at fault was still meaningful; however, resolution of the PE was more important. Regardless, the key narrative across the stories was how the appointment made participants feel.

An empathetic response from HCPs was critical, as evidenced across the narratives. Research shows that empathetic doctors have better clinical outcomes and patient satisfaction (Derksen et al., 2013; Mercer et al., 2008). Empathy can also mean feeling cared for, which is essential. However, for one of the Māori participants, it was also about feeling safe, as they had not previously been treated with care and respect. It is difficult to draw conclusions based on one participant's experiences; however, there is research to suggest Māori may not receive quality or non-discriminatory care if unable to choose their own HCP (Reid et al., 2016). Indeed, for this participant, finding her own HCP resolved ongoing issues with the standard of care. It also finally introduced trust to medical appointments, as her pediatrician demonstrated her son's needs were paramount.

Trust in the HCP and even the medical system as a whole was to a degree contingent on prior experiences. Previous negative interactions impacted future decisions. For example, one of the participants was hesitant to seek help from a dietician as her parenting competence had been challenged in an earlier dietician's appointment. Similarly, judgement or ineffectual care affected parental perceptions in Cunliffe et al.'s (2022) study. Conversely, in this study, positive prior experiences built faith and confidence in medical encounters. For example, a participant reflected on how helpful her GP had been and encouraged other parents to act sooner. Affirmative appointments also created positive perceptions in other qualitative research (Lamm, 2022).

In any good medical interpersonal relationship, an underlying feeling of trust on both sides is essential. Participants demonstrated this in the study, via their faith in the HCP they saw. In medical settings this has proven important for patient satisfaction and positive outcomes (Bova et al., 2012; Brennan et al., 2013). Despite this confidence, however, there was often still a level of ambivalence shown by participants. The apprehension felt by some parents around how much trust could be extended to their HCP was mediated by a range of factors, such as longevity of the relationship with the doctor and long-term results.

In the study, the majority of participants felt the advice they received was good. Even with the benefit of hindsight and long-term outcomes that have often been less than ideal, all the participants still deem the appointment positive. The study also found instances where the doctor's care and concern appeared as valuable as concrete actions. Ong et al. (2014) also found that a compassionate doctor sympathetic to PE can provide comfort to caregivers, even if they are unable to provide solutions. There were also instances in the study where the time taken to evaluate issues and provide a solution led to greater trust in the suggestions and was even articulated as such by participants.

Relatedly, "calm", "casual", and "matter of fact" were all terms parents used to describe how the doctor discussed issues in front of their child. The importance of using non-triggering language and demeanour was raised by a number of the parents and suggests sensitivity by the HCP to the feelings of both child and caregiver. Although a question was specifically asked around including the child in the appointment, there was no mention of how to discuss PE appropriately. The frequent reference across the stories to the challenge of explaining PE issues in front of their child and applauding the doctor's response reflects the importance placed upon getting this right. These findings contribute to the literature around what is valued by parents when visiting the doctor with their picky eater. The commonality across the stories reflects both HCP sensitivity and a core tenet of what produces a positive appointment. Not specific to PE, but similarly important, participants were often delighted by how their HCP included their child in the appointment, and this was universal rather than contingent on whether the doctor was the family physician providing ongoing care.

The topic of continuity of care was an important part of most narratives, even if not framed in those terms. Continuity of care has been shown to be critical in maintaining the

therapeutic relationship, and even lower mortality rates, and may be particularly relevant when a child needs the safety and confidence provided by an ongoing relationship (Detz et al., 2013; Pereira Gray et al., 2018). Indeed, one of the teen children may not have responded positively to the hand on the door question if it had come from a less familiar GP. The importance of continuity of care was clearly demonstrated in the study, particularly for children with additional diagnoses and was secured for all such families in this study, with one exception.

Relatedly, being unable to secure a regular doctor is shown to be a source of concern for the participants for whom this was not possible. In this situation, efforts were made to find a GP likely to be sympathetic to parent needs. For one participant, the importance of this was proven. When needing to return to the surgery for a new referral, a different GP did not accept that her son's PE was a problem, despite being deemed important by the first doctor and critical by ACC.

Therefore, it is unsurprising those caregivers in the study who do have children requiring more medical support recognised early on the importance of a trusted HCP, particularly in a public health system where this is not always possible (Silwal et al., 2023). They thus made it a priority to build a relationship with a HCP they liked and trusted, and this is demonstrated by how long parents have been seeing a particular doctor, as well as the lengths they go to in order to maintain the relationship, for example, driving considerable distance. It may also be the case that the high percentage of participants with neurodiverse children participating in the study hinges on how probable it is that they have a doctor of choice, thereby are more likely to be having needs met.

Parents who had a longstanding relationship with their doctor discussed them using superlatives such as "diamond". The words used were also those of interpersonal relationships rather than professional attributes, for example, feeling good when they see them. The framing of the relationship in this way suggests the doctor is viewed as someone who cares and supports caregivers, perhaps delivering help beyond a purely clinical need. Indeed, caregivers discussed their privilege in finding and maintaining this connection. Continuity of care with a trusted doctor therefore makes affirmative appointments likely.

Similarly, the participants also demonstrated how they contributed to positive appointments through their decisions and actions. Existing research has also found parent advocacy is a core feature of positive outcomes for children with feeding challenges, although this aspect has not previously been explored in the context of a HCP appointment (Chilman et al., 2023; Cunliffe et al., 2022; Lamm, 2022). Therefore, positive interactions appeared to be partially mediated by parental advocacy both during the original affirmative encounter and subsequently. An overriding theme was knowing their child well, and indeed research suggests that caregivers have unique insights into their child (Dokken et al., 2015). It is also important to recognise many participants had a history of seeking support for their child because of their other challenges. Due to their experience, they were perhaps more adept at navigating the health system than parents who were less frequent users. Indeed, parents in the study discussed both their current competence and former naivety. It is, therefore, important to question whether less empowered parents, even if visiting the same HCP, may have experienced different results.

Also apparent in the study was that parents were generally well prepared for their medical visit, particularly those seeking a specific outcome. Being armed with information and justification for a request was perhaps more likely to elicit a positive response from the appointment. Research in ANZ backs this up, with medical literacy likely to elicit better responses (Glynn, 2014).

Limitations of Care

In part 3 of the narratives, discussion centred on the outcomes of the affirmative interaction with their HCP. As PE presents heterogeneously and children discussed in the study were at different ages and stages of eating challenges, there were discrete stories, as is evident in previous research (Chilman et al., 2023; Cunliffe et al., 2022; Lamm, 2022). Further, these outcomes were contingent on a variety of factors, such as the differing positions doctors took determined by their understanding of PE, and the way symptoms were often siloed, or calories prioritised over diet composition. Results also depended on the approach of the parent, particularly in terms of advocacy. Therefore, in this section, much of the narrative covers areas under-studied in prior research. However, it also becomes clear through the narratives that results are mediated to a large degree by limitations to the care possible within the current public health system.

In the study doctors embraced differing positions on PE. Given the challenge around definition, this was not unexpected and mirrors the literature, which catalogues how inconsistent HCP positions on feeding problems are (Chilman et al., 2023; Cunliffe et al., 2022; Lamm, 2022). However, the findings must also be contextualised. For example, children were presenting at different points in their PE trajectory and with various problems arising from their eating issues. These factors necessarily impact how problems were viewed and addressed, for example, the intervention immediacy of a child losing weight versus a child whose diet is limited but development not a factor. Also, a reliance on parental reports throughout the study make it difficult to judge where emphasis is placed in a medical appointment. For example, if a mother's wellbeing is judged to be more important than a child's PE, emphasis may be on reassurance that a child's consumption of a variety of foods is less of an immediate issue, reducing stress for the parent.

How HCPs understood PE in terms of its transience also had implications for their advice. For example, some of the doctors deemed it part of a normative phase. When this was the case, although offering reassurance to the parent and even advice on how to best manage the PE, minimising the problem was a focus. As discussed, the upside of this was that parents often felt better, particularly in terms of mental health. Lower stress may also have resulted in less mealtime distress, which is important for appropriate feeding (Neece et al., 2012; Silverman et al., 2020).

A difference in the response from the HCP about the PE, contingent on the approach from the parent, also appears likely. Those parents who framed PE as a general problem were often reassured their child's eating was not an issue. For some of the parents this response had been an ongoing feature of previous healthcare appointments, with worries about PE minimised. Conversely, those parents who addressed the PE with specific concerns, such as a calcium deficiency, appeared less likely to be dismissed with reassurance that it may be a normative phase. When the parent presented strong evidence their child was deficient in a critical nutrient, it may have demanded acknowledgement that a general concern over PE may not.

The response to specific requests may also be indicative of a biomedical view that simplifies solutions by focusing on individual problems. Siloing of symptoms was a feature across many stories, with PE seen as discrete from other challenges. One of the participants expressed

her frustration about various specialists for her daughter, all focused on specific areas rather than seeing a connection between the diagnoses. The focus on individual problems has been identified in the literature by Rocca and Anjum (2020), who discuss how distinct issues are treated as discrete medical problems and so attract specific solutions. Across the stories, despite evidence of challenges posed by additional diagnoses, there was little acknowledgment of their importance for PE. For example, when examining a child with ASD, one of the GP's explained to the parent PE was common to all children and the autism was not a determining factor, despite research to the contrary (Kerzner et al., 2015; Ledford & Gast, 2006; Sharp et al., 2013).

Similarly, despite many of the doctors counselling participants about food for their children, research suggests that GPs do not receive sufficient education in nutrition to confidently discuss this with patients (Adamski et al., 2018; Caldow et al., 2022; Carter et al., 2022; Crowley et al., 2019). The complexity introduced by PE would make for even less surety. Doctors may therefore be basing advice on a combination of personal and professional experience and opinion. Indeed, across the study HCPs discussed nutrition varyingly. However, the overriding message was that eating according to public health guidelines was not essential.

Most participants were advised to think primarily about calories. Advice varied, but generally the content of the diet was deemed less important than ensuring adequate intake. Food is food was the overriding message. However, this introduced tension for the participants. Most parents were uncomfortable discounting research showing foods like fruit and vegetables provide for optimal long-term health and that processed food intake is often counter to this (Aune et al., 2017; Donaldson, 2011; Sattar & Forouhi, 2021; Wang et al., 2021; WHO, 2012). However, the degree of discomfort was mediated by how much emphasis parents put on nutrition, to a degree how much they trusted their HCP, and whether their child was maintaining weight.

Throughout the study there was also little medical attention to the impact of a limited diet. Indeed, only two doctors acknowledged the child's diet was problematic. Despite often very restricted intake, testing was done only on those nutrients where parents believed a deficiency was likely. For example, one mother was concerned about an iron deficiency, but no further tests were deemed necessary until she was seen privately, despite her son's

extremely limited diet. There is thus the potential to miss important clinical issues. Unlike weight, there may be no obvious external indicators that a key nutrient is deficient. For example, a lack of calcium may only be apparent long-term with increased risk of brittle bones. In the short-term nutrient deficiencies may also cause problems that are visible but not identified as such, for example, exacerbating neurodiverse behavioural challenges (Estrem et al., 2016). Many participants felt giving vitamin supplements to their children was an important way to bridge the gap between eating ideals and what was possible. Vitamins, or supplement drinks became the dietary equivalent of medication both for parents and HCPs.

Some participants were clearly conflicted about supplement drink use, referring to them in negative terms. Prior research shows, although ensuring growth and nutrient intake for a child is essential, parents may view supplements as proof they are unable to parent effectively (Maher et al., 2013). Perhaps counter to Maher et al.'s findings, however, the unease shown in this study seemed less perception of failure and more to do with discomfort about the drinks themselves, for example, the artificial nature. Using vitamins or supplements as a precautionary measure, a common recommendation from HCPs, also introduces somewhat of a paradox. Eating a range of nutrient dense foods is not framed as essential by doctors, and yet a limited diet may produce gaps that need to be filled by non-food substitutes. However, within a healthcare system where options for PE remediation are scarce, both HCPs and parents are constrained by limited choices.

It is also important to contextualise the minimising of PE as a problem and the focus on supplementation. First, few doctors can articulate comprehensively what constitutes problem eating. Once defined, there are no established protocols for treatment, so each HCP is drawing upon experience rather than evidence-based research. Jackson et al. (2022) found in their research in ANZ that feeding problem referrals may not be possible. Therefore, if a child is losing weight, currently there is little a HCP can do in the short term beyond supplements. Indeed, four of the children in the study were prescribed supplement drinks, designed to quickly increase weight, and potentially cover nutrient gaps. Another participant requested supplement drinks due to her son's severely restricted diet. However, the drinks were denied, as he was maintaining weight.

The reference to weight was another common narrative across the stories. In ANZ weight is commonly used to indicate appropriate growth. For some of the participants a child losing weight or the inability to eat enough was a key catalyst for seeking additional support. For another losing weight was flagged as problematic, attracting a FTT diagnosis, leading to intervention. Other studies have, however, shown that PE is not defined by weight. In fact, in Chilman et al.'s (2023) study in Australia, all children discussed were either of normal or above average weight, despite being extremely picky eaters. The focus on weight to the exclusion of other metrics of ideal development is perhaps indicative of a western biomedical emphasis on clinically defined parameters. Parents were, therefore, working within a flawed system.

Indeed, a common thread emerging from the narratives post appointment was that HCPs were restricted by a number of factors, including feeding problem experience, limited resources, and a general lack of procedures and processes in the healthcare system to support parents of PE. Similarly, other studies have found limited experience and protocols around PE to be a barrier to supportive treatment (Cunliffe et al., 2022; Simione et al., 2020). Therefore, despite a positive HCP interaction, there was still generally a level of ambivalence regarding outcomes and advice given. In prior research that touches on the results of treatments, a range of parental stances from acceptance to hope to frustration at the lack of easily accessible care options are recorded (Chilman et al., 2023: Cunliffe et al., 2022; Estrem et al., 2018; Lamm, 2022; Simione et al., 2020). However, the detail gleaned from the in-depth interviews reveals nuance and why ambivalence is apparent. For example, in some cases, the solution contradicted parent values, introducing internal conflict and tension.

Moreover, despite parents in the study finding a HCP who listened to their needs and acted in ways they deemed positive, what was overwhelmingly absent was a focus on resolving eating challenges. There was also little engagement of specialist help. Of those parents who did obtain a referral, only one received it for the purpose of support for the PE (with another referred and denied). However, from referrals, two of the participants were given strategies that did improve the PE. It is thus important to consider whether additional help could be a more engrained part of the health system. Despite some success, all the participants would still classify their child as a PE. It would, however, be remiss not to acknowledge that additional diagnoses may have played a part in the findings.

Although expecting children with ASD, ADHD, and other diagnoses to form part of the study, as neurodiversity is highly correlated with PE, that they would form the majority was unexpected (Kerzner et al., 2015; Ledford & Gast, 2006; Råstam et al., 2013; Sharp et al., 2013). However, Cunliffe et al. (2022), who researched sensory sensitivities and PE, also interviewed a high proportion of families with neurodiversity. As there is a correlation between sensory challenges and neurodiversity, and both sensory challenges and neurodiversity with PE, this is perhaps to be expected. Conversely, this was contradictory to my experience across almost 10 years of private practice. Similarly, Chilman et al.'s (2023) study of extreme picky eaters in Australia primarily recruited parents who had children who were neurotypical.

Implications

Learning to eat new foods has been shown to be a process and one that may require ongoing effort (Wolstenholme et al., 2020). Therefore, if emphasis is not focused on progress it is less likely PE will improve. Similarly, it is also possible further help-seeking may be prevented if PE is deemed intractable. Indeed, this was the case for several of the parents and has resulted in little improvement of PE. The parents had also frequently not received advice that facilitated better feeding or eating patterns. If parents were struggling to independently resolve PE prior to the visit to the HCP, unless in receipt of considerable support, it makes sense that improvement has been slight. The overriding focus on weight across the stories, rather than improving the quality of the diet, potentially introduces the same challenge: preventing improvement of the PE.

It also leads to a paradox: a positive appointment with the HCP may inadvertently lead to less positive outcomes in the long term, as reassurance that PE is unimportant prevents focus on resolution. New problems are also now becoming apparent for some families. For example, the advent of puberty means psychosocial challenges are foregrounded. When reflecting on their help-seeking journey and given the benefit of hindsight, several participants wished they had intervened sooner. However, that was also after finding a sympathetic ear. If participant concerns have been minimised, outcomes could have been markedly different.

Indeed, one of the main issues identified in the study was lack of clarity around all aspects of PE for both parents and HCP. The recent diagnosis of PFD, discussed in the literature, may,

however, provide a unifying definition medically, socially, and individually. Being able to specify exactly what issues are may take away much of the conjecture and opinion that currently surrounds PE. Therefore, identification of problem eating may become more straightforward. It may also elevate the importance of PE more generally. Minimising PE as a problem could also be part of the reason many appointments have not been deemed positive by parents in previous research (Chilman et al., 2023; Cunliffe et al., 2022; Lamm, 2022; Simione et al., 2020). If a parent has their concerns dismissed by a GP who views PE as a minor issue, the appointment could at best be frustrating and at worst affect the parent's confidence in themselves and possibly the medical system.

If it is widely believed PE is a problem both socially and medically, and that intervention is required, perhaps parents will be more willing to seek help. Doctors are in a unique position to evaluate effectively what is happening for families if given appropriate training, and to establish whether PE is normative or constitutes a problem (Ong, 2014). They are also well placed to offer advice about effective evidence-based feeding practices and so provide gentle interventions that may prevent PE from becoming a problem (Brown & Perrin, 2020). The parents in Chilman et al.'s (2023) study in Australia requested exactly this, whereas in this project, parents in many cases did not even deem the GP to be the appropriate person to see. However, should it be widely recognised GPs have this ability, parents may be confident about help-seeking promptly and in primary care. Intervening early when PE is a problem may also prevent ongoing caregiver stress. Reassurance, particularly that parenting skills are not in question, is important and may lead to more harmonious meals, proven to be supportive for improving PE (Walton et al., 2017).

Additional challenges are also more likely for neurodiverse children or those with sensory challenges. Not accounting for this in wider discourses is unhelpful and potentially damaging for both parent and child and, therefore, more understanding of factors contributing to PE is valuable.

Limitations of Study

As the study was the first of its kind, there were some challenges. For example, there were no blueprints on which to base aspects of the project. More importantly, though, it was not possible to work with families where there were specific PE diagnoses, as it is still

poorly defined and variously treated in ANZ. Therefore, comparisons to the existing literature may not be comparing like with like. Similarly, as is true of all qualitative studies, the findings are not representative of all families with a PE. Instead, the study sought to provide an in-depth exploration of caregiver experiences, and the unique ways in which they navigated their child's PE, from managing it themselves to outcomes after a positive interaction with a HCP.

The interviews were limited to parents with children aged 2–18 years (at the time of the appointment), living in ANZ, fluent in English, and whose child had feeding difficulties beyond a normative phase. If there was variation in any of those factors, the findings may have differed, for example, if additional younger children had been included. It is also important to note the children discussed in the study were primarily neurodiverse and, as outlined above, this too may impact on the findings.

Participants were recruited mainly through social media and half responded via the Massey University distance student Facebook page. Mature students participating in tertiary education may share characteristics that shaped these findings, for example, the ability to advocate for their child through research. Overall, the participants were well-educated, studying or working in paid employment or both, so again may have differed from other mothers in the community without these resources. The study did, however, include participants from a range of ages, backgrounds, ethnicities, and place of domicile. Two of the participants identified as Māori, and the majority of the others were NZ European. Although there was some difference in treatment for one Māori participant, it is difficult to draw any conclusions based on ethnicity, particularly as this may have been confounded by teenage motherhood, which she experienced as stigmatising in the health care system.

Future Research

Despite the growing body of research into PE there are still many avenues to explore, in particular, specific to ANZ. As this study has shown, overall, there is a lack of understanding of PE, its definition, and the point at which normative food refusals become a problem. Establishing simple guidelines, perhaps focused on the PFD diagnosis, may be valuable for both parents and HCPs, particularly as these were part of earlier negative experiences expressed by parents. This study has shown that even those parents who find a sympathetic HCP are struggling to get help for the PE itself. Finding a doctor who validates

issues is unhelpful if there are few avenues for referral, particularly those that are funded. Therefore, treatment options beyond primary care is also an area for focus.

Similarly absent in ANZ but foregrounded in this study, is the importance of research into the intersection between PE and neurodiversity, and PE and minority or disadvantaged populations. This study was also one of the few locally or internationally exploring PE in children of primary age or over. As research demonstrates, PE can be an enduring trait, so looking beyond pre-schoolers may provide new or important insights in both aetiology and treatment.

The gendered aspect to parenting a picky eater, and particularly the negative pressures placed on mothers, may be an avenue that requires more attention. The study showed the obligation to conform to societal discourses around feeding, and in many cases this was unhelpful. Feeding appears to have become both a responsibility to get right and yet simultaneously an area with virtually no support. Mothers seem to be tasked with the impossible, particularly when parenting a child who organically finds food more challenging.

Reflection

I expected a preponderance of women as participants, as mothers have primarily been the ones to seek help in my private practice. However, what was unforeseen was how integral gender and gendered aspects of parenting would be to the study. In fact, to represent the stories appropriately, it became essential to locate the participants' behaviours within a wider framework of socially dominant discourses around motherhood, feeding, and PE. It was also notable how agentic the mothers were, particularly within a system where positive experiences are rare. I was also surprised at the length and depth of the interviews. Many participants appeared to relish the opportunity to discuss their experiences in a receptive environment and particularly to share information that may be useful for improving future HCP appointments. When I sent the draft analysis for feedback, participants both agreed with the findings and were surprised at their shared experiences. The similarity across the stories and recognition of that suggests the study tapped into an important pattern.

Using appreciative inquiry in a novel way meant a certain level of experimenting to establish what was going to work best. Overall, the positive focus produced in-depth interviews where

participants became demonstrably comfortable relating their experiences. Similarly, using Wong and Breheny's (2018) modified version of Murray's four levels of analysis plus their additional methods for further discussion provided comprehensive ways to view the data set and draw conclusions that may not otherwise have been as apparent.

Conclusion

Positive experiences when help-seeking for PE are unusual. In this study they were characterised by personable, caring, and compassionate doctors who addressed the wellbeing of the mothers as well as the child, in the context of the dominant calories matter discourse, and apparent lack of knowledge about best-practice feeding guidelines that suggest otherwise. Experiences must also be contextualised by expectations of healthy eating, discourses of a good motherhood identity, PE understood as normative and potentially wider accounting for assumptions about other populations such as young or racialised mothers. The results of the affirmative appointment in relation to reducing PE were various, potentially because what was absent in the positive experience was professional training in expanding children's eating repertoires or an established referral path.

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Appendices

Appendix A – Cram's (2010) Suggestions for Researcher Conduct

As a Pākehā researcher it was not possible to provide a by Māori for Māori research dynamic. It was, however, possible to follow many of Cram's (2010) suggestions for researcher conduct. Although these are specifically for community-up studies, the concepts appear important for any respectful study involving Māori:

1. Respect for people, including the ability for them to meet on their own terms and define the space.
2. Looking, listening, and developing an understanding before speaking.
3. Sharing, hosting and being generous.
4. Be cautious and politically and culturally safe. Reflect on status particularly insider/outsider.
5. Uphold the mana and dignity of people.
6. Share knowledge.
7. Meetings are face to face or be a face that is familiar to a community. This was, unfortunately, not possible within the confines of the study.

Appendix B – Samples of Recruitment Advertising – 1 (Poster – text)

Do you have a child who is a picky eater?

Have you been to your GP/doctor or other healthcare professional to get help and had a positive experience?

If so, would you like to participate in a study and share your story with a sympathetic listener who also has experience in children's picky eating?

What is the study?

A master's student at Massey University, Judith Yeabsley, is seeking caregivers who have had positive interactions with their GP or other healthcare professional when seeking support for their child's picky eating.

The findings, provided by participants (anonymised and without personal details for privacy), will be made available to the medical community for discussion and may identify ways that medical professionals can better support families where picky eating is a challenge.

Who can take part?

The study welcomes any caregiver of a child with picky eating (aged 2 – 18 years old) where problems are more than a 'normal phase' who has had a positive interaction with their medical professional when seeking help.

Caregivers of all cultural and ethnic backgrounds are encouraged to take part.

What will you need to do?

Judith would audio record an interview with you. (If the interview is via Zoom, this would include video which would be deleted after details have been transcribed).

You would need to feel comfortable answering questions about your child's eating, your experiences with the healthcare professional and have the anonymised information (so your privacy is protected) become a part of the study's results.

When and where?

All interviews will be conducted either online via Zoom or via phone at a convenient time for you. If you are in the Wellington region and would prefer to meet face-to-face that is also possible.

If you decide to take part you will be contributing to research that may help to change the way medical professionals interact with caregivers of picky eaters and validate their challenges. You will also be given a voucher to the value of $ 40 as thanks for your time and contribution to the study.

If you would like to know more and receive an information sheet, please contact:

Judith Yeabsley

Student: Master of Science, Massey University.

Phone:

E-mail: judith.yeabsley.1@uni.massey.ac.nz

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Samples of Recruitment Advertising – 2 (Poster – A)

VISITING THE DOCTOR WITH YOUR PICKY EATER

If you've been to a healthcare professional, like your GP, & had a postitive experience, I would love to speak to you.

Help research into how medical professionals can best serve caregivers of picky eaters

Who can take part?
Caregivers of a picky eater aged 2-18 where eating problems are more than a 'phase.'

What will you need to do?
Agree to a recorded interview about your experience with your medical professional. (Interviews can be via Zoom, telephone or face-to-face in Wellington).

Caregivers of all cultural & ethnic backgrounds are encouraged to take part

Receive a $ 40 voucher as thanks for your participation!

For more information contact:
Judith Yeabsley
Master of Science student
Phone: [redacted]
E-mail: judith.yeabsley.1@uni.massey.ac.nz

Supervised by:
Professor Sarah Riley
Critical Health psychology & senior lecturer, Massey University
E-mail: S.Riley@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Ohu Matatika 1, Application OM1 23/09. If you have any concerns about the conduct of this research, please contact A/Prof Louise Brough, Chair, Massey University Human Ethics Ohu Matatika 1, telephone 06 356 9099 x 84575, emai humanethics1@massey.ac.nz."

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Samples of Recruitment Advertising – 3 (Poster – B)

VISITING THE DOCTOR WITH YOUR PICKY EATER

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

If you've been to a healthcare professional, like your GP, & had a postitive experience, I would love to speak to you.

Help research into how medical professionals can best serve caregivers of picky eaters

Who can take part?
Caregivers of a picky eater aged 2-18 where eating problems are more than a 'phase.'

What will you need to do?
Agree to a recorded interview about your experience with your medical professional. (Interviews can be via Zoom, telephone or face-to-face in Wellington).

Caregivers of all cultural & ethnic backgrounds are encouraged to take part

Receive a $ 40 voucher as thanks for your participation!

For more information contact:
Judith Yeabsley
Master of Science student
Phone:
E-mail: judith.yeabsley.1@uni.massey.ac.nz

Supervised by:
Professor Sarah Riley
Critical Health psychology & senior lecturer, Massey University
E-mail: S.Riley@massey.ac.nz

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Appendix C – System to Exclude Imposters

During the first week advertising was placed on social media, I was inundated with requests to participate in the study. Initially, I was both surprised and a little overwhelmed by the response. However, it soon became clear that many of the requests were inauthentic.

Eliminating those who were imposters, from genuine requests, became simpler over time as there were several red flags contained in inauthentic e-mails:

1. Names were often unusual for the demographic I was advertising to, such as Arthur Roberts, rather than female and more contemporary.
2. Generally, there was no personalising of the e-mail, so my name was absent as was theirs in the body of the e-mail.
3. Mostly, there was only one line in the e-mail that just put forward their willingness to participate.

Despite these red flags, I was uncomfortable ignoring e-mails on the small chance they were legitimate. I therefore responded with a series of questions to elicit more information, such as “can you please give me some more detail about how your situation maps onto the study?” Again, responses contained no personalisation and no emotion (which given my experience communicating with parents of picky eaters is unusual). Replies were also obviously written by AI so contained odd phrases, tenses, or information. At this point I was confident that the request was indeed inauthentic.

Appendix D – Screening Tool for Participation in the Study

There are multiple ways to assess picky eating; however, Estrem et al. (2016) believe it is simple to identify a paediatric feeding disorder. Although childhood feeding disorders sit along a spectrum, restrictive or selective eating combined with problematic feeding behaviours are indicative of an issue.

As part of my practice revolves around evaluating the extent of feeding problems, it is an area in which I have experience and can gauge which questions will indicate issues. I am also mindful of ensuring the process was quick and comfortable for caregivers. Questions, taken from the literature, included:

Restrictive or selective eating

Does your child

- refuse food or certain types of food?
- refuse new and/or familiar foods?
- accept only a narrow range of foods?
- eat foods inappropriate for their age (like a reliance on purees for older children)?

Feeding/eating behaviour

Does your child

- only eat small amounts of food?
- eat slowly (meals are over 30 minutes)?
- refuse to come to the table and/or not stay there?
- eat different meals to the rest of the family?
- become angry, anxious, or upset at mealtimes?
- gag, vomit, or hold food in the mouth?

If caregivers answered yes to one or more questions from both domains, and after clarifying this was not a transient issue, they were found to be suitable candidates for the study.

Appendix E – Information Sheet – Pages 1–5

Picky eating and positive outcomes from healthcare interactions:

Pathways to progress

Information sheet

Kia ora, my name is Judith Yeabsley, and I am a student in the Master of Science Health psychology programme at Massey University in Wellington. As part of this qualification, I am undertaking research into positive interactions between caregivers of picky eaters and a GP (General Practitioner, local doctor) or other healthcare professional, such as a dietician. The project is being supervised by Professor Sarah Riley from Massey University School of Psychology, College of Humanities and Social Sciences who specialises in qualitative research and health topics.

The aim of the research

The aim of the research is to explore positive caregiver interactions with a GP or other healthcare professional when seeking help for their child's picky eating. Studies have shown caregivers frequently face challenges when wanting treatment for their child's picky eating and that they may struggle to have their issues validated. Studies also show how supportive care is important.

Yet there has been no research either locally or indeed globally, exploring positive interactions between caregivers and GPs or other healthcare professionals. This study is therefore intended to fill that research gap and contribute to a greater understanding of how GPs and other healthcare professionals can provide supportive care and whether that also leads to positive outcomes for the children.

The positive experiences described by participants will be anonymised (so no personal details are revealed) and summarised. The findings can be made available to the medical community for discussion and may identify ways that healthcare professionals can better support families where picky eating is a challenge.

Who can participate?

We welcome caregivers of all cultural and ethnic backgrounds who have had a positive interaction with their healthcare professional when seeking help for their child's picky eating and are comfortable discussing this as part of this research project.

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Participants will need to:

1. Be the caregiver of a child aged 2 – 18
2. Be able to converse comfortably in English.
3. Be the caregiver of a child who is a picky eater who has had a positive interaction with a healthcare professional when seeking help for their child's eating and who is comfortable discussing their experience.

What will participation in the research involve?

For those who are interested, an initial, short interview via Zoom, over the phone or in person in the Wellington region (if you prefer), will be arranged to explain in detail what the research entails, and for you to ask questions so you can decide if you want to participate.

For those who would like to proceed, a longer interview will be scheduled at a convenient time. The interview will consist of a series of questions about your experience taking your child to a healthcare professional for support for their picky eating. The interview is semi-structured, which means I will ask some open-ended questions to help the interview flow. These questions may be used as a starting point for you to explain in your own words your experience and thoughts about the interaction you had with your medical provider.

If you decide to take part in the study:

1. I, Judith, will contact you to arrange a time for an initial call. During this first call I will ask several short questions to establish whether your experiences map onto the study. You will also be able to ask questions to ensure you are comfortable to go ahead. On this call we will go through this participant information sheet, the interview schedule, and give you the ability to ask any questions. You will also be given the opportunity to discuss any amendments you would like to make to the interview before agreeing to take part.
2. If you agree to take part you will sign a written consent form that explains exactly what participating entails.
3. A longer Zoom, phone or face-to-face interview (face-to-face only if Wellington-based) will be scheduled at a time convenient to you to discuss your experience with the medical provider. This will take approximately 45 minutes. It will be audio-recorded (video recorded, if on Zoom), with your consent. The information will be anonymised so your identity is kept private. Any video content will be deleted once information has been transcribed and only the audio kept.
4. At the conclusion of your interview, you will be reimbursed for your time with a voucher to the value of $40.
5. Participation is completely voluntary. Nonparticipation will not affect any current or future relationships with Judith in a personal or professional capacity.

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What happens after the interview?

The recorded interviews will be typed up by Judith to create your personal transcript.

In this transcript, your name and any information that may reveal your identity will be changed (for example, you will be given a fake name) or removed to protect your anonymity. No one aside from Judith and Professor Sarah Riley will have access to your personal details. All data will be stored securely either on the Massey Online Server/a passworded computer or back-up drive or in locked filing cabinets. Once the project is finished, all the data and consent forms are stored by my supervisor Professor Sarah Riley at Massey University for 5 years and then confidentially disposed of using the disposal facilities available in the Psychology department on the Wellington Massey Campus.

Your transcript will also be sent to you, and you will have two weeks to review your personal transcript and make any amendments.

The experiences you have shared with me in your transcript will then be analysed, and a draft summary of findings from all participants sent to you for comment, should you wish. Once the project is complete, you will be sent a summary of the findings, should you wish.

A summary of the research findings will be written up in a student thesis and potentially for presentations to health professionals. In these reports, some information such as quotes from your interview could be included, with personal identifiers removed.

It is possible that a summary of the findings may also be published in a scientific journal. In this instance, there is the potential for the journal to want to include the full interview transcripts from the study along with the report. These transcripts would be archived in an official data repository, Figshare, and publicly accessible. If this happens, I will come back to you and seek your consent to release your transcripts, with personal identifiers removed. I will explain the pros and cons of including your data in a public archive and you can decide then if this is something you want to do. This decision has no bearing on whether you can participate in this current project.

What are the possible benefits and risks of the study?

Little is known about what makes a positive experience for parents, when bringing picky eating children to their healthcare provider. By sharing your experiences with me, I hope to identify ways that the medical profession can better support families where picky eating is a challenge.

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Picky eating in children can be a stressful experience for caregivers. Should the interview cause any emotional distress it will be stopped and a break afforded, if desired. You can also postpone to another time or cancel altogether, should you wish. Sometimes, the experience of talking about something important to you in an interview makes people feel like they need additional support. If that happens to you, you can contact:

Parent helpline - https://www.parenthelp.org.nz/ 0800 568 856 or Plunketline 0800 933 922. Both offer free services to caregivers.

What are your rights as a participant?

- Participation in the study is completely voluntary.
- If you decide to participate you can withdraw from the research at any time up until two weeks after the main interview without giving a reason. At which point, your data will be incorporated into the analysis and cannot be removed.
- Should you withdraw from the study prior to two weeks after the main interview, you can decide whether to withdraw any information you have already provided to the study.
- You may ask questions at any time about the study prior to participating or during participation by e-mailing or calling Judith or her supervisor (details below).
- You may request amendments to the interview, or the questions asked to align with your requirements and needs, including cultural needs. Judith will do her best to accommodate your needs and make changes where possible.
- You may decline to answer any question without justification.
- You may ask to take a break at any time during the interview.
- You may have a support person present at your interview.
- You may review and amend your personal transcript within a designated 2-week period.
- You may request a copy of your audio recording and transcript within 2 weeks of doing your interview.
- You will be sent a draft summary of the research findings, if you wish.
- You have the ability to comment on the draft findings within a designated 2-week period.
- You will be sent a summary of the final research findings, if you wish to see them.

Who should I contact for more information or if I have any concerns?

You are free to contact myself, Judith, with any questions or concerns you have about the project at any point. You can also contact my research supervisor, Professor Sarah Riley.

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Appendix F – Consent Form

Picky eating and positive outcomes from healthcare interactions:

Pathways to progress

Consent Form

	Please initial if you agree
I have read and understand the provided project information sheet.	
I have had the details of the study explained to me, any questions answered satisfactorily and understand my right to ask further questions at any time.	
I have been given sufficient time to consider whether to participate in this study	
I understand participation is voluntary and that I may withdraw from the study at any time until 2 weeks after I have done the interview.	

Please circle the following that apply:

I agree to my interview being recorded for transcription and the content then used in the analysis to produce a final report (with all personal identifiers/information deemed identifiable replaced with a pseudonym/removed). I also understand that this research may be used for presentations, potentially to health professionals, and for scientific journals. In all of these reports, some information such as quotes from my interview could be included, with personal identifiers removed.	Yes	No
I understand that both video and audio may be initially used by Judith (if interviews are conducted via Zoom), to aid in transcription but then video will be deleted and only the audio will be kept until the end of the project, when it will be destroyed.	Yes	No
I would like to review my transcript following transcription.	Yes	No
I would like my audio recording returned to me with the transcript.	Yes	No
I would like to review and comment on the draft summary of results.	Yes	No

I would like a summary of the final project results emailed to me.	Yes	No
I agree to participate in this study under the conditions set out in the Information Sheet.	Yes	No

Declaration by Participant: I ____ agree

to take part in this study. Signature: _____________________________

Date: ______________________

So the reports can describe the range of people who participated in the study, please provide the following information if you are comfortable to do so:

Gender: ____

Ethnicity: ____

Age of child: ________________________________

This information will be used for Judith to contact you and will be kept confidential:

Contact number: _______________________________________

Email address: _______________________________________

Appendix G – Interview Schedule (1–4)

Picky eating and positive outcomes from healthcare interactions:

Pathways to progress

Semi-structured interview schedule: indicative questions

Greeting/opening

Kia ora, and welcome. I'll introduce myself and what I'm doing and then I'd love to hear a little more about you. My name is Judith and I'm a Master of Science Student at Massey University doing a thesis as part of my health psychology qualification. I also work privately with families where picky eating is a challenge.

I have chosen to explore positive interactions with GPs or other healthcare professionals when seeking support for picky eating as, frankly, this is unusual. As many caregivers find they do not have their concerns validated or find a sympathetic ear, it would be great to explore what has gone right and why. From there if things have gone well, does it also lead to positive outcomes for the child?

Participation criteria

Before we start I'd just like to check you've read the information sheet? Yes/No.

So, you are the caregiver for a child who is between 2 and 18 years old who is a picky eater? Yes/No.

You have been to the GP or other healthcare provider to seek support for your child's picky eating and had a positive experience? Yes/No.

Introduction

Excellent. Today I'd love to ask you in a bit more detail about your experience with your healthcare provider. I'll ask a few questions and give you space to explain what happened in your own words. It shouldn't take more than 45 minutes. I will be recording the interview so I can transcribe your words later. I will also change your name and any specific details that may identify you. I will refer to you by the pseudonym you chose.

I will also be using the term PE throughout. Although this is not my favourite term, it is commonly used to describe children who struggle to eat volume and variety of food.

Great, so I'd like to start by saying a big thank you for participating. Positive interactions with GPs when looking for help for a child's PE is not something that has been researched before, so your input is invaluable. It may also be something that leads to positive changes in the system.

Interview Questions

To start, I'd like to get to know you a little.

How old is your child who is a picky eater? And how old were they at the time of the GP visit?

Is it okay for me to know their name? I will not use it in the study reports but it's nice to be able to talk about them a bit more personally.

As neurodiversity is highly correlated with selective eating, I'd love to know how you would describe your child.

Does x have any diagnoses or challenges beyond PE?) (prompts, allergies, ASD, ADHD, anxiety, sensory sensitivities, "quirks")

When did you first realise x was a picky eater?

What made you think of your child as a picky eater? (prompts – using questions from the screening tool to develop a picture. Refuse food or certain types of food? Refuse new and/or familiar foods? Accept only a narrow range of foods? Eat foods inappropriate for their age (like a reliance on purees for older children)? Only eat small amounts of food? Eat slowly (meals are over 30 minutes)? Refuse to come to the table and/or not stay there? Eat different meals to the rest of the family? Become angry, anxious, or upset at mealtimes? Gag, vomit or hold food in the mouth?)

What did you do once you thought that they were a picky eater? To support their eating?

What were the results of that?

Were there people you asked for help?

What was good about the help?

Did you see any other HCP prior to the GP where the interaction was positive? (prompt – If so, can you tell me about that experience?)

Tell me your story of deciding to get help from the GP.

Tell me about the GP with whom you had a positive encounter (was it someone familiar?).

Where did you meet with them? (Prompt, private office) What was the seating arrangement?

How did the general encounter make you feel? (relaxed, nervous, empowered & why?)

How did you explain to your healthcare professional what was happening with x's eating?

What was their response?

Did they examine x? (prompts – what was that process like?)

Did they do any tests or order any? (prompts – how did they explain those to you?)

Did they speak directly to x? (prompts how did this make you feel? Was it what you expected?)

Did they offer any diagnosis or speak with you about one? (prompts – was this what you expected?)

Tell me all about why the interaction was positive? (prompts – feeling validated / understanding the problem / good advice / referral)

What was most valuable? What sticks in your mind?

Can you talk about whether this was what you expected from the GP and why?

Do you feel you were a part of what made your interaction positive? Do you have strengths that have led to better outcomes? (prompts, can you explain why?)

Was there anything about the GP visit that was unexpected?

Do you have advice for other parents who may be looking for help for their child's PE?

Have you heard of good experiences from other parents of PE? (Can you tell me more about that?)

- [If neurodiverse go to that section first]

What has happened since you met with the healthcare professional? (prompts – taken advice of healthcare professional / been referred)

Can you describe what happened after the interaction?

Have you seen an improvement in x's eating? (prompts – can you describe what's happened?)

Would you still feel they are a picky eater? (prompts – what makes you feel that way?)

Is there anything the GP could have done to improve your interaction?

What would you love to see from GPs in general when supporting families of PE?

What would be the best system you could imagine?

Are there any services that you feel would have helped x beyond the GP?

What would you love to have available to better support families and PE themselves?

Do you have any comments or suggestions?

……….

<u>Neurodiverse children</u>

Would you be open to sharing how your GP featured in x's diagnosis?

Does a diagnosis mean frequent visits to the GP and, if so, what does that look like?

Can you tell me about your GP. Do you have a specific GP and why? (prompts as to why, understanding complexities / not starting explanations from scratch)

How do you view the GP in terms of x's care? (prompts – more than medical, gatekeeper/referrer, help with additional support, insight beyond just treating medical issues)

Can you describe your relationship with the GP? (prompts – do you feel it's deeper, more supportive?)

Do you think your GP has been more likely to listen to your concerns about PE due to the additional challenges? (prompts – what makes you say that?)

Do you feel there were different opportunities for resolving PE open to your child as they are recognised as having additional challenges? (For example, referral to services that work with children with additional diagnoses.)

What was great about the GP?

What could they have done better?

Is there anything specific to children with more complex needs that could be done better/differently in terms of PE? What would you like to see done for other children who are PE and also have additional needs?

Closing

Thank you so much for your time and input today, I really appreciated hearing about your experiences and am delighted you decided to participate. I hope x is ….

I will email you a transcript of our interview once I have transcribed it, and you will have two weeks to make any changes to it, should you wish, before I begin to analyse the data from all of my interviews. I will be in touch in a week or so just to check in. I can also send you the audio file at this time if you want it.

Once I have collated everybody's interviews – which will take a while – I will put together a draft summary and if you like I can also send that out to you for comment. The draft will show what the other caregivers have said and enable you to be a part of shaping the results of the study. Again, I can give you two weeks to read, comment if you wish and send back.

Do you have any questions now?

If you have any questions at all during the next little while, please feel free to email me at [redacted] Thanks again.

Appendix H – Sample of Analysis Spreadsheet

Interview Jasmine	Personal level	Interpersonal level	Positional/ Ideological	Stage & setting	Characters	Tension – discomfort	Tension – humour	Tension – refrains	Similarity across participants
J: But I think it was it goes hand in hand. Like, you know, I was very happy to have that feedback from the doctor and the state that I was in, I was ready to be I was prepared to be told off.	J is happy to accept feedback from the doctor, even if negative		GP assumes the role of expert and even disciplinarian. Erosion of the more patriarchal role of the doctor over time	GP's office	GP as expert and with the ability to chastise. Parent in deference.	J feeling guilty, overwhelmed so accepting if doctor chastises. Places GP as expert.			Some of the other parents have this faith in the GP and others don't.
JKY: [laughing to visual cues from J]		Jasmine was quite self-deprecating					J uses self-deprecating words and gestures		Other parents poke fun at themselves about their naivety or worry about what the GP will say

Appendix I – Participant Dreams for Better PE Healthcare

Participants eagerly discussed how a more responsive and supportive healthcare system could be structured to support parents of picky eaters. These have been paraphrased and summarised for conciseness.

Annie:

After a face-to-face appointment with a familiar GP (within a reasonable time frame), a referral would lead to publicly funded care with an expert in eating challenges. Ideally, the help would be catered to the family after a home-based assessment. A plan would be created for the family with support (for example, questions answered), if needed, therefore, provide a quick solution. Simultaneously, apply a medical lens to the issues to assess whether blood tests/additional medical support is needed and to explore the aetiology of the PE.

Jasmine:

Envisions a funded service where an expert comes to the home and does an evaluation of what's necessary to support a parent to resolve the PE.

Katie:

Proposes early access to services, such as community workshops teaching parents how to effectively work with their child. If issues are more pronounced, ideally, an all-in-one clinic dedicated to supporting families of PE where multi-disciplinary specialists like speech pathologists, psychologists, dieticians, etc., could do a holistic evaluation.

Huia:

A holistic centre where families can go and get support in all areas, so issues are not siloed and information is shared between specialists and resources provided to parents.

Angela:

Found the dietician she was referred to for a prescription for calcium tablets was also helpful for the PE, particularly explaining some of the psychological elements of eating challenges. She would like to see referrals for psychological support made available if it appears that is one of the causes of the PE.

Rhiannon:

Also, would like to see funded psychological support as a private appointment supported her daughter to rationalise an egg aversion. She would also like GPs to have evidence-based information available to support parents with their child's PE with courses/workshops also available, if necessary.

Sarah:

Would like to remove any problem blaming in appointments. Instead, focus to be on the child, asking them what they need help with. She would like a referral to a more holistic place (rather than a site for those who have failed at eating) where children can go. Their goals would be identified and then programmes catered to attend to those, for example, providing more energy for participation in sports.

Susan:

Feels asking the child to explain why food is challenging is valuable so it's possible to evaluate what is happening for them. Also, to recognise it is a problem, not merely a phase, and to do appropriate testing to identify nutrient deficiencies. Most importantly, focus is on resolving the PE, not treating the symptoms, particularly not with emphasis on unhealthy foods. Preferably also with input from a nutritionist.

Genevieve:

Access to other health modalities not just the medical paradigm with GPs open to referring, for example to naturopaths.

Bridget:

Funded referral to a specialist in nutrition and support that is more natural rather than medicated for PE. Also, a holistic approach to treatment more in line with the Māori Te Whare Tapa Whā (Durie, 1994) where all aspects of the child are accounted for, diet, food, mental wellbeing, counselling, therapy, etc., rather than the treatment-based western model.

Tui:

Takes a different approach to PE after years of parenting a neurodiverse child. She believes that, rather than a focus on ameliorating PE, perhaps a better approach for the neurodiverse is referrals to programmes that emphasise how to make things comfortable for the child and offer support for the parent. Programmes may also be best provided by facilitators who are neurodiverse themselves so have an innate understanding of issues.

Appendix J – Narratives, Mini-Narratives, Themes, and Subsections

I would like to make explicit what constituted a narrative, mini-narrative, theme, and sub-section so it is clear to the reader:

Narrative – the collection of stories participants told which overall form the narrative.

Mini-narratives – there are three parts to each narrative:

1. Participants attempt to resolve PE independently. A catalyst precipitates help-seeking.
2. The positive interaction with the HCP.
3. Considering outcomes of the affirmative appointment.

Sub-sections – these became evident during analysis, were common across participant narratives, and were used to further explicate parent stories.

Within the first mini-narrative, sub-sections were:

1. managing PE themselves
2. the catalyst for visiting the doctor
3. failure and guilt.

Within the second mini-narrative:

1. validation of parent concerns
2. continuity of care
3. the relationship with the HCP
4. advocacy
5. how the HCP relates to the child
6. discussing PE in front of a child.

The third mini-narrative summarises outcomes since the positive appointment and therefore discusses heterogenous experiences, which are addressed as such.

Themes – there were four main overarching themes that became apparent through analysis of the narratives. These formed the structure for the discussion, particularly as they were not confined to a specific mini-narrative:

1. PE definition (and its challenges).

2. Wider social discourses of gender (and the impact on participants).
3. Primacy of the HCP relationship (the importance of the relationship between HCP–parent and HCP–child).
4. Limitations of care (HCP and systemic limitations).

Within these themes were subsections:

1. PE definition:
i) How parents framed the PE
ii) Parent acceptance of non-normative feeding
iii) Focus on eating within public health guidelines

2. Wider discourses of gender:
i) Personal responsibility around feeding
ii) Feelings of guilt and shame

3. Primacy of the HCP relationship:
i) Doctor's acknowledgement of participant concerns around PE
ii) Validation of mothers' mothering
iii) HCP creating relationship with the child
iv) The importance of parental advocacy
v) Continuity of care
vi) Parental perceptions of PE, and prior experiences.