AN EXPLORATORY STUDY EXAMINING PARENTAL FEEDING PRACTICES IN THE HOSPITAL

by

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This retrospective exploratory study exploratory intends to extend the current stock of knowledge on parental feeding practices that parents engage in while in the hospital and what influences these practices. Bronfenbrenner's Process Person Context Time (PPCT) Model is used as a framework for study, focusing the research on influences that impact the behavior of parents related to qualities of their "person" that impact how they engage in the feeding of their child, the proximal "processes" involving the mealtimes they provide their child, and their cultural "context" related to food and eating. The researcher interviewed and surveyed five participants who were all parents of children who had been hospitalized between the ages if 2-8 years old in the United States. The research revealed that a child's condition does seem to impact the feeding practices which parents engage, social interaction was reduced, and timing of meals was more irregular in the hospital compared to at home, parents reported concerns related to their child's condition and pain level as well as staff attentiveness, and finally, parents' customs surrounding food focused on their views on healthy vs unhealthy foods and clearing the plate. These findings have major implications for parents and hospitals and indicate the need for more targeted and in-depth research in a variety of topics related to parental feeding in the hospital.

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CHAPTER 1: INTRODUCTION

Poor diets and maladaptive eating behaviors are a serious concern for children today (Aguilar-Salinas, 2020; Campbell & Peebles, 2014). Additionally, children in hospitals are at elevated risks for malnutrition due to diet and disordered eating (Carvalho-Salemi, 2020). Recent research on parental feeding practices has shown the significant impact that parents have on their child's eating habits and the quality of their diets (Mais et al., 2017; Schmidt et al., 2019) therefore this subject should be explored in detail.

It is well understood that parenting practices play a significant role in the health and development of their children (Gadsden et al., 2016). Parental feeding practices are the behaviors parents engage in that help shape children's consumption habits and dietary quality (Jang et al., 2019). Restriction and pressuring parental feeding practices are commonly studied in this field of research (Boles et al., 2010; Wehrly et al., 2013). Both are categorized as controlling feeding practices; however, restricting is seen as restricting the amount of food or the consumption of less nutritious foods and pressuring is identified as pressuring a child into eating more food or more of what is considered healthy foods (Wehrly et al., 2013). Research shows that controlling feeding practices are positively correlated with disordered eating and poor diet and negatively correlated with intuitive eating. Therefore, it is important to understand how poor diet, intuitive eating and disordered eating can impact health.

Children's diets are an important factor not just in their current health but also in their eating behaviors later in life (Scagloioni et al., 2018). Poor diet is associated with a myriad of chronic conditions such as cancers, stroke, heart disease, obesity and diabetes (Micha et al., 2017). Diet is also integral to immune system maintenance, meaning that those with poor diets are more vulnerable to infections and communicable diseases (Calder, 2020). Estimates have

shown that approximately 49% of children from 2-19 years old, living in the United States, have poor diets (Aguilar-Salinas, 2020). Another study indicated that 56% of children between 2-19 in 2016 had poor quality diets in the US and that 44% had diets considered intermediate; shockingly, children's diets that were ideal was found to account for less than 1% (Liu et al., 2020).

Intuitive eating is an adaptive eating style that manifests in a variety of behavioral patterns that center around eating for physical rather than external pressures or emotional reasons, giving oneself unconditional permission to eat, and reliance on internal hunger and satiety signals (Tylka et al., 2006). Intuitive eating has been found to be associated with a range of positive physical health outcomes in adults including lower body mass index (BMI), weight maintenance, and possibly even improved diet as well as adaptive eating behaviors, and improved health indicators such as blood pressure and cholesterol levels (Van Dyke & Drinkwater, 2013). The psychological impacts of intuitive eating were found to include improved self-esteem, body image, and wellbeing (e.g., measures of depression; Linardon et al., 2021; Van Dyke & Drinkwater, 2013).

Campbell and Peebles (2014) noted that eating disorders generally develop before the age of 18 and pose a serious threat to the health and development of youths. The extensive and health risks linked with eating disorders include neurological delays and deficits, pre-, co- and post-morbid psychiatric conditions, as well as disruptions or diseases in every organ system. Campbell and Peebles' thoroughly reviewed the literature regarding pediatric eating disorders and found that they were more prevalent in this population than type 2 diabetes. They note that eating disorders in children are underdiagnosed, however research has found anorexia nervosa

occurring at 0.5-2%, bulimia nervosa between 0.9-3% and eating disorders not otherwise specified (EDNOS) at 4.8% (Campbell & Peebles, 2014).

The Need for Research in Hospitals

Poor diet and eating skills have a clear impact on health, and the influence of parental feeding practices on nutrition and eating habits in children has become a popular area of research. However, despite the growing number of studies that have examined the impact of various feeding practices on child outcomes, there is no research that specifically examines the prevalence of certain feeding practices in the pediatric hospital setting. Recent research indicates that an estimated 6.4% of pediatric patients in hospitals in the United States were diagnosed with malnutrition in 2019 and that poor diet and disordered eating contribute to many of these cases (Carvalho-Salemi, 2020). Studies have indicated that malnutrition decreases the body's immune response in children which can lead to a variety of complications related to hospitalized children's conditions (de Souza Menezes et al., 2012; Hecht et. al., 2015; Radman et al., 2014). Additionally, malnutrition has been shown to result in significantly longer hospital stays for children (de Souza Menezes et al., 2012; Hecht et. al., 2015; Huysentruyt et al., 2013; Radman et al., 2014). As hospitalized children are already at a greater risk for malnutrition due to disordered eating and nutritionally insufficient diets (Carvalho-Salemi, 2020) it is in the best interest of both patients and healthcare institutions that parental feeding practices be examined in pediatric hospitals.

Age Group Selected

Some research has shown that eating habits are developed in early childhood and that these habits can extend even into adulthood (Northstone & Emmett, 2008), it is essential that this

critical period be examined (Kaar et al., 2016). Food neophobia, or the fear of novel foods, is seen to peak between the ages of 2 and 6 years old (Białek-Dratwa et al., 2022) and has been found to influence the feeding habits in which parents engage (Tan & Holub, 2012). The importance of studying early childhood in the context of parental feeding is clear, however, middle childhood is also important to study as after this period, the influence of parents becomes less isolated as peer influences become a more significant part of children's lives in late childhood and adolescence. Peers are found to have a more significant influence on children from late childhood through adolescence (Sentse et al., 2009; Telzer et al., 2014) and eating habits may be impacted by this influence (Ragelienė & Grønhøj, 2020). Therefore, the feeding habits that parents adopt in early and middle childhood may be most influential before children's spheres of influence become more diverse. Furthermore, CDC (2022) reports that the first eight years of life a period of high neural plasticity. Nutritional and social factors that are experienced the first eight years of life have the potential to set an individual up for future success or struggles when it comes to health (Robinson et al., 2017).

Early childhood is a critical period for examining the influences that shape children's current and future health (Robinson et al., 2017). Parents of children hospitalized between 2 and 8 years old were recruited for this study which examines the experiences of parental feeding practices during their children's hospitalization. This age range of children is particularly relevant as young children's dietary habits remain largely under parental influence (Sentse et al., 2009; Telzer et al., 2014) and the onset of food neophobia around age 2 shows a unique challenge for parents, often influencing their approach to feeding their children (Białek-Dratwa et al., 2022; Tan & Holub, 2012). The current study uses interview questions that have been guided by concepts in the Comprehensive Feeding Practices Questionnaire for which the validity

and reliability has been examined for mothers of children aged 2 to 8 (Musher-Eizenman & Holub, 2007). Therefore, examining the role of parents who have over children aged 2 to 8 is an appropriate and necessary scope of study.

Purpose of this Exploratory Study

The purpose of this study is to explore the prevalence of different parental feeding practices in hospitals within the United States and to explore the potential influences on these practices. As these factors are likely numerous and highly diverse, Bronfenbrenner's theory is an appropriate framework as it highlights the expansive network of personal and environmental influences that shape human development and behavior. A broad exploration of parental feeding practices and what influences them within hospitals is necessary as research in this area is limited. The goal of this study is to guide future research aimed at the development of evidence-based interventions that target the root causes of the inadequate diet and eating behaviors of children today.

CHAPTER 2: LITERATURE REVIEW

Child Outcomes Related to Parental Feeding Practices

Feeding Practices Linked with Poor Nutrition

Some research has been conducted on how parental feeding practices impact the current nutritional composition of their children's diets. Research has established the important role that nutritionally and calorically appropriate diet has in health and illness recovery (Wischmeyer, 2017). Therefore, the prevalence of negative feeding practices in the hospital should be identified. Children whose parents pressure them to eat rather than allowing them to follow their hunger and satiety cues are less likely to eat certain high fat foods, fewer calories in general (Lee & Keller, 2012), and fewer fruits and vegetables (Galloway et al., 2005). Another study found that both restricting and pressuring feeding practices were associated with poorer diets in children (Mais et al., 2017). The effect of pressuring children to eat appears to be the opposite of its intent. Therefore, health outcomes for hospitalized children could be greatly improved if more research is conducted on why parents engage in controlling feeding practices.

Feeding Practices Linked with Reduced Intuitive Eating Skills

As previously discussed, intuitive eating skills have been correlated with a myriad of positive physical and psychological health factors (Linardon et al., 2021; Van Dyke & Drinkwater, 2013). Controlling feeding practices are suggested to decrease a child's ability to develop their own self-regulatory skills (Frankel et al. 2012; Wehrly et al., 2013). Intuitive eating is centered around listening to one's own body regarding what, when and how to eat (Tylka et al.,

2006). Therefore, it is not hard to understand why research indicates that controlling feeding practices reduce intuitive eating skills (Ellis et al., 2016; Lessard et al., 2008).

Ellis et al.'s (2016) research indicates that when children are food avoidant, parents tend to increase pressure to eat. Ellis and her colleagues found that children exposed to pressured feeding styles reduced their intuitive eating behaviors later in life. It is not difficult to rationalize this finding, as these individuals would have learned to mistrust physical cues to eat or stop eating in childhood based on parental pressure.

Ellis et al. (2016) and Mais et al. (2017) found that parental concern regarding child weight increases feeding practices of restriction or pressuring. Parental attempts to influence adolescents' eating habits via restrictive or critical messages are found to predict the perception that their family does not accept their body and predicts lower intuitive eating (Lessard et al., 2008). Children with chronic health conditions have been found to have more body image struggles (Piquart et al., 2013). Therefore, it is likely that controlling feeding practices may have an even greater impact on hospitalized children, however research has not yet been conducted on this subject in the hospital setting.

Feeding Practices Linked with Disordered Eating Habits

Research conducted by Schmidt et al. (2019) has indicated that parental feeding habits during childhood are not just predictive of intuitive eating skills but are also associated with individuals' tendencies for disordered eating. The study found that when mothers of children who are higher in weight status are highly controlling of their child's diet, children are more likely to present with greater eating disorder symptomatology. Overall, current research seems to indicate that parents who are overly concerned about their child's intake or attempt to modify it through

feeding practices such as pressuring or restricting may lead to disordered eating (Ellis et al., 2016.; Galloway et al., 2010; Schmidt et al., 2019).

Conviser et al. (2018) found that individuals with chronic conditions that require special diet regimes are already at higher risk of developing disordered eating or an eating disorder. Disordered eating is shown to result in poor health outcomes (Conviser et al., 2018). Therefore, the role of parental feeding practices in the development of disordered eating and eating disorders should be a focus of future research that could result in improved health for children.

Summary of Feeding Practices Outcomes

In summary, research has shown that controlling parental feeding practices, such as restricting and pressuring, may reduce intuitive eating skills (Ellis et al., 2016; Lessard et al., 2008), increase disordered eating behaviors (Ellis et al., 2016.; Galloway et al., 2010; Schmidt et al., 2019) and result in nutritionally deficient or unbalanced diets (Galloway et al., 2005; Lee & Keller, 2012; Mais et al., 2017). Intuitive eating is associated with numerous beneficial physical and psychological health indicators (Linardon et al., 2021; Van Dyke & Drinkwater, 2013), while disordered eating (Conviser et al., 2018) and poor diet (Wischmeyer, 2017) have been linked with poor health outcomes in children. Identifying the factors that may drive or influence parental feeding practices is therefore a priority.

Theoretical Framework

Influences on Parental Feeding Practices

Bronfenbrenner's bioecological theory, specifically the PPCT model (Lerner et al., 2006), provides a valuable framework for this exploratory study. This model offers a comprehensive lens to explore the influences shaping parental feeding practices. Bronfenbrenner's early work

focuses on delineating an individual's spheres of influence: the microsystem (inner circle interactions), mesosystem (connections between systems), exosystem (indirect influences) and the macrosystem (influences of social/cultural values/beliefs) (Smith & Hamon, 2017; Tudge et al., 2009). However, Bronfenbrenner's mature theory (1993-2006) stresses the importance of genetics and proximal processes in increasing the genetic potential of human development and introduced the process-person-context-time (PPCT) model (Smith & Hamon, 2017). Tudge et al. (2009) gives an overview of the PPCT model, writing that the process components are the primary mechanisms of development and refer to the regular activities that make up day to day life. The person component refers to the person's biology, genetics, temperament, etc., that impact these interactions. The context has already been discussed as this is the different environmental systems covered in Bronfenbrenner's earlier work. Finally, the time component notes the significance that historical events and major life transitions play in the individual's development and makes up a new system level termed the chronosystem.

Process.

Smith and Hamon (2017) described the different elements of the process-person-context-time model, beginning with the process component. They write that as a child is developing, their primary influence will stem from what Bronfenbrenner calls proximal processes. Proximal processes are the enduring patterns of interactions that a person has with other individuals as well as with objects and symbols. A parent may also exhibit certain feeding practices because of the proximal processes that they experienced as a child. If their parents engaged in more pressuring or restrictive practices during proximal processes involving food, it is possible that this could influence their own practices. Proximal processes that influence what feeding practices a parent engages in may include family mealtimes. For example, an increase in consumption of

nutrient dense foods is shown when social interaction is prioritized at mealtimes (Weatherspoon et al., 2013). On the other hand, poor eating environments, such as ones with distractions, have been shown to result in slightly higher calorie consumption and slightly less fruit and vegetable consumption (Avery et al., 2017). It is possible that parents feel the need to pressure their child to eat more vegetables or feel the need to restrict the amount of food they eat if their children seem distracted. These mealtime interactions would be just one example of how the quality and types of proximal process that parents engage in might influence their feeding practices.

Person.

Smith and Hamon (2017) describe the person component of the PPCT model as the individual characteristics that a person has which will influence the way that they interact with their surroundings. There are three categories of this factor: demand characteristics, resource characteristics and force characteristics. Demand characteristics refer to the characteristics that are immediately obvious, including age, skin color, and gender. Studies have indicated that gender may be correlated with certain feeding practices. For instance, fathers have been found to be more likely than mothers to participate in pressuring practices (Loth et al., 2013; Tarro et al., 2022).

Resource characteristics are not as readily apparent as demand characteristics as they comprise mental and emotional qualities as well as experiences that an individual has had (Coyne et al., 2021; Smith & Hamon, 2017). A parent's educational experience for instance would be a resource characteristic (Coyne et al., 2021). Research has indicated that maternal education is inversely associated with pressuring practices during feeding (Ayine et al., 2020; Sacco et al., 2007). Furthermore, a parent’s past experiences in childhood with food insecurity

may influence the way that they currently feed their child as well, possibly leading them to increase pressure on their child to eat (Arlinghaus & Laska, 2021).

Finally, force characteristics are inherent qualities in an individual such as their temperament or their motivation (Coyne et al., 2021; Smith & Hamon, 2017). It is debatable whether factors such as levels of stress and depression are inherent qualities (and therefore force characteristics) or whether they are more in line with Bronfenbrenner's resource characteristic. Regardless, these personal factors have been found to be associated with parental feeding practices. A recent review of the literature conducted by Arlinghaus and Laska (2021) found that when parents are actively experiencing food insecurity, they are more likely to exhibit depressive affect, lower stress tolerance and less attentiveness to their children's needs. Parents' behaviors and even their goals for feeding change in the context of food insecurity, therefore, it is important to study parental feeding practices exhibited by parents experiencing food insecurity (Arlinghaus & Laska, 2021).

Context.

Research shows that socio-cultural factors can influence and guide certain feeding practices as well (Cardel et. al., 2012; Blissett & Bennett, 2012; Musher-Eizenman et al., 2009; Wehrly et al., 2014) and it is possible that hospital factors may interact with these demographic factors in a way that amplifies or diminishes their influence on feeding practices. As parents are essentially "nutritional gatekeepers" when it comes to the quantity and variety of their child's food intake it is not surprising that different economic and cultural factors might play a significant role in how they feed their children.

Studies have linked different ethnic groups in the United States with different feeding practices. For instance, some research has shown that White American parents engage in less pressuring and in less restricting feeding practices than non-White Americans (Asian, African and Hispanic/Latino Americans in this study; Loth et al., 2013). However, this study also found that parents restricting was inversely related to household income and that pressuring was inversely corelated with educational level, household income and amount of employment (Loth et al., 2013). This might suggest that these practices are better or more fully understood in the context of factors found in many different areas of the PPCT model.

Latino parents in the US have been found to engage in an elevated level of pressuring practices (Ochoa & Berge, 2016). Research shows that pressuring is commonly exhibited in Latino populations when parents require that children "clean their plates" (eat everything on their plates; Skala et al., 2012). Little research has been done to examine what cultural factors may be increasing the likelihood of pressuring practices in this population however, one study found Hispanic parents viewed grandparent's permissive and indulgent feeding of grandchildren as a hindrance to healthy household changes (Mena et al., 2015). As familial piety is important in this culture (Steidel & Contreras, 2003), future research should examine the impact that grandparent involvement in this might have on the feeding practices in which parents feel they should engage.

African American parents have been found to engage in more pressuring and restrictive practices than Non-Hispanic White parents (Sacco et al., 2007; Spruijt-Metz et al. 2006). One study by Skala et al. (2012) showed that African American families are more likely to restrict than Hispanic families. One of the ways that this restriction is evident in this population is parents' tendency to not allow their children to snack whenever they want (Skala et al., 2012).

The majority of African American parents in this study also indicated that their children are pressured to finish everything on their plates. Again, the research regarding what cultural factors may be contributing to these elevated levels of pressuring or restricting is limited.

Asian American parents tend to engage in more restrictive and pressuring feeding practices than other ethnic groups according to Wehrly et al. (2014). Wehrly et al. (2014) suggests that traditional Asian values related to parents being responsible for guiding and monitoring their children may be causing Asian parents to feel they need to restrict the amount of unhealthy food that their child consumes. Furthermore, it is possible that Asian parents pressure their children to eat more traditional Asian foods when they notice their children becoming acculturated to less nutritionally dense "American" options (Wehrly et al., 2014). Another study found that Chinese immigrant mothers often engage in practices such as spoon-feeding vegetables when their child would not eat them, pointing out other children's eating habits in order to pressure their child to eating a certain way, heavily regulating eating routines according to what is believed to be healthy, and finally intentional home preparation of meals and specific foods considered to be healthy (Zhou et al., 2015).

Summary of PPCT Model Influences on Feeding Practices

Various factors related to proximal processes, personal characteristics, and context are associated with different parental feeding practices. Research that supports different components of the PPCT model guided the development of the demographic questions in this study and some of the open-ended questions in this study as well. These questions will help to illuminate personal and environmental influences that can help to explain why parents engage in certain feeding practices

Gaps in the Research

Controlling parental feeding practices have been shown to have negative impacts on child outcomes such as eating skills and diet (Ellis et al., 2016.; Galloway et al., 2010; Galloway et al., 2005; Lee & Keller, 2012; Lessard et al., 2008; Mais et al., 2017; Schmidt et al., 2019). Furthermore, research shows the important role that eating skills and diets have on health (Conviser et al., 2018; Linardon et al., 2021; Van Dyke & Drinkwater, 2013; Wischmeyer, 2017). However, research specifically in pediatric hospitals in on feeding practices is yet to be conducted. This gap must be filled with particular attention to the numerous personal and environmental factors that may influence the feeding practices that parents engage in. Research examining the prevalence of and influences on feeding practices among parents of hospitalized children must be examined if interventions are to be implemented in hospitals wish to promote pediatric health.

Aims of the Current Study

This study's aim is to explore feeding practices that parents of hospitalized children implement by measuring their prevalence in these settings and identifying associations of various personal and environmental factors that parents experience with the use of different feeding practices. The study will attempt to explore 4 research questions (RQ). (RQ1) How do parental feeding practices differ based on the reasons for hospitalization among children? (RQ2) What are some proximal processes that may be influencing the feeding practices of parents who have children in the hospital? (RQ3) What are some motivations or concerns that may be influencing the feeding practices of parents who have children in the hospital? (RQ4) How do cultural factors impact parental feeding practices for hospitalized children and what specific cultural factors may play a role in shaping these practices?

CHAPTER 3: METHODS

Participant Criterion and Recruitment

Participants were parents of children who were hospitalized in the United States of America when they were between the ages of 2 and 8 years. Participants were legal guardians of the children (and will be referred to as "parent" in this study) and they were 18 years old or older. All participants were fluent in English and had a child who had some level of voluntary oral intake (e.g. enteral or parenteral feeding cannot be their sole means of nutrition) while in the hospital. Convenience and snowball sampling was be used to collect participants. The researchers reached out to their own contacts at ECU or from their personal or work lives and asked them to either participate or if they know of anyone who would be eligible to participate in this study. The email addresses of potential participants were gathered, and they were emailed an informational flier about the survey and its goals which contained a link to a survey on Qualtrics (an online survey system) where they were able to begin the process of participating in the study if they choose. The email asked the participants to reach out to the researcher after this had been completed and the researcher then scheduled an interview time that worked for both the researcher and the participant. The participant was then sent a Zoom meeting invite. The interviews were held and recorded on Zoom and uploaded automatically to Zoom cloud.

Measures

Demographic Questions

The survey began by gathering basic demographic information from participants (See Appendix B). This section of the survey was aimed at identifying any personal characteristics or environmental factors that may influence these parent's feeding practices based on the PPCT

model and recent research. There were 12 demographic questions total which focused on parents' gender, age, occupation, ethnicity and educational level, food security, income, the number of adults in the child's household and finally their children's age, number of siblings, reason for being in the hospital and amount of time spent in the hospital.

Influencing Factors Interview Questions

The first section of interview questions was asked first and was intended to further illuminate any factors that may have influenced the feeding practices exhibited by the respondents based on the PPCT model. These questions also allowed for qualitative analysis which illuminated future directions of research that may not have been evident from quantitative data.

1. What did a typical mealtime look like in the hospital? Describe a typical mealtime at home in comparison. (e.g., You might include information about potential distractions, social interaction, eating meals as a family, involvement during or before mealtime such as who is involved in preparation or who decides what the meal will be, setting the table, serving their own portions and washing their plates, etc.)
2. What concerns, if any, did you have regarding your child's food intake related to your child's hospital stay, illness, treatment, etc. while they were in the hospital? What potential solutions to these concerns might you suggest to other parents or to the hospital?
3. What are some of your beliefs or customs concerning how to feed young children? (e.g., food as reward; food selection; hot vs cold food/drink; what is considered a healthy body type; what type of food is important in your community; what type of food are considered healthy in your community, is clearing plate emphasized, are snacks allowed whenever

desired, are meals at regular set times). Please describe any recommendations that might make hospitals more sensitive to your beliefs/culture.

Feeding Practices Interview Questions

The second section of interview questions briefly assessed the feeding styles that parents practiced while in the hospital. These questions were synthesized based on relevant questions that assess pressuring and restricting in Musher-Eizenman's and Holub's Comprehensive Feeding Practices Questionnaire. These questions were adapted to fit the retrospective nature and specific population of parents who have had hospitalized children that were studied in in the current research (2007).

4. When your child was in the hospital, what were the expectations around food? For instance, were they expected to clear their plate or encouraged to eat more after finishing what they wanted? Can you tell me about this?
5. While your child was in the hospital did you feel any need to regulate the less nutritious foods and sweets your child ate in order to improve their health or recovery? If this was ever the case, could you tell me how you went about this?
6. While in the hospital was your child's weight ever a concern? Did you ever feel the need to put your child on a diet or discourage or limit high-fat foods, snacks, large portions or big meals in order to address this concern?

Study Design and Data Collection

This is a retrospective exploratory study which used semi-structured interviews to answer the four research questions. The data was collected via Qualtrics where participants read an informed consent text and were asked to indicate their informed consent electronically. The text included (1) a description of the criterion they must meet to participate (2) a description of the

study goals, (3) an assurance that responses will be kept confidential and that no identifying information if revealed unsolicited in the interview will be included in the study write up, (4) a reminder that participants should not include any identifying information in their responses, and (5) a reminder that participation is voluntary. When consent was given, they were then able to proceed to answer demographics questions. The participants were linked to their demographic survey based on the time they completed the survey, which was recorded in Qualtrics. The data was collected via recorded Zoom interviews between the researcher and participants. The two sections of interview questions were asked with the first section assessing the potential influencing factors on parental feeding practices and the second section exploring the parental feeding practices that were practiced in the hospital. These interviews lasted approximately 15-30 minutes. In addition to the interviews being recorded, the interviewer took notes on the participant's answers which were analyzed at a later time.

Potential follow up questions were left up to the interviewer during the interview and include questions such as those included in Chapter 5 of Magnusson's and Marecek's 2015 book entitled Designing the Interviews. For example, the researcher may have prompted more detail by asking "Could you walk me through that?" (Magnusson & Marecek, 2015, p. 55).

These questions helped guide the participants without pressuring them or influencing them. The interviewer was able to ask these follow up questions or improvise basic follow up questions during the interview when necessary.

Data Analysis

Table 1

Rational for Statistical Analysis

Research Question	Relevant Data Source	Data Analysis	Rationale
(RQ1) How do parental feeding practices differ based on the reasons for hospitalization among children?	Demographics questions and Interview Questions 4, 5 and 6	Thematic Analysis	Analyzing the themes that parents report for what feeding practices they participated in while in the hospital and comparing the frequency or intensity of these practices with the different reasons for hospitalization that are reported in the demographic questions.
(RQ2) What are some proximal processes that may be influencing the feeding practices of parents who have children in the hospital?	Interview Questions 4, 5, 6 and 1	Thematic Analysis	Explore how the eating proximal processes provided to their children may have impacted the feeding practices they adopted in the hospital. We want to learn what are parents feeding practice or food intake environment at home is outside of and inside of their hospital stay so as to learn more about how the hospital environment might be impacting feeding practices.
(RQ3) What are some motivations or concerns that may be influencing the feeding practices of parents who have children in the hospital?	Interview Questions 4, 5, 6 and 2	Thematic Analysis	Exploration of motivations and concerns related to past feeding practices in the hospital and how they might be addressed in the future. We want to understand more about how parents worry about their child's intake can be alleviated while in the hospital.
(RQ4) How do cultural factors impact parental feeding practices for hospitalized children and what specific cultural factors may play a role in shaping these practices?	Interview Questions 4, 5, 6 and 3	Thematic Analysis	Explore the cultural factors that may have influenced feeding practices in the hospital and how they might be accounted for in an appropriate manner by hospitals in the future. We want to learn more about parents feeding beliefs, experiences and social context in order to learn more about how they may be impacting their feeding practices for their hospitalized child.

In order to explore RQ1, interview questions 4, 5 and 6 were studied. Thematic analysis was conducted by putting aspects of participants responses to questions 4-6 (which deal with the actual feeding practices that parents engaged in while their child was in the hospital) in to categories which were then used to help identify if there were any trends in the answers to these questions and in the conditions for which the children of these participants were hospitalized.

Interview question 1 aimed to answer RQ2 by investigating the proximal processes that may have shaped the feeding interactions (that will be later identified in questions 4-6) between parents and children in the hospital setting. Theme analysis of the answers to this interview question enabled the researcher to identify what factors were involved in the proximal process of a child's mealtimes which may be associated with different feeding practices. Participants' own answers to the questions of why their child's mealtimes were conducted in a certain way or any themes identified between certain populations allowed for a better understanding of these proximal process (Refer to Table 1 on page 19).

Interview question 2 aimed to answer RQ3 by exploring what motivations or concerns might have driven the feeding practices, identified in interview questions 4-6, of parents of children in the hospital. The literature review revealed that there might be associations between feeding practices and many different factors, so these open-ended questions allowed for exploration of potential sources of motivation for the practices. Parents specifically identifying the concerns they had provided potential avenues for future research. The themes identified in the responses to these questions could be analyzed based on different parent characteristics so that future research might look more specifically at certain populations who have unique concerns in common or high levels of certain concerns (Refer to Table 1 on page 19).

Interview question 3 aimed to answer RQ4 by examining the cultural factors that might influence the specific feeding practices that were assessed in interview questions 4-6. The PPCT model and current research recognizes the significant role that different cultural aspects may have on feeding practices. These questions prompted parents to think specifically about what cultural influences may have impacted the way that they fed their children and how hospitals might be cognoscente of these cultural differences (Refer to Table 1 on page 19).

CHAPTER 4: RESULTS

Deductive thematic analysis was used analyze the participants interviews in order to answer the four exploratory research questions in this study. The demographics of the sample population will first be laid out so that an understanding of the population, its commonalities and disparate elements, can be gained before exploring the findings uncovered in the qualitative analysis of the interview transcripts. For many research questions these findings are explored in conjunction with the demographics survey responses. The findings uncovered by the researchers further illuminate our current understanding of the impacts of a variety of different factors on the parental feeding practices parents engage in within different settings such as the hospital and the home.

Sample

The five interviewed participants were aged between 24 and 45 at the time of their child's hospitalization, with three falling within the 25-34 age range and two within the 35-44 bracket. Participants reported that, during their child's hospitalization, only one other adult was present in the household, potentially influencing their child's eating habits. The population sampled was not ethnically diverse, as all participants reported being White. All participants acknowledged food security. Finally, most of the individuals willing to be interviewed and surveyed were women; only one of the participants in this study was male (Refer to Table 2, pg. 23). To ensure anonymity, the names of interviewees appearing in the text and in Tables 2 and 3 have been replaced with pseudonyms.

Table 2

Participant Demographics Table

Participant #	Gender	Age	Ethnicity	Occupation	Education	Reliable Access to Food	Adults in Household	Household Income
Emma	Female	25 to 34	White	Homemaker	High school degree/GED or less	Yes	2	75,000 to 125,000
Ivana	Female	25 to 34	White	Teacher training or education	Bachelor's degree	Yes	2	25,000 to 75,000
Bonnie	Female	35 to 44	White	Business, consultancy or management	Master's degree or higher	Yes	2	More than 125,000
Radcliffe	Male	35 to 44	White	Healthcare	Master's degree or higher	Yes	2	75,000 to 125,000
Helena	Female	25 to 34	White	Healthcare	Bachelor's degree	Yes	2	25,000 to 75,000

The participants' age, gender, ethnicity, sense of food security, and number of adult influences on their child's intake were relatively homogenous. However, the participants' measures of socioeconomic status such as educational level, occupation and income was diverse. The participants' educational level, at the time of their child's hospitalization was highly variable, ranging from a high school degree or GED to a master's degree or higher. Similarly, participants' occupations were highly varied and included "Homemaking", "Healthcare", "Teacher training or education" as well as "Business, consultancy or management". Furthermore, the participants' income was between 25,000 to more than 125,000 (Refer to Table 2, pg. 23).

This research is exploratory in nature and could reveal interesting avenues for discovery on parental feeding. The wide range of educational and occupational paths and income levels the

participants represent could provide insights into the influences on parents and children. These insights build the current stock of knowledge on how different populations of parents feed their children and illuminate future areas of critical research.

Table 3

Child Information Table

Participant #	Age	Number of Siblings	Condition	Amount of Hospitalization between ages 2-8
Emma	8 years	5+ (five or more siblings)	Nervous System Condition	One week to one month
Ivana	3 years	0 (only child)	Salmonella Food Poisoning	Less than a week
Bonnie	8 years	4 (four siblings)	Cranial Facial	Less than a week
Radcliffe	6 years	3 (three siblings)	cleft lip + palate	Less than a week
Helena	8 years	1 (one sibling)	Digestive Condition	One week to one month

It is important to examine factors that may impact the ways parents engage in different feeding practices more related to the child than the parent. In this study, the age range of the participants' children at the time of their hospitalization was three to eight. The hospitalized children had a wide range of siblings, with everything from one to five or more siblings. Finally, there was a wide range of reasons for hospitalizations of the children, impacting everything from nervous and digestive systems and involving everything from foodborne illness to invasive facial and oral/esophageal surgery. The total amount of time that the participants' children were hospitalized between two and eight years old was between less than a week and one month (Refer to Table 3, pg. 24).

Identification of Parental Feeding Practices of Participants

Outside of the hospital, parents reported engaging in various feeding practices. Some parents had high levels of parental control over meal and snack choices. Some parents gave children more control over the preparation and serving of meals and their overall intake. Examples of this included having snacks always available or providing guidance alongside choice by restricting certain foods seen to be unhealthy while offering options of foods deemed healthier.

> If you come to me, and you say you're hungry, and you have eaten often times depending on the, I mean, I'm not like super hardcore 'You could never have chips for a snack' but you know my first inclination is to offer you a cheese stick or some fruit or you know something like that, as opposed to, you know a processed package of ‘blah blah blah’, you know, although that is the preferred snack, right? - Bonnie

Some parents were far more relaxed about what their children ate; some preferred to be more involved in restricting or monitoring the amount and types of food their child consumed. All the parents expressed a wide range of feeding practices that reflect intuitive eating practices, as well as pressuring and restrictive patterns of feeding, and many other feeding practices (See Participant Feeding Practices Table in Appendix D).

Interestingly, although parents’ feeding practices were varied outside of the hospital, when their child was hospitalized, many parents reflected that they became much more concerned about encouraging or at the very least allowing their child to consume whatever they chose and in as much quantity as they desired or could tolerate. However, the reasoning for this shift in how parents viewed the purpose of feeding was different. One parent viewed food as a

way to help regulate their child's emotions in the hospital and make it a more tolerable experience overall. Others (3/5) reported that the goal they strove for was simply to have them eat and keep food in them as much as possible.

> When [child's name] was recovering from surgery, it was, 'What can you eat?', 'What are you able to eat?', 'What tastes good?' and 'What are you able to keep down?' and if that's yogurt, if that's if that's you know, a juice box, maybe that's some of those things that we didn't necessarily have, as you know, as one of the one of the plate items during a meal at home, so be it. We're gonna we weren't so focused on that as much as just, 'Can you eat and can you keep it down?' - Radcliffe

At home parents may still have encouraged or put pressure on their child to eat, the shift is seen in what is being pressured. At home parents encouraged their kids to try new foods and sometimes had strategies such as hiding vegetables in milkshakes. In the hospital most parents (4/5) encouraged them to eat anything, as long as they were eating. All the parents reported not being restrictive in the hospital, and four out of the five said this was different from how they would normally feed their child at home. The researchers explore potential reasons for this occurrence in answering the four research questions.

Research Question 1: Reasons for Hospitalization

(RQ1) How do parental feeding practices differ based on the reasons for hospitalization among children?

Identifying what practices parents used based on their answers to the interview questions allowed the researchers to compare these practices with the participants reason for hospitalization (refer to Table 3, pg 24). This allowed the researchers to understand how a child's reason for hospitalization might influence their feeding practices. The reasons for hospitalization

were diverse and, according to parental reports, did impact the way in which they fed their children.

Some participants reported that the hospital staff put pressure on them to feed their children in a certain way and others reported feeling the need to feed them in an atypical way compared to at home due to the nature of their child's condition or due to the nature of their treatment or surgery. Ivana for instance indicated that she felt the need to pressure her child to eat more food while in the hospital as she was suffering from Salmonella and was concerned that her child was simply not eating due to her condition and was typically asleep during meal times. Helena had a child with a chronic digestive condition and expressed the sense that she always felt pressured to try and put more weight on her child, (in this instance the participant also experienced this pressure outside of the hospital as well as her child's condition was chronic in nature):

> The focus on [child's name] was always that he was never on the chart so doctors would always really freak out about that and there was just this ton of pressure that I felt to get a child who didn't eat, on the chart, and it was very stressful and very hard and so I understand that they use this chart to help identify illnesses in children if they're not there. But [child's name] is healthy, but he's just never been on the chart like he's very thin, and he's just. This is not say-- doctors need those charts-- but it was such an emphasis for us as a family to get him on the chart, and whatever it takes and so we did food as a reward. - Helena

It is significant to note that the resultant practices that this participant mentions of pressuring, hiding nutritional foods in other food, using high fat ingredients and bribing their child to eat were practices that extended beyond the hospital. However, these were still not what the parent

seemed to believe was the best way to feed children without this condition. She also even expressed that her practices may have been less extreme if not for the pressure put on her by doctors to get their child on the BMI chart.

In total, four out of the five participants indicated that their child's surgery or illness itself was what caused them to want to try and get their child to eat as much as possible. According to Helena:

> You know he had two different things going. He had this bowel that didn't work, so all his, the stool would back up and it would keep him from wanting to eat, because he was just so constipated, you know. So we were battling two issues at the same time and so yeah, it was a little double-edged sword almost try to get him to eat, but he didn't feel like it, so cleaning him out and then starting over. - Helena

All of these participants had children whose conditions impacted their child's desire or ability to eat significantly, whether due to surgical operations involving the mouth and throat or the aforementioned chronic digestive illness and food poisoning. There are many reasons why this might have occurred besides the fact that parents will naturally try and feed their child more if they see a decrease in their intake. These possible contributors may include the way in which the hospital itself encourages or influences parents which is covered in the section entitled "Motivations and Concerns" which reviews the findings for research question 3 (pg. 30).

Research Question 2: Proximal Processes

(RQ2) What are some proximal processes that may be influencing the feeding practices of parents who have children in the hospital?

Interesting themes arose when the proximal processes that parents reflected on both inside and outside the hospital were analyzed. Limited social interaction within the hospital at mealtimes was noted by four out of the five participants and did seem to be a significant concern of these parents (see Proximal Process Table in Appendix E). Emma observed "There's really no interaction at all. They just kind of set a food tray down and are like 'Bye.'" Bonnie also notes the limited social contact surrounding her child's meal times "No, it was just she and I. She had her own private room. [Spouse's name] was working, so he only came in the evenings to come and visit." Three out of five parents report that social interactions were a regular part of their mealtimes at home (i.e. family mealtimes). Three out of the five participants also emphasized the inconvenience of having unpredictable and irregular mealtimes in the hospital noting that meals were based on staff schedule availability and the meals were scheduled at times of day that were often unfamiliar to the parents and children (see Proximal Process Table in Appendix E). Emma stated: "My kids don't eat breakfast at home until eight or nine […] they're homeschool kids so I guess typical like public school kid probably would be eating breakfast that early." Similarly, Radcliffe notes" She was dependent on her meals based like on what is the staff doing and what is their schedule for meals. Furthermore, the hospitals rarely provided meals at consistent times. This meant it was harder for parents to plan times to eat with their children.

> [...] there's no way for the family to eat at the same time as the patient. So you can't order off of the menu for the like if the mom and the dad are going to be there at dinner time to eat with the child. So the child is eating alone, and the mom and the dad are having to forego dinner, in order to be able to be there. - Bonnie

> So this particular hospital did allow you to have a menu and you know you could pre order what she was getting, but you not always got it. So there was times that they would bring you the normal meal and you would have to call and request something else so then it would be you know an hour later and she would finally be eating dinner. - Emma

> And often times they say, 'Well, you can go down to the cafeteria', but that means I have to leave my child. I have to go down there. I've stand in line, come, bring this all back up, and then I've got to take all that stuff back, trays and stuff. It's just- it's not conducive to everybody eating together. - Bonnie

As the proximal processes surrounding mealtimes are shown to have impacts on parental feeding the finding that the mealtimes were so consistently disrupted for these participants is significant.

Research Question 3: Motivations and Concerns

(RQ3) What are some motivations or concerns that may be influencing the feeding practices of parents who have children in the hospital?

When asked about the concerns that they had in regard to their child's intake in the hospital there were to significant categories of concern, the first was concerns related to their hospital stay in general and the second was concerns related to their child's condition. The concerns that may be influencing parents' feeding practices by extension can be seen in respect to the hospital stay in general, concerns directly related to their child's condition and finally, concerns related to their child's care or treatment.

Hospital Stay Concerns

Three out of the five participants noted that they were concerned about the quality or amount of the nutrition that their child was receiving. When examining parents' concerns about the hospital stay in general many parents also reported concerns about how the staff interacted with them or with their child. For instance, Emma stated that a nutritionist was called in to talk to her about BMI and healthy eating and that this made her feel judged for letting her child eat whatever she preferred. In this particular case, however, it did not seem that this experience had caused any significant change in feeding practices by this participant. Bonnie (female, child: 8yrs, "Cranial Facial" surgery) noted "So while she was in the hospital, nobody checked on how much she was eating, how many calories she was getting, whether she finished any of the stuff that she ordered. No, there was absolutely no monitoring." The primary intake concern for these parents was not related to the number of calories that their child was consuming but the quality of nutrition that they receive (see Motivations and Concerns Table in Appendix F). Ivana (female, child: 3yrs, "Salmonella Food Poisoning") noted that her child "had an IV but it was fluid only: "Honestly I wanted them to include other nutrients in that IV because I was worried about what she was taking in". Bonnie (female, child: 8yrs, "Cranial Facial" surgery) discussed her concerns with the lack of healthy options on the liquid diet that her child was placed on while in the hospital, stating: "I would look for things on the menu that were available in the "soft foods menu", and like apple sauce and broth, chicken broth. There just weren't a lot of things that I would consider to be healthy".

Two out of the five participants also expressed dissatisfaction with staff attentiveness. Bonnie (female, child: 8yrs, "Cranial Facial" surgery) was particularly concerned that the hospital staff did not provide an explanation of how to administer the liquid diet to her child after an

invasive surgery impacting her ability to swallow: “[...] like a food service person, would bring the food, not even a nurse and the ensure, they gave me a couple of cans, and they gave me the syringe and they're like 'And you're on your own.'” The staff simply provided the cans of ensure and a syringe with no explanation of the process which the participant noted could have been a stressful and challenging task for a less experienced parent. Ivana (female, child: 3yrs, “Salmonella Food Poisoning”) also noted that staff would not even bring her child food when they first arrived at the hospital but said that they could go down to the cafeteria.

Condition Concerns

Three out of five participants expressed concerns related to their child’s comfort and how it impacted their eating ability, desire or enjoyment:

> I think she was just when we were there she's very, very sick and her stomach hurt. She had salmonella so that totally disrupted her eating enjoyment, habits so she would be asleep through the actual mealtime or she wouldn't be interested during that mealtime. - Ivana

Nonetheless, only Ivana (female, child: 3yrs, “Salmonella Food Poisoning”) seemed to believe that their child’s treatment or pain control was handled poorly. However, Bonnie (female, child: 8yrs, “Cranial Facial” surgery) did state:

> I would say 'Well why don't we wait until the next pain pill comes', or whatever you know. Maybe we could try to eat again and a little bit after that once, because it'll take down the pain. So if I didn't feel like she was getting enough, and I knew she wasn't, because she eats way more than what she was eating. I would try to look for times that would maybe be a little easier for her. - Bonnie

Though this participant did state that she believed her child's pain was managed appropriately, We might conclude that coordination of pain management with food delivery may improve patient intake outcomes. Overall, the results seem to indicate that poor nutrition and the discomfort levels of their children based on their condition were the primary concerns of parents related to their child's intake.

Research Question 4: Customs/Cultural Factors

(RQ4) How do cultural factors impact parental feeding practices for hospitalized children and what specific cultural factors may play a role in shaping these practices?

When specifically asked to describe their personal cultural beliefs or customs when it comes to feeding their children the participants chose to focus on a few major topics. Although some of these topics are discussed by participants in other portions of the interview, the following results are limited to the answers that were provided specifically in response to the research question addressing cultural beliefs. The researchers have chosen to focus on these responses as this is what the parents chose to present as their cultural beliefs rather than simply referring to beliefs or habits that may be less important to them in response to other interview questions (see Customs and Beliefs Table in Appendix G).

All participants choose to share their customs regarding healthy or unhealthy foods. Two participants chose to focus on their beliefs about using food as a reward. Beliefs about how to handle snacks were important for three participants to share. One participant reiterated the importance of family meals in training children about mealtimes and how to share a meal with others. One other chose to express her views on food waste as well. Portion size was mentioned by two participants. Trying food was spoken of as a tool for exposing children to new foods and

helping them eat more balanced meals according to two participants. Finally, a major topic was clearing the plate with four out of the five participants choosing to focus on this topic.

Healthy vs Unhealthy Food

The views on healthy vs unhealthy foods and how they should or shouldn't play into your child's overall diet were relatively diverse. The two other participants views tend more towards simply trying to find strategies to get their child to eat more of certain foods. They employ strategies such as only making the vegetables that they know their child prefers because they see eating the same vegetable as better than eating no vegetable at all. The other participant's strategy for incorporating the foods she viewed as more nutritious was to blend these foods into different foods or to use only ingredients that were high in fat. One parent stated that their family ate "unhealthy" and did not by word or intonation suggest that she viewed this as a critical concern but simply as a fact. Other parents felt more strongly that "healthy meals" should be the main source of intake rather than snacks with less nutritional value. Another parent's view was similar in that food should be fuel and have a purpose outside of having a desire for a certain food. These parents' views are summed up well in the following excerpts: "[...] probably 75% of the time I'm gonna say, 'If you're not hungry enough for an apple or cheese stick or an orange, then you must not be that hungry.'" (Bonnie); "It's about eating foods that are prepared that are healthy and nutritious rather than eating for reward or eating for a treat [...]" (Radcliffe). It is clear from these experts how these parents views might impact the feeding practices they adopt. These beliefs are closely tied to the two following themes of customs and beliefs surrounding food as a reward and views on snacks that follow.

Food as a Reward

Two participants who chose to share their beliefs on using food as a reward and both had nuanced opinions that considered child differences. For one participant reflected on the importance of taking into consideration factors like susceptibility to eating disorders as well and the potential danger of food rewards leading to emotional eating in the future:

> I think it, it really depends on the individual. I mean, some kids, some kids– like being rewarded with food can lead to, you know, eating disorders. They get to see food as a reward, and it's a comfort and if they're in stress they go to food as their source of comfort, so that can lead to eating disorders. So I don't know that using food as a reward is necessarily appropriate for every kid, you know, not every kid struggles with, you know, food, or has food issues like that, or could you be susceptible to developing an eating disorder, but some do and so it's, you know it's really important to you know where your son or daughter is at, and if that's, you know, potential struggle for them. - Radcliffe

This participant noted that their personal beliefs were that in general it is not “good practice” to use food as a reward for most children.

Similarly, the other participant who commented on food being used as a reward stated that although her and her spouse did use food as a reward, but that it was more due to doctors putting pressure on them to help their child gain weight:

> [...] he was never on the chart so doctors would always really freak out about that and there was just this ton of pressure that I felt to get a child who didn't eat, on the chart, and it was very stressful and very hard and so I understand that they use this chart to help

> identify illnesses in children if they're not there. But [child's name] is healthy, but he's just never been on the chart [...] it was such an emphasis for us as a family to get him on the chart, and whatever it takes. And so we did food as a reward. - Helena

Overall, using food a reward did not seem to be a commonly supported belief among the parents.

Snacks between Meals

Two of the three parents that brought up beliefs about snacks as a significant personal view on feeding, saw snacks as secondary to the main meals of the day. Snacking was regulated by these parents and based on the child's intake choices that the child themselves made at the previous mealtime: "I don't let anybody have snacks or treats if they don't finish the dinner that they serve themselves" (Bonnie). Bonnie also noted that she allowed the some choice in the snack by offering some healthy options stating that "snacks were by permission and she could ask for a snack and I would offer her options and she would pick whatever she preferred" (Bonnie). Emma had very different beliefs on snacks stating that her children "[...] they eat snacks whenever. I mean, if they're like 'Mom I'm hungry' like, I'm gonna feed, you". These statements indicate that the different beliefs that parents hold when it comes to food in between more structured meals varied among the sampled population.

Portion Control

Portion control was also mentioned by two participants who had different reasoning for bringing up this particular custom related to feeding children. One participant when she stated that she prefers smaller portions and brings it up in the context of food waste stating, "I'm fine with leftovers. I'm fine with throwing food out, I really don't like throwing food out if there's enough

for leftovers, I'll want to save it and take it to the school lunch the next day or something". The other participant that focused on portion control as one of her significant beliefs noted:

> I do believe that regular meal times, at least once a day, and, if possible, especially when they're younger, you know, like three meals a day, and the training of sitting down, waiting for others, serving yourself a portion that you can have seconds, but let's- you know pile up the plate, share what's on the table. So you look around and you're like 'Okay, there's 11 people, 1/11th of this is mine, and not half'. - Bonnie

For this parent, the child should be learning to make personal portion control choices in a social context, taking into consideration the number of people that are eating the meal together.

Trying Food

Two parents found it very important for their children to explore new foods and to at least sample what was served for meals. However, there were two different tactics for dealing with the child who does not like the food tried. For one parent the child can serve themself a very small portion of the food they are hesitant to try and if they do not like it they do not have to have more than they served themselves:

> [...]for family meals is that it should be colorful and so there should be various colors on the table like carrots and peas and chicken, and you know, whatever and that everybody should find, they maybe don't like this particular vegetable or that particular thing, but everybody at the table should find something on the table that they're looking forward to eating. Like I know I could eat rice, and there is rice today there's asparagus, and I'm going to have to eat asparagus, but... and that was the other thing is, you must try a little bit of everything. You can't just say, 'Yeah, I'm only eating rice today.' 'No, you, if you want the

rice, you're also gonna have a little bit of each of the other things and you served yourself, you can have one asparagus spear. That's fine, but you need at least one.' - Bonnie

In this case the parent believed it was important to have a variety of foods on the menu stating that having colorful meals was important and having at least one food that the child knew they liked on the table was important for this strategy as well. On the other hand, Ivana allows more child choice in the meal:

> If you don't like it, you have to at least try it and then, if it's really that bad, you can go make something else, and sometimes it is, I'll try new things. You know, I like to experiment, and sometimes it's like I don't like it either. So we dump it out, and everybody, makes a sandwich or something. - Ivana

For this parent they simply required their child to try the food prepared and if they do not like it they could choose to eat a different meal that they preferred.

Clearing the Plate

Finally, four out of the five participants chose to share their personal beliefs about clearing the plate. None of the parents required their child to finish their plate. However, it is important to note that the consequences for not clearing the plate were different. For one parent not clearing the plate was fine and it was not her belief that overeating should be encouraged; her child was welcome to grab snacks from low shelves in the pantry at any time. For another, “sticking to a plan” and making sure the plate was cleared was unimportant:

> As far as like cleaning your plate we're a family like if I cook something at night and like you don't like it, you're gonna eat something else like I don't make my kids what I cook like. I don't make them- like I do like them to try things, but like, if you want a bowl of

cereal because you don't like what we cook, I'm good with that. So like I'm not big on you know having to stick with a plan, basically. - Emma

On the other hand, two participants were more structured when it came to the consequences of choosing to not eat what was on the plate for a meal. For one parent, letting the child serve their own portions was normal and if they did not finish that portion, they would not be allowed snacks till the next meal. For the other, the belief was that if children do not finish the healthy meal served, they are not really hungry and so do not need to be eating snacks or desserts/treats. All of the beliefs and customs discussed in the interviews could be analyzed in the context of different feeding practices such as monitoring, pressuring, restriction, intuitive eating, child choice and parental control and many others.

CHAPTER 5: DISCUSSION

This exploratory research was intended to examine the different feeding practices that parents engage in while in the hospital and outside of it to answer four major research questions: (RQ1) How do parental feeding practices differ based on the reasons for hospitalization among children? (RQ2) What are some proximal processes that may be influencing the feeding practices of parents who have children in the hospital? (RQ3) What are some motivations or concerns that may be influencing the feeding practices of parents who have children in the hospital? (RQ4) How do cultural factors impact parental feeding practices for hospitalized children and what specific cultural factors may play a role in shaping these practices? The demographic surveys and interviews that were conducted revealed many interesting findings, the most significant of which are valuable in furthering our understanding of the influences that impact parental feeding.

The researchers found that a child's medical condition did seem to impact the way they fed their child. Furthermore, the proximal processes surrounding meals were different in the hospital compared to in the home in that hospital mealtimes involved less social interaction and were irregular and unpredictable. The current study also revealed that the three primary concerns of parents in the hospital that may have influenced their feeding practices: the nutritional needs of their child, staff attentiveness, and child comfort level. Finally, the beliefs and customs of parents that may influence their feeding practices were their views of healthy vs unhealthy foods and their practices surrounding clearing the plate at mealtimes.

Interpretation and Implications

Condition Impacts Feeding Practice Engaged

In answer to RQ1, the researchers found that how parents fed their children differed based on their children's medical condition. For instance, children whose conditions or surgeries

reduced their ability or desire to eat were pressured by their parents to eat more. On the other hand, a parent whose child was having seizures was less concerned about her child's intake in general. Though the research on this subject is limited, Sdravou et al. (2020) discovered that children with gastrointestinal problems were fed differently by their parents compared to the general population. Parents who had children with gastrointestinal conditions were more actively engaged in feeding their children. In Sdravou et al's (2020) research, it was shown that, compared to parents of healthy children, these parents engaged in more habits such as verbal praising, correlation of food with pleasure, promotion of food benefits, and assistance during feeding. These tactics are intended to pressure or persuade children into eating more. The findings of the researchers in the current study revealed that parents who pressured their children also used various tactics intended to increase consumption of food or of certain types of food. However, in the current study, parents tended to use different techniques such as offering the food at different times, offering desirable foods, hiding nutritional or caloric foods in other foods, providing more snacks, using food as a reward, and bribing their child to eat more.

Non-Social and Unpredictable Mealtimes

The environment of a child is clearly described in Bronfenbrenner's theory through the "process" element of his Process Person Context Time (PPCT) Model (Smith & Hamon, 2017). Bronfenbrenner highlights in this PPCT model how routine interactions and experiences, termed "proximal processes", shape and mold individuals' behaviors. Therefore, the mealtime dynamics and elements that a parent and child experience are bound to impact the feeding practices of parents according to this theory.

Regarding RQ2, parents in the current study emphasized that there was limited social interaction around hospital mealtimes compared to mealtimes at home and that these mealtimes

were irregular and unpredictable. Studies have been done to test the effectiveness of interventions aimed at protecting and supporting mealtimes in the hospital (Manning et al., 2012; Markovski et al., 2016). The interventions in Manning et al.'s (2012) and Markovski et al.'s (2016) study touch on many of the aspects of hospital mealtimes that the current study found to be lacking. Markovski et al. (2016) focused on how a social dining room setting could benefit older adults in the hospital. Manning et al. (2012) also focused on elderly patients in the hospital and identified how meal assistants could give more personal attention to these patients during meals. The research on how these mealtime proximal processes could impact the way that parents feed their children in the hospital is yet to be researched.

Nonetheless, the impact of proximal processes on child eating habits is documented (Avery et al., 2017; Weatherspoon et al., 2013). Social meals tend to be correlated with children eating more nutrient-dense foods (Weatherspoon et al., 2013), and distracting meal environments tend to correlate with higher calorie intake and lower fruit and vegetable intake (Avery et al., 2017). Therefore, implementing healthy proximal processes into hospital mealtimes, such as allowing children who are eligible based on their condition to eat in a dining room, where other children and families are eating, may be beneficial. This type of dining setting may be found to reduce negative feeding practices and improve children's quality of nutrition and health indicators such as appetite. As revealed in the literature review, the proximal processes surrounding mealtimes for children have been shown to have significant impacts on children (Manning et al., 2012; Markovski et al., 2016). Therefore, the changes in mealtime patterns and interactions at these mealtimes should be studied more in-depth to understand how they might impact the feeding practices of parents who have hospitalized children.

Poor Nutrition, Inattentive Staff, Under-addressed Pain

Bronfenbrenner's PPCT model suggests that an individual's resource and/or force characteristics such as their temperament and emotional qualities may impact the way their engage in the world (Coyne et al., 2021; Smith and Hamon, 2017). If a parent is dealing with intense anxiety because of their child's condition and care, Bronfenbrenner's theory supports the idea that the emotional qualities and temperament they possess might impact how they interact with their child. Feeding practices therefore could be greatly impacted by the "person" characteristic laid out in the PPCT model.

When examining the findings related to RQ3 the researchers discovered that parents were primarily concerned about the poor nutrition, lack of staff attentiveness and discomfort their child experienced in the hospital. While the specific concerns about nutrition, staff and pain that parents presented may have all been valid, prior research indicates that it is certainly true that parents need more reassurance about their child's care when in the hospital (Farrel & Frost, 1992). Farrel and Frost (1992) found that parents report that their primary need in the hospital is more information. They also reported that they needed more relief from anxieties about their child's condition and more staff availability and willingness to communicate (Farrel & Frost, 1992). Parents in this study even reported that these needs outranked their own social/emotional and physical needs (Farrel & Frost, 1992). Based on Farrel and Frost's (1992) research and the findings of the current study, hospitals might consider taking steps to manage parental concerns regarding children's nutritional intake and pain and having staff be more attentive and more communicative. Child life specialists could play a critical role in bridging the communication gap as they are specially trained in how to communicate with stressed parents in empathetic and therapeutic ways. If these steps are taken,

parents' anxiety and confusion regarding their child's needs might be assuaged, thereby reducing negative feeding practices that could arise from these concerns.

Healthy vs Unhealthy Foods and Clearing the Plate

The "context" component of Bronfenbrenner's PPCT model involves sociocultural factors that define and shape environments (Smith & Hamon, 2017). The culture that parents and children are a part of would fall under this definition. Therefore, the feeding practices that parents exhibit may be impacted according to this theory by the cultural customs that were uncovered in this research.

Finally, the researchers identified a wide variety of customs and beliefs surrounding food when answering question RQ4. Most parents chose to focus on discussing their beliefs about healthy vs unhealthy food and their views on clearing the plate. The researchers found that many parents were adamant that their child ate healthy food regularly, while others were more relaxed. Although the parents that chose to speak on cleaning the plate all said that they did not require their child to clear their plate, the consequences of not doing so were different. Some parents had no consequences and some eliminated snacks or deserts between meals. Still others had their child make something else for their meal if they did not like the meal served. As noted in the literature review, Loth et al. (2013) found that White Americans generally tend to pressure and restrict their children's eating less than other cultural groups. Loth and colleagues also found that households that made more money tended to restrict intake less than those that made less. Finally, an inverse correlation between educational level and pressuring, as well as household income and pressuring (Loth et al., 2013). The current study has extended Loth et al.'s research on contextual influences of parental feeding as it focused on children in and out of the hospital setting whereas Loth et al.'s study did not have a focus in the hospital. Pressuring and restricting were feeding practices that

where clearly seen among the population in the current study. The implications of this finding indicate the need for more comparative research to be done that examines these contextual factors and their impact on parental feeding.

Recommendations for Hospitals

Based on participant interviews, hospitals should consider three recommendations that could reduce parental concerns and improve child outcomes. Hospitals should consider: (1) improving staff communication with parents when it comes to feeding, (2) developing education specific to different conditions, and (3) facilitating more timely and social meals for hospitalized children.

Improved Staff Communication

Better communication was a subject that was brought up by many of the participants and would seem to assuage many of the concerns that parents had regarding their child's intake. Many parents had concerns related to their child's nutritional intake and the management of their child's pain, which could have impacted their intake. These concerns may have been addressed if parents had received more assurance, guidance or simply had hospital staff that were more willing to listen to them. The participants' concerns, while they many have been valid, also may have simply been due to communication breakdowns between staff and parent. As this is not unexpected due to the fast paced, high-stress environment of hospitals, it is reasonable to assume that additional training for staff on how to communicate effectively with parents of hospitalized children is necessary. Training staff on how to deliver information to parents under stress might be highly beneficial as well. Standardization and requirement of debrief sessions after procedures or treatments between medical personnel and parents could help ensure that essential information

that could minimize parental concerns is conveyed reliably and effectively. These trainings may enable staff to minimize the concerns of parents, thereby reducing negative feeding habits that may arise out of their concerns.

Education on Different Conditions

Certain types of hospitalized conditions may have a remarkable impact on how parents feed their children, therefore, it is important for hospital staff to be well educated on feeding practices of parents and how they may negatively or positively impact children and their overall health or recovery. Parents should also be educated about the basics of their child's condition and what to expect in a manner that does not place a great amount of strain on staff. Child life specialists are well-positioned, to serve as an information resource for parents. Child life specialists have specific education in communicating complex medical topics to parents and children. This knowledge allows them to communicate information in a therapeutic manner that reduces anxiety, even in stressful situations. Through their skilled communication, these child life specialists would ensure parents feel informed and understood, empowering parents to navigate their children's needs.

For instance, hospitals also might inform parents better by developing pamphlets, booklets or even webpages that walk parents through what their child might go through and that answer basic questions based on the condition or procedure for which their child has been hospitalized. Even simple signs at the bedside of patients with certain conditions that inform parents on how to tell if their child is in pain or in need of something could reduce parental anxiety. For instance, a sign might inform parents that if their child is capable of performing certain activities, there is no need to call the anesthesiologist. On the other hand, if they are unable to perform these activities it may indicate that their child is in pain or in need of

something and that medical staff should be called. Future research on this subject may help parents avoid certain practices that may actually hinder their child's recovery in the hospital and may extend beyond the hospital if parents form habits of the practices.

Facilitate Timely and Social Meals

The facilitation of more timely and social meals is another area that the present study reveals should be focused on by hospitals. Hospitals might work to improve the flexibility of meals so that children can eat at times that are more familiar to them. Having a window of time in which a meal could be ordered may be helpful, rather than patients being dependent on food service schedules. Cafeterias might achieve this by having meals on standby that are easily prepared in advance and stored, such as sandwiches and fruit cups. This would mean that even if a child was not hungry or wanted to wait until a parent could eat with them, they could choose to opt for the standby meals. This would mean they could forgo the regular mealtimes, where a hospital might serve a more complicated hot meal. Participant interviews also suggest that hospital staff might work to make it easier for parents to eat with their children. One way to do this might be to have hospital volunteers deliver meals to parents. More social meals and more coordinated parent and child meals might be achieved by allowing parents to order off a cafeteria menu virtually rather than having to go to the cafeteria. This would help ensure that the parents' and the children's meals arrive at the same time. It would also enable parents to stay with their child rather than worrying that their child might need them or might not be well cared for in their absence. Hospitals might also ensure that parents know and can be confident in when a meal is arriving. This could enable children to eat with family members or even other visitors who might not be at the hospital as regularly, thereby improving their social interactions at meals.

Limitations and Future Research

Larger and Diverse Sample Population

The small sample size and homogeneity of many characteristics of the participant sample were limitations of this study. This study is exploratory and intended to point towards avenues of future research, therefore, the findings of this study are not statistically significant. Nonetheless, the findings of this study constitute an important first step towards more in-depth research and are valuable resources as they are drawn from the firsthand accounts of parents who have experienced and dealt with the hospitalization of a child. Though the socioeconomic factors such as career, financial standing, and educational level were wide, the range of race, gender and age of participants was limited. Finally, the participants selected were drawn from individuals known to the researchers and therefore the nature of the relationships between researcher and participant may have influenced the answers given to different degrees and in different ways. Future research should focus on extending both the number and diversity of the sample population.

The population of this study was ethnically similar, however, the answers to the beliefs and customs questions were diverse, making further investigation of the impacts of the dissimilar traits of these participants, such as socioeconomic factors, an interesting avenue for future research. Factors such as income, educational and occupational differences, and their impact on how parents believe they should train or guide their child when it comes to eating should undoubtedly be the focus of more targeted research.

Mixed Method Studies

This study was limited in that it could only assess the semi-structured interview responses of five participants. A mixed method approach of quantitative and qualitative data collection and analysis would be beneficial as well. Having parents feeding practices quantitatively assessed

was not something for which this study had the scope. Therefore, future research that uses feeding practice surveys and compares the responses of these surveys on a large scale could build upon the qualitative findings of this study. Extending the quantitative and qualitative aspects of research to assess hospital staff and even children would also provide a more detailed picture of the impacts that hospitalization has on feeding practices.

Prospective Studies

Finally, it is important to note that the current study was retrospective meaning that the responses to interview questions were based on participants memory of the specific hospitalization they chose to focus on. Future research should include studies that interview parents who actively have children in the hospital. Prospective studies that interview parents at multiple points of a current hospitalization of their child would allow for a nuanced view of parental feeding practices during a hospital stay and even of how these practices change. It would be interesting to see which feeding practices increase or decrease. It would also be helpful to see what factors could be causing these shifts in parents' practices. Such influencing factors might include changes in their child's condition or treatment. Prospective studies on these topics could limit errors common in retrospective studies that arise due to participants incorrectly remembering events. This new research could also allow parents to include richer detail in their responses to interview questions, as the events of which they are speaking are fresher in their memory or even presently occurring.

Conclusion

Findings in the current study suggest that digestive conditions and surgeries impacting eating ability may cause parents to try and pressure their child to eat more than they would under normal circumstances. This study also highlighted the differences in the proximal processes

sounding meals that a child who is hospitalized experiences compared to those at home, such as the reduced social interaction and the variability of mealtimes. The researchers also found that parents were primarily concerned with their child's nutrition, the staff's attentiveness and the level of pain that their child had. The beliefs and customs of parents are also important and the findings of this study showed that parents had varying views on how to help their child engage with healthy and unhealthy foods and the importance of and consequences of not clearing their plate at mealtimes. An understanding of these factors that influence how parents interact with their child regarding food intake should be prioritized so that hospitals and parents can be equipped with the tools to help children successfully recover during hospitalizations.

The findings of this study are important for hospitals and parents, and they provide a foundation for understanding parental feeding and the many different influences that may impact it. It is no surprise that a child's illness and hospitalization results in many changes to their daily living, not least their eating habits. However, this research may help parents and hospitals become more aware of what influences feeding practices. It may also encourage them to take active steps to understand the impact that different feeding practices have on their children's eating habits. Furthering our understanding of these topics could significantly improve children's hospital stays as well supporting a successful transition from hospital to home.

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APPENDIX A: IRB APPROVAL LETTERS

EAST CAROLINA UNIVERSITY
University & Medical Center Institutional Review Board
4N-64 Brody Medical Sciences Building· Mail Stop 682
600 Moye Boulevard · Greenville, NC 27834
Office **252-744-2914** · Fax **252-744-2284** ·
rede.ecu.edu/umcirb/

Notification of Exempt Certification

From: Biomedical IRB
To: Madison Harmon
CC: Chia Jung Yeh
Date: 2/28/2023
Re: UMCIRB 23-000189
PARENTAL FEEDING PRACTICES IN THE HOSPITAL

I am pleased to inform you that your research submission has been certified as exempt on 2/27/2023. This study is eligible for Exempt Certification under category # 2a,b.

It is your responsibility to ensure that this research is conducted in the manner reported in your application and/or protocol, as well as being consistent with the ethical principles of the Belmont Report and your profession.

This research study does not require any additional interaction with the UMCIRB unless there are proposed changes to this study. Any change, prior to implementing that change, must be submitted to the UMCIRB for review and approval. The UMCIRB will determine if the change impacts the eligibility of the research for exempt status. If more substantive review is required, you will be notified within five business days.

Document	Description
Informed Consent.pdf(0.01)	Consent Forms
Invitation Email.pdf(0.01)	Recruitment Documents/Scripts
Survey Flier.pdf(0.01)	Recruitment Documents/Scripts
Survey Thesis.pdf(0.01)	Surveys and Questionnaires
Thesis Proposal-Harmon.pdf(0.01)	Study Protocol or Grant Application

For research studies where a waiver or alteration of HIPAA Authorization has been approved, the IRB states that each of the waiver criteria in 45 CFR 164.512(i)(1)(i)(A) and (2)(i) through (v) have been met. Additionally, the elements of PHI to be collected as described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

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University & Medical Center Institutional Review Board
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rede.ecu.edu/umcirb/

Notification of Amendment Approval

From: Biomedical IRB
To: Madison Harmon
CC: Chia Jung Yeh
Date: 7/14/2023
Re: Ame1_UMCIRB 23-000189
UMCIRB 23-000189
PARENTAL FEEDING PRACTICES IN THE HOSPITAL

Your Amendment has been reviewed and approved using expedited review on 7/13/2023. It was the determination of the UMCIRB Chairperson (or designee) that this revision does not impact the overall risk/benefit ratio of the study and is appropriate for the population and procedures proposed.

Please note that any further changes to this approved research may not be initiated without UMCIRB review except when necessary to eliminate an apparent immediate hazard to the participant. All unanticipated problems involving risks to participants and others must be promptly reported to the UMCIRB. The investigator must adhere to all reporting requirements for this study.

If applicable, approved consent documents with the IRB approval date stamped on the document should be used to consent participants (consent documents with the IRB approval date stamp are found under the Documents tab in the study workspace).

The approval includes the following items:

Document	Description
Revised 2 Informed Consent.pdf(0.01)	Consent Forms
Revised Demography.pdf(0.01)	Interview/Focus Group Scripts/Questions
Revised Flier.pdf(0.01)	Recruitment Documents/Scripts
Revised Interview and Demographic Questions.pdf(0.01)	Surveys and Questionnaires
Revised Interview and Demographic Questions.pdf(0.01)	Interview/Focus Group Scripts/Questions
Revised Invitation and Introductory Email to Potential Participants.pdf(0.01)	Recruitment Documents/Scripts
Revised Thesis Proposal (CH 1-3).docx(0.01)	Study Protocol or Grant Application
Thesis Revisions.pdf(0.01)	Additional Items

For research studies where a waiver or alteration of HIPAA Authorization has been approved, the IRB states that each of the waiver criteria in 45 CFR 164.512(i)(1)(i)(A) and (2)(i) through (v) have been met. Additionally, the elements of PHI to be collected as described in items 1 and 2 of the Application for Waiver of Authorization have been determined to be the minimal necessary for the specified research.

The Chairperson (or designee) does not have a potential for conflict of interest on this study.

APPENDIX B: DEMOGRAPHY QUESTIONNAIRE

IMPORTANT NOTE: To the best of your memory, please answer questions based on the longest stay your child has had in the hospital when they were between the ages of 2 and 8.

<u>If you had multiple children who were hospitalized, please focus on only one for this study.</u>

1. What was your gender identity?

(Answer based on the longest stay your child has had in the hospital when they were between the ages of 2 and 8.)

   a. Male
   b. Female
   c. Other (Please specify_____)
   d. Prefer not to answer

2. What was your age?

(Answer based on the longest stay your child has had in the hospital when they were between the ages of 2 and 8.)

   a. 18 to 24
   b. 25 to 34
   c. 35 to 44
   d. 45 to 54
   e. 55 to 64
   f. 55 to 64
   g. 65+

3. Select the option that best described your field of work or occupation:

(Answer based on the longest stay your child has had in the hospital when they were between the ages of 2 and 8.)

   a. Accountancy, banking or finance
   b. Business, consultancy or management
   c. Charity and voluntary work
   d. Creative arts or design
   e. Data processes
   f. Energy and utilities
   g. Engineering or manufacturing
   h. Entertainment
   i. Environment or agriculture
   j. Food services
   k. Healthcare
   l. Hospitality or events
   m. Hotel services
   n. Information services

o. Computing or IT
p. Legal Services
q. Law enforcement and security
r. Leisure, sport or tourism
s. Marketing, advertising or PR
t. Media or digital
u. Military
v. Property or construction
w. Public services or administration
x. Publishing
y. Recruitment or HR
z. Retail
aa. Sales
bb. Science or pharmaceuticals
cc. Social care
dd. Teacher training or education
ee. Transport or logistics
ff. Student
gg. Unemployed
hh. Other (Please specify) _____
ii. Prefer not to say

4. What is your ethnicity?
    a. White
    b. Black
    c. Latino/Hispanic
    d. Asian
    e. Biracial (Please specify_____)
    f. Multiracial (Please specify_____)
    g. Unkown or prefer not to answer
5. What was your highest level of education?

(Answer based on the longest stay your child has had in the hospital when they were between the ages of 2 and 8.)

    a. High school degree/GED or less
    b. Associates degree
    c. Bachelors degree
    d. Professional trade certification
    e. Masters degree or higher
6. Did you and all members of your household have reliable access to enough nutritious and affordable food?

(Answer based on the longest stay your child has had in the hospital when they were between the ages of 2 and 8.)

    a. Yes
    b. No
    c. Prefer not to answer

7. How many adults (18 years+) lived in your household who offered some level of care to the child or who spent regular time in your home at least once a week in order to care for your child before their hospitalization (This could be your spouse/partner/co-parent, the child's grandparents or adult siblings, regular nannies, etc.)?

(Answer based on the longest stay your child has had in the hospital when they were between the ages of 2 and 8.)

    a. Just myself
    b. Myself and one other adult
    c. Myself and two other adults
    d. Myself and more than two other adults

8. Which best described your total household income for the majority of your child's hospitalization?

(Answer based on the longest stay your child has had in the hospital when they were between the ages of 2 and 8.)

    a. Less than 25,000
    b. 25,000 to 75,000
    c. 75,000 to 125,000
    d. More than 125,000
    e. Prefer not to answer

9. How old was your child?

(Answer based on the longest stay your child has had in the hospital when they were between the ages of 2 and 8.)

    a. 2 years old
    b. 3 years old
    c. 4 years old
    d. 5 years old
    e. 6 years old
    f. 7 years old
    g. 8 years old

10. How many siblings did your child have (include half siblings if involved in child's life during the time of hospitalization)?

(Answer based on the longest stay your child has had in the hospital when they were between the ages of 2 and 8.)

    a. 0 (only child)
    b. 1 (one sibling)
    c. 2 (two siblings)
    d. 3 (three siblings)
    e. 4 (four siblings)
    f. 5+ (five or more siblings)

11. What was the primary reason for your child's hospitalization?

(Answer based on the longest stay your child has had in the hospital when they were between the ages of 2 and 8.)

a. Respiratory condition
b. Digestive condition
c. Nervous system condition
d. Mental disease/disorder
e. Bodily injury
f. Cancer
g. Heart condition
h. Other (please specify)_____

12. What was the total amount of time your child spent in the hospital when they were between the ages of 2 and 8?
    a. Less than a week
    b. One week to one month
    c. One month to six months
    d. Six months to a year
    e. One year to five years
    f. Five or more years

APPENDIX C: INTRODUCTORY EMAIL TO POTENTIAL RECRUITS

Hello [Insert Name]!

Thank you so much for considering participating in this important research!

My thesis explores the feeding practices that parents and guardians, who are **18 years or older,** engaged in while their child was hospitalized between the ages of **2 to 8 years** in the U.S. Below I have provided additional information about the study if you are interested in learning more!

If you would like to participate, please reach out to me to **schedule a time to set up a Zoom interview**. I am most available on the weekends, however, I want to be as flexible as possible with you and so I may be able to do weeknights if this is better for your schedule. This interview will be recorded and automatically uploaded to Zoom cloud where it can be securely stored.

Before your scheduled interview, please indicate your electronic consent and answer a brief set of demographic questions by following the link below or using the QR code.

My research committee and I greatly appreciate your time and hope to hear from you soon!

—

Note: During your child's hospitalization they would have needed to have some level of oral dietary intake in order for you to qualify to participate in this research.

More Information on Our Study and Goals:

The purpose of this research study is to determine the prevalence of different parental feeding practices within the hospital setting and what demographic, cultural, and contextual factors may influence these practices. This study may improve our understanding of the changes in feeding

that occur in the hospital, what causes these practices and how parents can be supported in this area while their child is in the hospital. Monetary incentivization will not be offered.

The study consists of several demographic questions followed by interview questions regarding meal habits and contexts, cultural factors and parental concerns surrounding feeding, and questions designed to identify parental feeding practices.

I truly appreciate your time and consideration!

Best,

Madison Harmon

843-819-8342 harmonm21@students.ecu.edu

APPENDIX D: PARTICIPANT FEEDING PRACTICES

Emma's Feeding Practices

Context	Feeding Practice Identified	Description Draft
In the Hospital	Emotional Regulating	We always let--you know, they're sick, they're in the hospital so of course, like she's eating junk, where normally at home she would definitely not be doing that.[...] food makes any kid happy like I don't care what any parent says. ***Food makes a kid happy!*** So I mean I'm like if you want the ice cream eat the ice cream. ***Like you're sick laid up in a hospital bed, you know, like, I don't care what you're eating*** at this point.
	Intuitive Eating	The nurse would always come in and be like, 'Oh, how much did you eat?' And there it was always like, 'Oh, you need to try to eat a little more.' 'Did you not like this like?' 'Do you want something else?'. So they definitely always wanted them to like- I think, finish the meal honestly, because my kid never did. I'm like, 'Well, ***she's kind of full, you know, like she ate this*** and this so...', and a lot of times we would end up going and buying food, because, like, even though it was a cheeseburger, she's like, 'This is nasty'.
At Home	Routine	Yeah, we definitely all do family meals here, I mean, you know***, breakfast, lunch, and dinner*** pretty much. We all sit down as a family and eat
	Child Control	Yeah, I mean, we do eat unhealthy, obviously. But like, I mean, like we don't like as far as like cleaning your plate like we're a family like ***if I cook something at night and like you don't like it you're gonna eat something else.*** Like I don't make my kids what I cook like. And like snacks, ***they eat snacks whenever*** I mean, if they're like "Mom of hungry like, I'm gonna feed, you' you know?
	Guidance	***I do like them to try things***, but like, if you want a bowl of cereal because you don't like what we cook, I'm good with that. So like I'm not big on you know having to stick with a plan, basically.
	Restricting	I was like, ***I don't let my kid eat like this at home,*** clearly she'd be big as a house [...]

Ivana's Feeding Practices

Context	Feeding Practice	Description Draft
In the Hospital	Pressuring	"I just wanted her to have calories at that point. She was eating so little. I didn't care if she was just eating candy. She wasn't, she wasn't eating anything. But there, the- yeah, there was no concern over nutritious snacks versus, no snacks. It was **<u>whatever she was willing to take in</u>**."-Shera "You know, because there comes the reality of **<u>get food down them</u>**. And if they're willing to eat a milkshake from water burger that's better than having nothin"-Shera I would say I definitely encourage her to eat more because I was so worried about her intake[...] But definitely while she was in the hospital, there was encouragement to eat because she was not hardly eating, and she wouldn't ask for food later, plus there was no, you know she couldn't walk into our kitchen and grab her fruit snacks and sit down and eat them if she wanted to, or her animal crackers, or whatever it is, she'd go in there and get. And so yes, so I definitely ***encourage her to eat and and continue to eat*** while there, which was different from home.
	Child Choice/ Intuitive Eating	I wouldn't say it was a big difference, because, like I said, we've got we would have snacks brought in, or I would go down to the vending machine and buy snacks. If she actually indicated she was hungry. It was

		more I was doing it in encouragement it versus she just helped herself whenever she was hungry and wanted a snack.
At Home	Control	So meals would be ***cooked by me or my mom*** [...]
	Encouragement	Yeah, I definitely don't require you to clear your plate. I mean, there's no point encouraging, overeating. If you don't like it, ***you have to at least try it***. and then, if it's really that bad, you can go make something else [...]
	Choice	[...] my daughter was a picky eater, and so ***I'd often included a separate meal just for her.*** I like to experiment, and sometimes it's like I don't like it either so ***we dump it out, and everybody, makes a sandwich or something.*** [...] 'fed is best' and so if eating broccoli was going to make her gag and throw up then it was green beans every night. You know, I mean, I got her to try broccoli once, and she was puking on the trash. So we gave up on broccoli. ***You know, if what she's gonna eat is chicken nuggets and some french fries and a little bit of green beans, we went through a lot of green beans. That was the only vegetable she'd eat for a long time.*** [...] ***half the time you could still walk in and free range in the kitchen***. So even if I was like 'This, is it, this is dinner'. If she walked in there and got into her box of you know, fruit snacks. I didn't say a word. She just she was- she could go in there and help herself anytime. And all those were kept on low shelves, and she just went in and got what she needed whenever.
	Restriction	[...] normally at home, no, ***if you don't finish your plate and you're hungry later 'Oh, well!'*** [...]
	Intuitive Eating	And I mean I've always just been like, ***eat until full.*** I do smaller portions. I'm fine with leftovers. I'm fine with throwing food out.
	Pressuring	I didn't worry so much about doing all the food groups. Our biggest concern with my own- with her was ***getting vegetables down her.***

Bonnie's Feeding Practices

Context	**Feeding Practice Identified**	**Description Draft**
In Hospital	Monitoring	I obviously noticed that she only drank half a thing of apple juice, and she didn't eat the jello, and you know she had half a popsicle, and ***that's all she's had, since whatever time***, you know, but they never came and checked any of that. I told you one of the things they had was like a popsicles and I think they had like little cups of ice cream, you know, with a little paper tops on them and I'm just not a huge treat person so I'm like, 'Is there nothing that we could put in here that's not just sugar, you know, just yuck?'. So I mean, I just let her have it and was like, okay, it's three days, you know, whatever she can eat just trash for three days. But ***I feel like every time I pulled a lid, and every time I pulled out something it was apple juice and ice cream and popsicles. And I was like, this is really, it's hard for me to feed this to my child meal after meal for days on end.***
	Child Control	I know what she likes, like I know what her preferred foods are so you know. And while she was going through that like soft food phase and she had options, she said, she doesn't really like pudding. Okay, she doesn't like a lot of sweet foods and she doesn't like ***Jello. So we, even though those were really convenient and easy things, we didn't do them because she doesn't like them***. But when she got back to regular physi-, I just probably for several weeks, just most of our meals were things that [child's name] particularly liked.
	Pressuring	I would say 'Well why don't we wait until the next pain pill comes', or whatever you know. Maybe we could ***try to eat again and a little bit after that*** once, because it'll take down the pain. So if I didn't feel like ***she was getting enough***, and I knew she wasn't, because she eats way more than what she was eating. I would try to look for times that would maybe be a little easier for her.
	Intuitive Eating/ Tolerance	You know, I wasn't calculating calories. ***I was just willing to give her food until she said she didn't want anymore.***

At Home	Balance/ Guidance	I had a friend who was a Phd. in nutrition science and she said one of the things that she always focuses on is for family meals is that ***it should be colorful*** and so there should be various colors on the table like carrots and peas and chicken, and you know, whatever and that everybody should find, they maybe don't like this particular vegetable or that particular thing, but ***everybody at the table should find something on the table that they're looking forward to eating.***
	Encouragement / Monitoring	Like 'I know I could eat rice, and there is rice today there's asparagus, and I'm going to have to eat asparagus, but...' and that was the other thing is, you must ***try a little bit of everything***. You can't just say, 'Yeah, I'm only eating rice today.' 'No, you, if you want the rice, you're also gonna have a little bit of each of the other things and you served yourself, you can have one asparagus spear. That's fine, but you need at least one.'
	Control	***I make the meal menu plan. I set the table. I put all the food on the table,*** and it's family style, everybody can serve themselves, whatever size portions they want.
	Routine	And that's the way [child's name] experienced meals prior to that so-- and that included ***breakfast, lunch, and dinner*** at that time, because she was not actually in a school environment. Ok, I do believe that ***regular meal times, at least once a day, and, if possible, especially when they're younger, you know, like three meals*** a day, and the training of sitting down, waiting for others, […]
	Monitoring	[…] serving yourself a portion that you can have seconds, but let's- you know pile up the plate, share what's on the table. So you look around and you're like 'Okay, there's 11 people, ***1/11th of this is mine, and not half'.*** And dessert is a a special treat. It's not an everyday thing, but you know ***I'm not anti- you can't have cookies, or you can't have cakes. I just don't think it should be every day***
	Child Control/ Choice	So to this day like I'm making lasagna on Sunday, and she's coming home for the weekend, and I said, 'Don't worry', ***we won't have lasagna, you know, until after you leave***. I mean I'm gonna put it in the oven and stuff so you might smell it, but you will not, you're not expected to eat it. She hates it because it was so gross in the blender. She was she was able to serve herself whatever amount she wanted, and if she finished everything, and everything was gone off the table, and she said she was still hungry. I'd say, 'Well, what do you want?' and ***I would make whatever we had that she was interested in eating.*** And then snacks were by permission, and she could ask for a snack, and ***I would offer her options, and she would pick whatever she preferred.***
	Restricting	***I don't let anybody have snacks or treats if they don't finish the dinner*** that they serve themselves. So if you serve yourself a giant plate of food, and you don't eat it all. That's totally fine, but you don't come to me two hours later and say I'm gonna eat a snack. 'No, no, you can wait until next meal.' If you come to me, and you say you're hungry, and you have eaten often times depending on the, I mean, I'm not like super hardcore 'You could never have chips for a snack' but you know my first inclination is to ***offer you a cheese stick or some fruit or you know something like that, as opposed to, you know a processed package of blah blah blah,*** you know, although that is the preferred snack right? And that's totally okay to have sometimes, but like I would say, probably 75% of the time I'm gonna say, '***If you're not hungry enough for an apple or cheese stick or an orange, then you must not be that hungry***.' Right?

Radcliffe's Feeding Practices

Context	Feeding Practice Identified	Description Draft
In the Hospital	Intuitive Eating/ Recovery Focused	I don't think there was as much pressure to because, you know, ***you're trying to demonstrate that you can eat and you're able to keep food down.*** It was more it was, it was not, there's not so much pressure on cleaning the plate. I mean your purpose for eating in a hospital, I mean, hospital is your, as you're recovering from surgery, your hospital staff has certain objectives to like, okay, you need to ***demonstrate that you can, you can consume food and you can keep it down*** before we're going to discharge you. So it's a different purpose than you know, normal nutrition and eating regular meals at home. The hospitals like, okay, you're recovering from surgery, let's demonstrate that you're able to eat and keep things down, because we don't want parents to struggle with that at home, and then have to come back to the hospital because my daughter wasn't able to actually, she's not able to eat, and she's starting to, you know, suffer malnutrition, or she's she hasn't eaten in two days because she won't or she can't and now it's becoming an urgent issue. When [child's name] was recovering from surgery, it was, ***'What can you eat?', 'What are you able to eat?', 'What tastes good?' and 'What are you able to keep down?' and if that's yogurt, if that's if that's you know, a juice box, maybe that's some of those things that we didn't necessarily have, as you know, as one of the one of the plate items during a meal at home, so be it.*** We're gonna we weren't so focused on that as much as just, 'Can you eat and can you keep it down?' When she was recovering from her surgeries it's ***what can she get down more so than you know all of the you know best possible foods*** at that point we're just what can you get down let's go with what is easy and what is comfortable to to eat and swallow. With [child's name]-- I mean [child's name] is a good eater, and she's also very active. The only the only concern was whether or ***not she was able to eat in the hospital, and how much she was able to eat was never concerned about putting her on a diet or her eating too much.*** That was never a concern.
At Home	Parental Control	Personally, if you're not willing to eat the healthy meals that your parents provide for you, ***you shouldn't be looking for desserts or treats or snacks in between meals***. We mostly-- it was us serving the kids, because at that age you know [child's name] was about 6 years old, 5 or 6 years old, so you know, ***we were making plates and setting them,*** for the kids. I don't think that kids- kids may have bussed their dishes...
	Routine	[Spouse's name] really communicates pretty openly about what to expect, when meal time is and so ***they always knew when dinner time was, always at the same time.***
	Intuitive Eating	So if you decide not to eat your vegetables, ***you leave, you know, food on the plate then, well, then, that means you're not really hungry.*** I mean, some kids-- like being rewarded with food can lead to, you know, eating disorders. They get to see food as a reward, and it's a comfort and if they're in stress they go to food as their source of comfort, so that can lead to eating disorders***. So I don't know that using food as a reward is necessarily appropriate for every kid.*** You know, not every kid struggles with, you know, food, or has food issues like that, or could you be susceptible to developing an eating disorder, but some do and so it's, you know it's really important to you know where your son or daughter is at, and if that's, you know, potential struggle for them. But I think a good practice is, it's not, it's not necessarily a great practice to use food as a reward.
	Nutrition Focused	We eat pretty healthy at our house. [Spouse's name]'s done a great job of meal, planning and making sure that we have ***fresh vegetables well balanced meal.*** It's about, it's about eating foods that are prepared that are ***healthy and nutritious rather than eating for reward or eating for a treat*** we're looking for something that's super like yummy and tastes good, you know.

Helena's Feeding Practices

Context	Feeding Practice Identified	Description Draft
In the Hospital	Presuring	For [child's name], it was 'Any calorie is a good calorie'. So we weren't trying to like, say, 'Hey, this too much sugar! We want you- want you to eat this vegetable.' It was just like 'You want this Jello, great, Jello is great. Have a Jello!' you know what I mean? Like we weren't itemizing, 'Oh, he needs some vegetables right now'. We- we weren't doing that. We were like ***whatever we can get in him*** is a calorie and so we wouldn't let him have all, Jello. I don't think that we were picky about whether or not he ate vegetables or not. We were always encouraging [child's name] to eat more and doing what- any and doing whatever way we could, you know we're feeding him and ourselves, or-- yeah, I mean, ***we would try to push as much food as we could on him.*** I mean like back to the part where ***we would hide vegetables***, we would do that, so I would hide spinach and kale in pasta sauce. I might make him a chocolate milkshake and hide some sort of vegetable in that.
	Intutitve Eating	No he's ***never been on a weight control diet***.
At Home	Pressuring	The focus on [child's name] was always that he was never on the chart so doctors would always really freak out about that and ***there was just this ton of pressure that I felt to get a child who didn't eat, on the chart,*** and it was very stressful and very hard and so I understand that they use this chart to help identify illnesses in children if they're not there. But [child's name] is healthy, but he's just never been on the chart like he's very thin, and he's just. This is not say-- doctors need those charts-- but it was such an emphasis for us as a family to get him on the chart, and ***whatever it takes a***nd so ***we did food as a reward***. ***We put like kale in stuff***, we were-- like a milkshake. ***We would hide vegetables*** in like ground up, you know what I mean, like we would do that. ***We would make everything with butter and whole milk, milkshakes.*** ***We were just trying to get him to eat.*** ***We would provide rewards for eating***. That might be toys or now our case is extreme, right. I mean, most parents are not gonna provide toys, but we were in an extreme situation. So you know, I had a closet full of dollar tree toys that I would like 'Hey, if you can finish this, then you know, we'll look at our dollar tree toy, you know, toy closet or whatever'. So that was some of the extreme things that we did in order to try to get him to...
	Child Control/ Choice	We would, you know, a lot of times families are like very cut and dry with, you know, if, when dinner time is over, it's over, but we were like, ***whenever you want to eat, you can eat.***

APPENDIX E: PROXIMAL PROCESSES TABLE

Theme	Codes (Number of Participants that Mention Code/Total Number of Participants)	Description Draft
Hospital Mealtime Proximal Processes	Limited Social Interaction (4/5)	There's really no interaction at all. ***They just kinda set a food tray down and are like 'Bye.'*** -Emma A food service person would bring the food not a nurse and the insure, they gave me a couple of cans and they gave me the syringe and they're like and ***you're on your own***.' -Bonnie They come in with the meal, and then ***they leave you with the meal.*** They may, you know, be checking your medications or but typically you're there with yourself, or whoever is with you. -Radcliffe No, ***it was just she and I***. She had her own private room. [Spouse's name] was working, so he only came in the evenings to come and visit. -Bonnie [...] people would bring us food and so ***sometimes we would wait while they visited, and sometimes we would eat,*** but it was only a couple of nights. -Ivana She was really in a lot of pain and really tired so generally, if someone was there bringing a meal most of the time in the hospital, ***she was sleeping versus being the center of all attention at home*** so... -Ivana
	Irregular Times for Meals (3/5)	***My kids don't eat breakfast at home until eight or nine*** […] they're homeschool kids so I guess typical like public school kid probably would be eating breakfast that early. -Emma Breakfast I think is the hardest because ***they want to serve these kids breakfast at like 6am***. -Emma [...] in the hospital would be *like* ***lunch would be anywhere between 11 and two, like you never really knew***. So like, of course***, my kid always pretty much ate by herself because we didn't know-you know, like we couldn't prepare food for us and eat with her*** of course. -Emma So this particular hospital did allow you to have a menu and you know you could pre order what she was getting, but you not always got it. So there was times that they would bring you the normal meal and you would have to call and request something else so the***n it would be you know an hour later and she would finally be eating dinner***. -Emma She was dependent on her meals based like on what is the staff doing and what is ***their schedule for meals***. -Radcliffe [...] there's no way for the family to eat at the same time as the patient. So you can't order off of the menu for the like if the mom and the dad are going to be there at dinner time to eat with the child. ***So the child is eating alone, and the mom and the dad are having to forego dinner, in order to be able to be there***. -Bonnie And often times they say, 'Well, you can go down to the cafeteria', but that means I have to leave my child. I have to go down there. I've stand in line, come, bring this all back up, and then I've got to take all that stuff back, trays and stuff. It's just- ***it's not conducive to everybody eating together.*** -Bonnie
	Low Involvement in Meals (1/5)	***I know what she likes, like I know what her preferred foods are*** so you know. And while she was going through that like soft food phase and she had options, she said, she doesn't really like pudding. Okay, she doesn't like a lot of sweet foods and she doesn't like Jello. So we, even though those were really convenient and easy things, we didn't do them because she doesn't like them. But when she got back to regular physi-, I just probably for several weeks, just most of our meals were things that [child's name] particularly liked. -Bonnie
Home Mealtime Proximal Processes	High Social Interaction (4/5)	We definitely all do family meals here [...] ***breakfast lunch and dinner pretty much we all sit down as a family*** and eat. -Emma Okay, so we had you know, ***pretty regular meal times*** we typically ate, and between six or seven o'clock at night, we ***always ate together as a family***. -Radcliffe

		And so ***often was the three of us, my brother and his wife*** live next door, so sometimes they joined us, so sometimes the aunt and uncle were in the house. **-**Ivana So ***it's family style*** so when we're talking about after she was on to soft foods, and, you know, serving herself again. **-**Bonnie
	High Involvement in Meals (2/5)	My daughter was a ***picky eater and so I often included a separate meal just for her.*** **-**Ivana So it's family style. So when we're talking about after ***she was on to soft foods, and, you know, serving herself again.*** **-**Bonnie She was ***she was able to serve herself whatever amount she wanted***, and if she finished everything, and everything was gone off the table, and she said she was still hungry. I'd say, 'Well, ***what do you want?***' and I would make whatever we had that she was interested in eating. **-**Bonnie
	Low Involvement in Meals (2/5)	***I make the meal menu plan I set the table I put all the food on the table*** and its family style everybody can serve themselves whatever portion size they want [...] that included breakfast lunch and dinner. **-**Bonnie We mostly it was, it was us serving the kids, because at that age you know [child's name] was about 6 years old, 5 or 6 years old, so you know, ***we were making plates and setting them, for the kids.*** I don't think that kids-- kids may have bussed their dishes... **-**Radcliffe

APPENDIX F: MOTIVATIONS AND CONCERNS TABLE

Theme	Codes (Number of Participants that Mention Code/Total Number of Participants)	Description Draft
Hospital Stay Concerns	Poor Nutrition (3/5)	Nutrition, I mean like, is she, is she getting healthy foods, you know I would. We eat pretty healthy at our house. [Spouse's name]'s done a great job of meal, planning and making sure that we have fresh vegetables well balanced meal. I don't know that that's really the case in the hospital, to the degree that we had a home. ***It's gonna be more, you know, processed foods.*** You know? I, I picture her getting like juice boxes, just imagining what what I've had in the hospital, or what I've seen her get served in the hospital getting fruit juices, or, you know. milk. You might get a processed meal from the cafeteria you know, premade pre prepared meals as opposed to from scratch. **-**Radcliffe There's not a lot of choices, right? So that's the thing that I struggled with a lot. It's like, I mean, the healthy choices were like apple juice, which is just a big pile of sugar. You know, like so I think, like I would look for things on the menu that were available in the "soft foods menu", and like apple sauce and and broth, chicken broth. ***There just weren't a lot of things that I would consider to be healthy***. **-**Bonnie She had an IV but it was fluid only. Honestly, ***I wanted them to include other nutrients in that IV because I was worried about what she was taking in***. **-**Ivana
	Lack of Staff Attentiveness (2/5)	I stayed overnight, and really I don't remember the nurses doing-- We had circled everything on like-- they gave us a menu of soft items she could choose from, and I could select whatever, you know, off that menu that she-- I thought she would eat and and but then and then, ***like a food service person, would bring the food, not even a nurse and the ensure, they gave me a couple of cans, and they gave me the syringe and they're like 'And you're on your own.'*** Haha so... **-**Bonnie I was down there [in the cafeteria] trying to find something she would eat because ***they wouldn't bring us anything.*** **-**Ivana
Condition Concerns	Discomfort (3/5)	I think she was just when we were there ***she's very, very sick and her stomach hurt. She had salmonella so that totally disrupted her eating enjoyment, habits*** so she would be asleep through the actual mealtime or she wouldn't be interested during that mealtime. **-**Ivana But she wasn't eating ***the nature of her illness made her not hungry*** at that time and so she would have a tray, but I don't know that she would eat it much. **-**Ivana That pharyngeal flap surgery is pretty horrific in terms of how ***it affects you for your eating ability afterwards***. **-**Bonnie You know I wasn't calculating calories, I was just willing to give her food until she said she didn't want anymore. But ***usually the the pain and the you know, the trauma of actually swallowing was what stopped her from carrying on.*** Probably, she was probably still hungry, but she just couldn't take it anymore. **-**Bonnie You know he had two different things going. He had this bowel that didn't work, so all his, the stool would back up and ***it would keep him from wanting to eat, because he was just so constipated,*** you know. So we were battling two issues at the same time and so yeah, it was a little double-edged sword almost try to get him to eat, but he didn't feel like it so cleaning him out and then starting over. **-**Helena
Treatment Concerns	Prescribed Diet (1/5)	Yeah, I would say, probably the fact that ***when you're on a liquid diet they're just- it's really hard to get enough calories to really satiate***. **-**Bonnie I knew how to work the syringe. I think the syringe part of it where they I actually had to inject the the meal, pull the liquid meal stuff into her mouth. I think that would have been-- I mean, it was very obvious how to do it. So there wasn't a lot of training, but ***I wonder if, like other parents, might have felt really uncomfortable*** **.**[...] They just gave it to me. I mean they just assume that you're gonna do it. **-**Bonnie

	Comfort Level (1/5)	I felt like ***they didn't address the comfort level,*** helping her with food intake. **-**Ivana Because when I was asking about pain meds- cause, ***I know you can take higher doses of pain meds***, but I didn't know what it was for her age and weight, and I needed the doctor to clearly tell me. And that, doctor, I think she was a Med student, I don't know, she calculated it to be less than what the bottle even said. I'm like 'That's not accurate.' She's like 'No, no, it is. It is'. I'm like, 'No, it's not because the bottle says I can at least give this much, and you're telling me I have to give less. You're not doing this right'. **-**Ivana

APPENDIX G: CUSTOMS AND BELIEFS TABLE

Theme	Codes	Description Draft
Customs and Beliefs	Healthy vs. Unhealthy Foods (5/5)	Personally, if you're not willing to eat the healthy meals that your parents provide for you, you shouldn't be looking for desserts or treats or snacks in between meals. ***Typically treats in between meals or snack treats or snacks, are less healthy*** than what, at least in our house, what is prepared for meal time. So if you have, if you decide not to eat your vegetables, you leave, you know, food on the plate then, well, then, that means you're not really hungry. You're not really so hungry that you need to have ice cream. ***Ice cream is a treat. It's not, it's not a meal***. **-** Radcliffe It's about, it's about eating ***foods that are prepared that are healthy and nutritious*** rather than eating for reward or eating for a treat we're looking for something that's super like yummy and tastes good, you know. Eating should be, it should be, it should taste good, it should taste good, but the purpose for eating is more around nutrition than it is about like a treat, or because ice cream and cookies and crackers and chips are not nutritious, they're a treat. So kind of separating a treat from food. **-**Radcliffe If you come to me, and you say you're hungry, and you have eaten often times depending on the, I mean, I'm not like super hardcore 'You could never have chips for a snack' but you know ***my first inclination is to offer you a cheese stick or some fruit*** or you know something like that, as opposed to, you know a processed package of blah blah blah, you know, although that is the preferred snack right? **-**Bonnie And that's totally okay to have sometimes, but like I would say, probably 75% of the time I'm gonna say, 'If you're not hungry enough for an ***apple or cheese stick or an orange***, then you must not be that hungry.' Right? **-**Bonnie And ***dessert is a a special treat. It's not an everyday thing,*** but you know I'm not anti- you can't have cookies, or you can't have cakes. I just don't think it should be every day. **-**Bonnie ***I didn't worry so much about doing all the food groups***. My biggest concern with my own with her was getting ***vegetables*** down her. **-**Ivana I guess my biggest thing, and this comes from being a lactation consultant [...] ***'fed is best'*** and so if eating broccoli was going to make her gag and throw up then it was green beans every night. You know, I mean, I got her to try broccoli once, and she was puking on the trash. So we gave up on broccoli. You know, ***if what she's gonna eat is chicken nuggets and some french fries and a little bit of green beans***, we went through a lot of green beans. That was the only vegetable she'd eat for a long time. **-**Ivana We would ***hide vegetables*** in like ground up, you know what I mean, like we would do that. We would make everything with ***butter and whole milk, milkshakes.*** We would, you know, a lot of times families are like very cut and dry with, you know, if, when dinner time is over, it's over, but we were like, whenever you want to eat, you can eat. That's how- that's how we were with him. **-**Helena Yeah, I mean ***we do eat unhealthy***, obviously. **-**Emma
	Food as a Reward (2/5)	I guess, I think it, it really depends on the individual. I mean, some kids-- like ***being rewarded with food can lead to, you know, eating disorders.*** They get to see food as a reward, and it's a comfort and if they're in stress they go to food as their source of comfort, so that can lead to eating disorders***. So I don't know that using food as a reward is necessarily appropriate for every kid.*** You know, not every kid struggles with, you know, food, or has food issues like that, or could you be susceptible to developing an eating disorder, but some do and so it's, you know it's really important to you know where your son or daughter is at, and if that's, you know, potential struggle for them. But I think a good practice is, it's not, it's not necessarily a great practice to use food as a reward. **-** Radcliffe Well, the focus on [child's name] was always that he was never on the chart so doctors would always really freak out about that and there was just this ton of pressure that I felt to get a child who didn't eat, on the chart, and it was very stressful and very hard and so I understand that they use this chart to help identify illnesses in children if they're not there. But [child's name]'s healthy, but he's just never been on the chart like he's very thin, and he's just. This is not say-- doctors need those charts-- but ***it was such an emphasis for us as a family to get him on the chart, and whatever it takes and so we did food as a reward.*** **-**Helena
Customs and Beliefs	Portion Control (2/5)	[...] the training of sitting down, waiting for others, ***serving yourself a portion that you can have seconds,*** but let's- you know pile up the plate, share what's on the table. So you look around and you're like 'Okay, ***there's 11 people, 1/11th of this is mine,*** and not not half'. **-**Bonnie

(Cont.)		***I do smaller portions. I'm fine with leftovers.*** I'm fine with throwing food out, I really dont like throwing food out if there's enough for leftovers I'll want to save it and take it to the school lunch the next day or something. **-** Ivana
	Opinions on Snacks (2/5)	***Snacks were by permission*** and she could ask for a snack and I would offer her ***options*** and she would pick whatever she preferred –Bonnie I ***don't let anybody have snacks or treats if they don't finish the dinner*** that they serve themselves. **-**Bonnie Personally, if you're not willing to eat the healthy meals that your parents provide for you, yo***u shouldn't be looking for desserts or treats or snacks in between meals***. **-**Radcliffe And like snacks, ***they eat snacks whenever.*** I mean, if they're like "Mom of hungry like, I'm gonna feed, you." **-** Emma
	Importance of Family Meals (1/5)	Ok, I do believe that ***regular meal times, at least once a day***, and, if possible, especially when they're younger, you know, like three meals a day [...] **-**Bonnie
	Tyring Food (2/5)	And I had a friend who was a Phd. in nutrition science and she said one of the things that she always focuses on is for family meals is that it should be colorful and so there should be various colors on the table like carrots and peas and chicken, and you know, whatever and that everybody should find, they maybe don't like this particular vegetable or that particular thing, but everybody at the table should find something on the table that they're looking forward to eating. Like I know I could eat rice, and there is rice today there's asparagus, and I'm going to have to eat asparagus, but... and that was the other thing is, ***you must try a little bit of everything.*** You can't just say, 'Yeah, I'm only eating rice today.' 'No, you, if you want the rice, you're also gonna have a little bit of each of the other things and you served yourself, you can have one asparagus spear. That's fine, but you need at least one.' **-** Bonnie If you don't like it, ***you have to at least try it*** and then, if it's really that bad, you can go make something else, and sometimes it is, I'll try new things. You know, I like to experiment, and sometimes it's like I don't like it either. So we dump it out, and everybody, makes a sandwich or something. **-**Ivana
	Clearing Plate (4/5)	I definitely don't require you to clear your plate. I mean ***there's no point in encouraging over-eating.*** **-**Ivana [...] ***if you don't finish your plate and you're hungry later 'Oh, well!' and then, half the time you could still walk in and free range in the kitchen.*** So even if I was like 'This, is it, this is dinner'. If she walked in there and got into her box of you know, fruit snacks. I didn't say a word. She just she was- she could go in there and help herself anytime. And all those were kept on low shelves, and she just went in and got what she needed whenever. **-**Ivana As far as like cleaning your plate like we're a family like if I cook something at night and like you don't like it, you're gonna eat something else like I don't make my kids what I cook like. I don't make them- like ***I do like them to try things, but like, if you want a bowl of cereal because you don't like what we cook, I'm good with that.*** So like I'm not big on you know having to stick with a plan, basically. **-**Emma So if you serve yourself a giant plate of food, and ***you don't eat it all. That's totally fine***, but you don't come to me two hours later and say I'm gonna eat a snack. 'No, no, you can ***wait until next meal.***' **-**Bonnie So if you have, if you decide not to eat your vegetables, ***you leave, you know, food on the plate then, well, then, that means you're not really hungry***. **-**Radcliffe