

“It feels like we have tried everything!” - a follow-up qualitative study on mealtime experiences with parents with high levels of alexithymia

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ABSTRACT

Alexithymia refers to a general deficit in interoception whereby individuals struggle to identify and describe emotions and feelings and exhibit an externally oriented thinking style. In our previous research, high caregivers' alexithymia scores were associated with poor awareness of infant hunger and satiety cues during feeding. The present study aimed to explore mealtime emotions, parental sensitivity, and feeding practices of caregivers who scored high for alexithymia. With participants selected based on their scores on the 20-item Toronto Alexithymia Scale (mean: 59.4 ± 5.4 , range from 53 to 74) from the previous study, a follow-up qualitative study was conducted using one-to-one semi-structured, video elicitation embedded interviews. Overall, 12 mothers and 2 fathers of children aged 18–36 months (mean age = 26 ± 7 m; 7 boys, 7 girls) completed the interview, including discussion of a mealtime reported one year earlier and of a recently filmed typical mealtime interaction. Reflexive thematic analysis revealed that participants perceived mealtimes as more than feeding, as an important social activity. Participants reflected on specific challenges such as their child's food sensory needs, but felt that feeding resources were unhelpful. Multiple coping strategies were described as a means of “doing their best”. Progress with feeding was both reported and noticed during observations of the video-clips. In conclusion, caregivers with high alexithymia scores described mealtimes as challenging, adopting a variety of ways to meet feeding challenges and adapting to their child's appetite cues as they grew. Caregivers with high levels of alexithymia may benefit from tailored responsive feeding support beyond generic feeding guidelines to improve their mealtime experience.

1. Introduction

During early life, infants express a variety of behavioural and affective cues to their mothers to signal nutritional needs, such as hunger cries, orientation towards the breast, mouthing, agitation and distress (Hetherington, 2017). Responsive feeding (RF) requires sensitive parenting, which involves caregivers providing a prompt, emotionally supportive, contingent, and developmentally appropriate response to their child's hunger and satiety cues (Black & Aboud, 2011). Mealtime interactions are bidirectional with infants encouraged to communicate their needs, which prompts a response by parents which in turn contributes to healthy appetite regulation (Black & Aboud, 2011). Appetite regulation in infancy has the potential to promote a healthy weight gain trajectory and reduced risk of childhood obesity (Eneli et al., 2008; Redsell et al., 2021). However, the ways in which parents interpret their

child's cues and communications might be determined by multiple external components or internal attributes of both the caregiver and their child (Satter, 1995). For example, feeding practices could be influenced by caregivers' body mass index (Shloim et al., 2015), or child's weight status and appetitive traits (Moore et al., 2007; Webber et al., 2010). Results from a discordant twin study using data from the British Gemini birth cohort showed that mothers appeared to adapt their feeding strategies according to their children's eating behaviours, with higher child “Food Fussiness” significantly associated with more maternal pressure to eat and instrumental feeding practices (Harris et al., 2016). In a longitudinal randomised controlled trial of Australian families, non-responsive feeding practices such as using food as a reward and persuasive feeding at child age 2 years were prospectively positively associated with child emotional overeating at 3.7 years (Jansen et al., 2015).

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One characteristic of caregivers which may affect their capacity to apply RF practices is alexithymia. The construct of alexithymia is defined as a stable trait that relates to an individual's reduced capacity to identify and describe emotions and bodily sensations, in addition to a constrained imaginary life (Taylor, 1984). In clinical studies, participants with alexithymia report problems in verbalising emotions and feelings, and having an impoverished inner emotional life (Taylor et al., 1985, 1991). Content analysis of speech revealed that individuals with alexithymia show limited use of emotional vocabulary, suggesting the presence of a communication problem (Taylor, 1984). Alexithymia presents as a general deficit of interoception which involves difficulties processing non-affective interoceptive cues including hunger, arousal, and fatigue (Brewer et al., 2016). Given that RF relies on caregivers' appropriate recognition and response to infant appetite cues, this interoceptive deficit may compromise caregivers' responsiveness.

An individual's ability to recognise both affective and non-affective cues is particularly important since it serves a fundamental feature of being able to respond to the needs of others (Brewer et al., 2016). In the feeding context, caregivers might struggle to offer timely and appropriate responses to their child's needs linked to limited recognition of child cues and communications (deCock et al., 2016). Results from a free play observation indicated high maternal alexithymia was associated with maternal depression and a lower mother-infant relationship quality, compared to low maternal alexithymia (Yürümez et al., 2014). In a laboratory setting with video-recorded mother-infant free play interactions, high maternal alexithymia was associated with weak maternal sensitivity and poor maternal negative emotion regulation (Ahrnberg et al., 2021).

In a recent online study, alexithymia was associated with individuals' poorer recognition of infant hunger and satiety cues in video clips (Yu et al., 2025). Furthermore, caregivers who scored lower on alexithymia tended to score higher on recognising and responding (i.e. "tuning in") to their own internal satiation cues (Yu et al., 2026). Results also showed that mothers who scored higher on "tuning in" to their own internal satiation cues reported higher scores on recognising their infant's hunger and satiety cues during feeding compared to those who were less "tuned in" to their own internal state (Yu et al., 2026). These findings aligned with previous literature suggesting that maternal consideration of their child's thoughts, intentions, and needs was predictive of more sensitive and responsive parenting practices (Degotardi & Sweller, 2012; Farrow & Blissett, 2014; Li et al., 2014; Meins et al., 2001).

Some successful parenting intervention programmes which aimed at enhancing caregiver sensitivity used video clips from mother-child interactions to provide personalised feedback. For example, 68 Turkish mothers with children aged 9-30 months were included in a randomised controlled trial to test the effectiveness of the Video-feedback Intervention to Promote Positive Parenting Sensitive Discipline (VIPP-SD) (Alsancak-Akbulut et al., 2021). Findings demonstrated significant improvement in maternal sensitivity and reduction in physical intrusiveness including fewer maternal controlling behaviours in intervention mothers (Alsancak-Akbulut et al., 2021). By systematically reviewing evidence from 25 randomised controlled trials, the employment of the VIPP-SD resulted in benefits in multiple domains, such as consistent improvement in sensitive parenting and parental responsiveness across diverse samples (e.g. low-income families, autism risk), positive attitudes in parenting/feeding and higher self-efficacy in intervention groups (van Ijzendoorn et al., 2023). In addition, intervention children were more likely to develop secure attachment relationships with their parents, indicating that VIPP-SD may be a reliable, evidence-based intervention that promotes parental sensitivity, parenting attitudes, and child attachment security for healthy development (van Ijzendoorn et al., 2023). Therefore, a video-elicitation component was included in the present study to support parents in observing and reflecting on their child's appetite cues during real mealtime interactions. Based on evidence from video-feedback

interventions such as VIPP-SD, this approach enables caregivers to capture subtle, moment-to-moment signals that may be overlooked in the moment and to develop greater sensitivity to their child's needs.

For children, family mealtimes and social eating is a typical occurrence, where their eating behaviours and food intake are influenced by multiple factors, including genetic factors and environmental factors. It has been demonstrated that variation in infant appetite is partially genetically determined and present from birth (Llewellyn et al., 2010). For example, eating traits such as food responsiveness and satiety responsiveness are moderately to highly heritable (Llewellyn et al., 2010). However, the environment remains important since the interplay of genetic factors and environmental factors has a significant impact on individuals' appetite and displayed eating behaviours (Llewellyn & Fildes, 2017). In an eating episode with families, shared mealtimes involving language and social interaction, including the ways children are fed, can help determine what and how much children eat (Van der Heijden & Wiggins, 2025). It has been proposed that appropriate feeding practices help and support children's development, allowing them to eat in response to their needs, while others encourage children to override internal appetite cues (Satter, 1995). It is important to understand the impact of alexithymia on everyday feeding interactions and mealtime communications, including the nature of any challenges. In the previous study, findings suggested that caregivers' ability to "tune in" to their own internal appetite cues and affect (i.e. alexithymia) was associated with their recognition and response to infant appetite cues (Yu et al., 2026). As a follow-up study involving some of these participants, the aim of the present study was to explore mealtime emotions, parental sensitivity, and positive feeding experience of caregivers who scored high on alexithymia, as well as how they have adapted their feeding practices to meet their child's needs as their child grows.

Existing studies have used "video-elicited" interviews (i.e. where mothers watched and discussed videos of themselves feeding their infants) to explore maternal perceptions of infant appetitive cues and encourage reflection on feeding interactions (McNally, 2018; McNally et al., 2020). The qualitative research method with video elicitation embedded was crucial in investigating parental complex and subjective experiences, which couldn't be captured by quantitative methods. It helped researchers explore nuanced parental perceptions of child's hunger, satiation, and needs during feeding, and reveal contradictions between feeding paradigm and actual practices (McNally et al., 2020). Therefore, in line with previous studies, the present qualitative study involved one-to-one interviews, with video clips taken from a recently recorded mealtime of participants accounting for the video elicitation, to explore the following research questions:

- A) Do caregivers with alexithymia notice and comment on both contextual cues, and affective cues from their child to guide their feeding practices?
- B) What are the struggles/difficulties and related coping strategies caregivers with alexithymia report when feeding their child?
- C) How do caregivers with alexithymia report adapting their feeding practices as their child develops?

2. Method

2.1. Participants

Participants were recruited from the previous study (Yu et al., 2026) through Prolific (<https://www.prolific.co/>) and invited to complete an online survey hosted via Qualtrics (<https://www.qualtrics.com/uk/>). All participants were asked if they would be interested in participating in a further study "Identifying your baby's hunger and satiety cues during feeding in a home setting". Overall, 244 participants gave consent with a valid email address, of whom 98 caregivers were eligible for the study. Eligibility was determined by the caregivers' alexithymia

score on the 20-item Toronto Alexithymia Scale (TAS-20) (Bagby, Parker, & Taylor, 1994; Bagby, Taylor, & Parker, 1994). The TAS-20 is a self-report measure of alexithymia containing three dimensions: Difficulty Identifying Feelings, Difficulty Describing Feelings, and Externally Oriented Thinking. It has 20 items and each of them is rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). TAS-20 uses cut-off scoring with scores of 52–60 indicating *potential alexithymia*, and scores above 60 indicating *present alexithymia*. Therefore, the higher individual scores, the more alexithymia traits are present, and the more certainty there is that the response reaches the clinical threshold for alexithymia. In total, 33 participants with alexithymia (TAS-20 scores above 60) and 65 with potential alexithymia (TAS-20 scores ranged from 52 to 60) were eligible for inclusion in the present study.

The targeted sample size for the semi-structured interviews was 15. Participants were paid £20 in total (£10 for completing the filming task, and £10 for completing the interview) with a digital voucher.

2.2. Study design

This qualitative study was conducted as a follow-up of the previous study (Yu et al., 2026) with one-to-one semi-structured online interviews using video-elicitation techniques via Microsoft Teams. Participants were recruited by email and provided an information sheet outlining the aims of the present study - which was to “investigate the relationship between caregivers' mealtime emotions, their sensitivity towards their child's hunger and satiety cues, and their feeding practices”.

The present study consisted of two stages: participants replied via email with consent to participate. Then they were invited to film a typical mealtime in a home setting to complete Phase 1. In Phase 2, participants were interviewed and asked open-ended questions regarding their typical mealtime experiences. The video, and their previous answers to an open-ended question asking about the most recent mealtime experience they had with their child (see Fig. 3 in the Results section under Theme 5 for an illustration) in the first study (Yu et al., 2026), served as elicitation prompts that encouraged participants to revisit their most recent mealtime experiences. This process enabled them to articulate tacit aspects of feeding, such as challenges, adaptive strategies, and coping resources that are often difficult to express in conventional interviews.

The study protocol was pre-registered on the Open Science Framework (OSF): <https://doi.org/10.17605/OSF.IO/3V5BW>.

2.3. Procedure

First, participants who had agreed to be contacted were sent an email informing them about the study. Once they consented to participate, the filming guidelines and the secure OneDrive link were shared with them. In the filming guidelines, participants were instructed to choose from breakfast, lunch, or dinner to film one typical mealtime at home, while other family members can also be included at the same time. Guidelines on the seating position, as well as the camera position, were illustrated with figures so that both the child and the main caregiver were clear in the video clip (available on OSF: <https://osf.io/3v5bw>).

During Phase 1, participants were invited to film one typical mealtime at home and upload the video clip (mean length received: 20 min) via a OneDrive link. Participants were then invited to join a one-to-one online interview arranged to suit the caregiver's schedule. The mealtime video clips were reviewed and edited by the research team prior to the interview. To analyse and code video clips, the Feeding Infants: Behaviour and Facial Expression Coding System (Hetherington et al., 2016) was used. This is a validated video coding tool to measure infant food preferences (e.g. liking and wanting) through 6 behavioural measures and 7 facial expressions (Hetherington et al., 2016). A section of the original video clip in which infant appetite cues were expressed

and, in which the caregiver interacted with their child, was selected.

In Phase 2, during the interview, participants' answers to an open-ended question from the previous study (Yu et al., 2026) regarding a recent mealtime experience were presented (an example see Fig. 3), followed by a discussion about their current feeding experience and any adaptation they had made in response to their child's needs as they grew. Next, a shortened video clip (mean length: 107s) edited from the recent mealtime video shared by participants was presented to facilitate caregivers' observation and reflection of their feeding interaction and mealtime experience (see study procedures in Fig. 1; see interview questions in Supplementary materials, Table S1).

2.4. Data collection

All data were collected between August and December 2024 via MS Teams. Interviews were recorded and conversations were transcribed using the Transcription function in MS Teams. Recordings were replayed and transcriptions were amended for accuracy. One of the senior members of the project (MMH) was present during 6 out of the 12 interviews as an observer. This was for the training purposes for the first author (SY), while the presence had no discernible impact as the senior member (MMH) did not intervene in the conversation with participants. After transcriptions were cleaned and corrected, the last author (MMH) helped with the sense check to ensure clarity, coherence, and credibility of the analytic process, which was aided by being present during half of the interviews.

2.5. Data analysis

Descriptive statistics were calculated for demographic variables using SPSS v29 (IBM Corp., Armonk, N, USA). Reflexive Thematic Analysis (RTA) was used to identify themes of interest (Braun & Clarke, 2021). RTA is a form of thematic analysis which is interpretivist and centres the researcher's perspective as a valuable component of the analysis. The analysis was conducted by the first author (SY), a post-graduate researcher aged 29 years, with some research experiences in exploring the association between caregivers' interoceptive sensitivity, their responsive feeding practices, and infant appetite cues displayed during mealtimes. All authors have a research-focused, academic background in infant feeding and personal experience of feeding infants and conducting qualitative research.

The six phases of thematic analysis (Braun & Clarke, 2006) were conducted. By conducting interviews, the researcher (SY) was familiar with the content of the interview. Additionally, reading and re-reading the transcripts helped the researcher have an overall understanding of the dataset and develop initial ideas. In the second phase, an inductive approach was applied to generate “data-driven” codes without a set of *a priori* themes or an existing conceptual framework. This technique of “open-coding” (Braun & Clarke, 2013) allowed an exploration of the latent meaning, rather than decoding the semantic meaning of real-life feeding experiences that caregivers shared; it also promoted a constructivist interpretation of the conversations with caregivers. In the third phase, initial themes were developed based on the coding, and then discussed within the research team. Next, the candidate themes were reviewed and further refined multiple times, with a thematic “map” generated to address the research questions. The fifth phase consisted of defining and refining the scope and focus of each theme. Lastly, compelling data extracts were selected to support the analysis of the research questions and literature, and to complete the study report.

The theme development was achieved by collating data in MS Excel and then visualising themes, codes and quotes using a MIRO digital board (Miro©2025, RealtimeBoard, Inc., available at: <https://miro.com/>) to illustrate the thematic contents. An example of how raw data was used to develop codes and formulate themes is illustrated in Table 1. Reporting for the study followed the Standards for Reporting Qualitative Research (O'Brien et al., 2014).

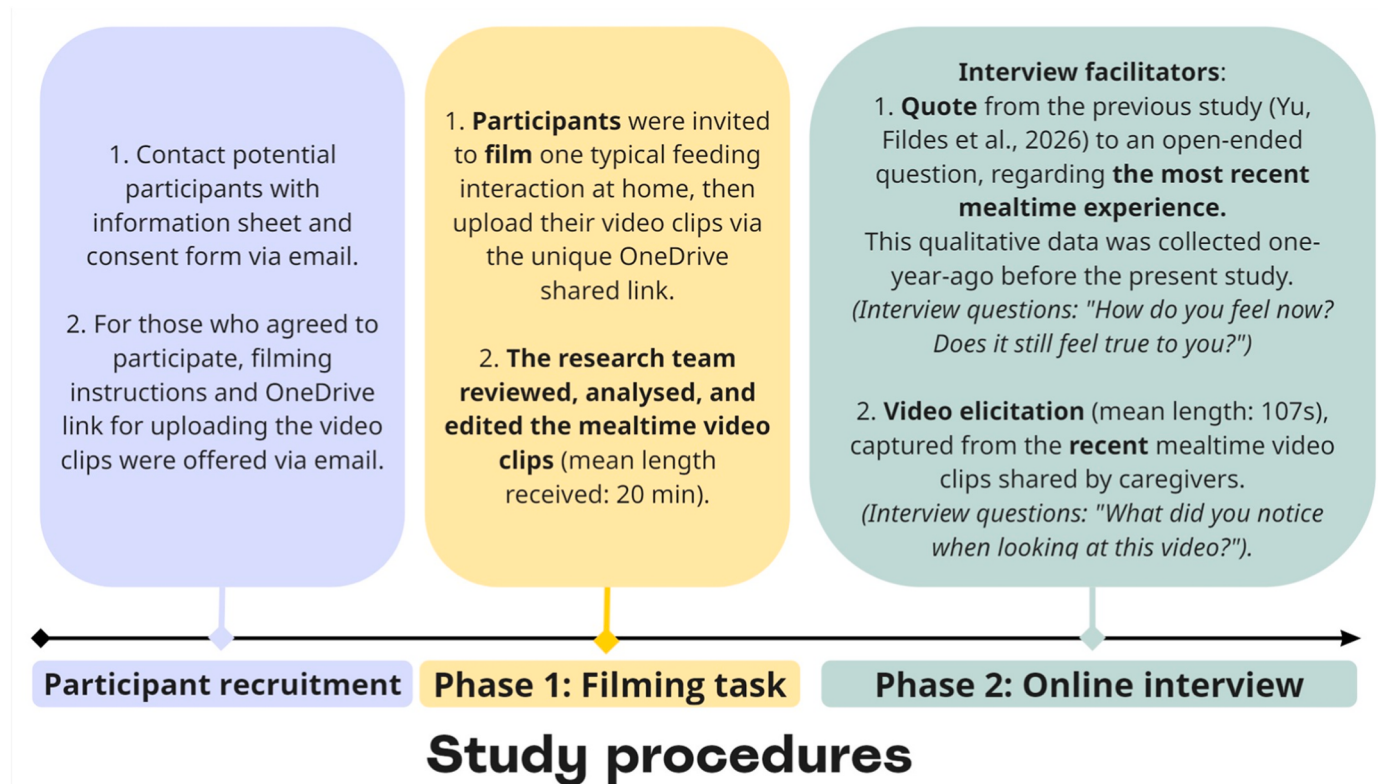


Fig. 1. Study procedure from recruitment to phases 1 and 2 of the study.

Table 1

Examples of how raw data was used to develop codes and themes.

ID	Raw data	Codes	Code description	Themes	Theme description
11	"It's an important time of the day that we normally try and get us to sit at tables together, have that conversation , because you don't get much time in the day as we are always busy."	Sit and eat as a family	Participants reported that mealtimes are a critical time for the family to sit at the table together, have conversations, eat as a family to have a positive and pleasant mealtimes.	Mealtime is more than feeding, it's a social activity	Participants showed how much they value mealtimes. For them, mealtimes were more than being functional or providing foods, but a social activity where they could enhance the family bonding and connection.
1	"I still find myself getting frustrated when she refuses to eat the things that we know she likes as well, as that really keeps us on our toes, keeps us guessing ."	Transient/fluid liking	Participants reported that their children's liking of certain foods might be changing day by day, which made selecting foods difficult.	Mealtime in reality: behind the door	Participants reported their real-life feeding experiences, their true feelings during mealtimes, as well as challenges and difficulties they have encountered.

3. Results

3.1. Participant characteristics

Of all potential participants who scored high on alexithymia from the previous study and gave permission for further contact ($N = 98$) (Yu et al., 2026), 22 expressed an interest in participating in the present study. Overall, 14 caregivers (2 fathers and 12 mothers) of children aged 18–36 months (mean age = 26.2 ± 6.7 m; 7 boys, 7 girls) with TAS-20 scores between 53 and 74 (mean: 59.4 ± 5.4) completed this study. In addition, 2 mothers who scored above 60 on TAS-20 reported that due to personal reasons, including one who self-reported an autism spectrum diagnosis, they could not join the online interview but were able to answer questions via email. Therefore, both provided a video clip of their typical family mealtimes and a written script to the adapted interview questions. Their reflective written accounts and videos were treated as equivalent qualitative materials, contributing to the overall thematic analysis. A summary of participant demographics is provided in Table 2. The recruitment process is presented in Figure S.1 in the Supplementary materials. More detailed participant characteristics are

Table 2

A brief summary of participants' age (yr), TAS-20 score, child gender and child age (m).

ID	Participant gender	Participant age in years	Participant TAS-20 score	Child gender	Child age in months
1	Male	42	62	Girl	36
2	Female	31	74	Girl	35
3	Female	38	65	Boy	18
4	Female	34	59	Boy	27
5	Female	33	56	Boy	29
6	Female	32	55	Boy	20
7	Female	30	58	Girl	35
8	Male	33	60	Girl	32
9	Female	30	60	Boy	27
10	Female	29	55	Girl	18
11	Female	31	59	Boy	28
12	Female	44	53	Girl	22
13	Female	29	54	Boy	32
14	Female	36	62	Girl	23

provided in the Supplementary Materials Table S.1.

Independent sample *t*-test revealed no significance in TAS-20 scores of those parents who completed the study, compared to those eligible participants who did not participate in the present study (data not shown). Through the conversation, all participants shared their general feeding experiences, feelings towards their typical family mealtimes, day-to-day difficulties and specific challenges experienced in feeding their children, as well as their coping strategies and responses to child appetite. In thinking of the existing struggles and feeding progress, some participants provided an earnest reflection on their child's growth and their feeding practices during the interview.

While experiences like stress and food fussiness occur broadly, our analyses were situated entirely within the context of elevated caregiver alexithymia. The analytic focus was not to identify exclusive challenges, but to explore how caregivers who relied on external cues notice, interpret, and manage mealtimes. Driven by a reflexive approach, our themes represented contextually patterned interpretations of mealtime dynamics within this high-alexithymia cohort, rather than generalisable claims about all parents. See Fig. 2 for an illustration of the five themes identified in the present study with selected codes.

3.2. Theme 1: Mealtime is more than feeding, it's a social activity

Caregivers viewed mealtime as more than feeding, as a social and relational activity. They described mealtimes as an opportunity to sit together and eat as a family, have mealtime conversations and social interactions. Caregivers suggested it was important to have the child involved in the meal preparation, which helped their children feel engaged and develop a good relationship with foods.

"It's an important time of the day that we normally try and get us to sit at tables together, have that conversation, because you don't get much time in the day as we are always busy" [ID 11];

"It's something from the very beginning I've always been really quite aware that I want to sit down for the two main meals. Even if they're not eating very much, it's about having that consistency of sitting to the table and talk. Even just talking about the food will help with language skills as well" [ID 12];

"He is now getting more and more keen to be involved in the cooking process. If he knows I'm cooking, he will drag over the chair and wants to get involved ... We've invested in some kiddie toddler knives that he can come and chop some bits and pieces. He's developing that side of it ... He thought it was so exciting ... He just wants to be part of what you are doing" [ID 5].

In addition, caregivers noted child appetite cues during mealtimes, *"(with my child growing older) I still get joy watching her try new foods, especially ones I wasn't sure she would like"* [ID 14]. These cues were used when making decisions about when to introduce solid foods during complementary feeding: *"He started weaning just before 6-month because he was sitting up and was showing the signs. I kept it until then because I know that was the recommended time"* [ID 9].

3.3. Theme 2: Mealtimes in reality: behind the door

During the interview, participants shared their feelings during typical family mealtimes, as well as a variety of struggles they had during meals such as food sensory issues, and the balancing working schedule and mealtimes. Participants described mealtimes as emotional, usually challenging, and that feeding could be very hard. The experience varied and was often meal-dependent: *"No two mealtimes are the same"* [ID 10], *"My child is quite a good eater but she does have her odd days"* [ID 7]. Several caregivers reported that their child was described as "underweight" when younger which made the feeding stressful: *"It's quite difficult to take"* [ID 1]; *"I did go a bit loopy with it"* [ID 5]. A few mothers shared the same feeling that *"it's quite hard to balance the snacks and the mealtime"* [ID 9]. Some caregivers admitted that they had to make a compromise in feeding due to working hours or schedule, while some caregivers perceived food availability and food waste as an influence in their daily feeding.

"Stress, stressful is probably my main word to describe mealtimes. That's really negative but that's the honest truth ... I don't really know how and what other people's mealtimes are behind closed doors. They could have exactly (the) same problems as me. No one is wanting to really speak about it when you are with other mums. No one wants to have that kind of

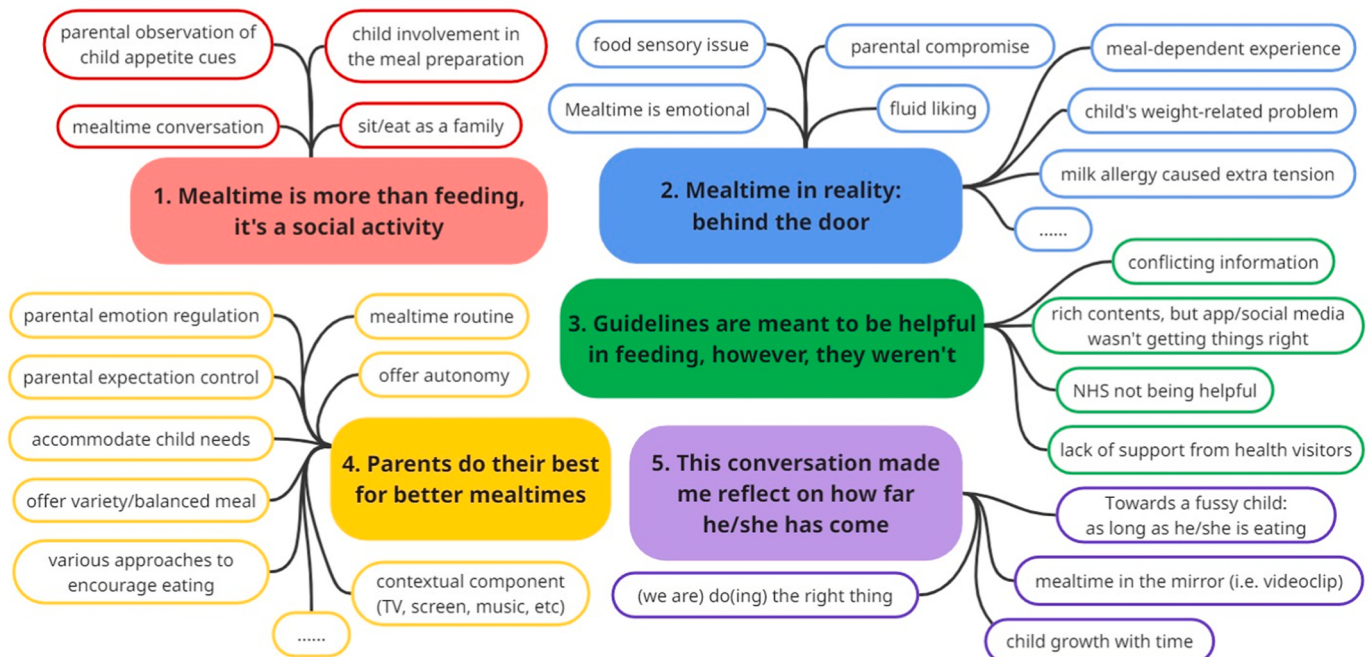


Fig. 2. Five themes identified in the present study, presented in coloured boxes with bold font. Several selected codes are linked to the themes with solid lines.

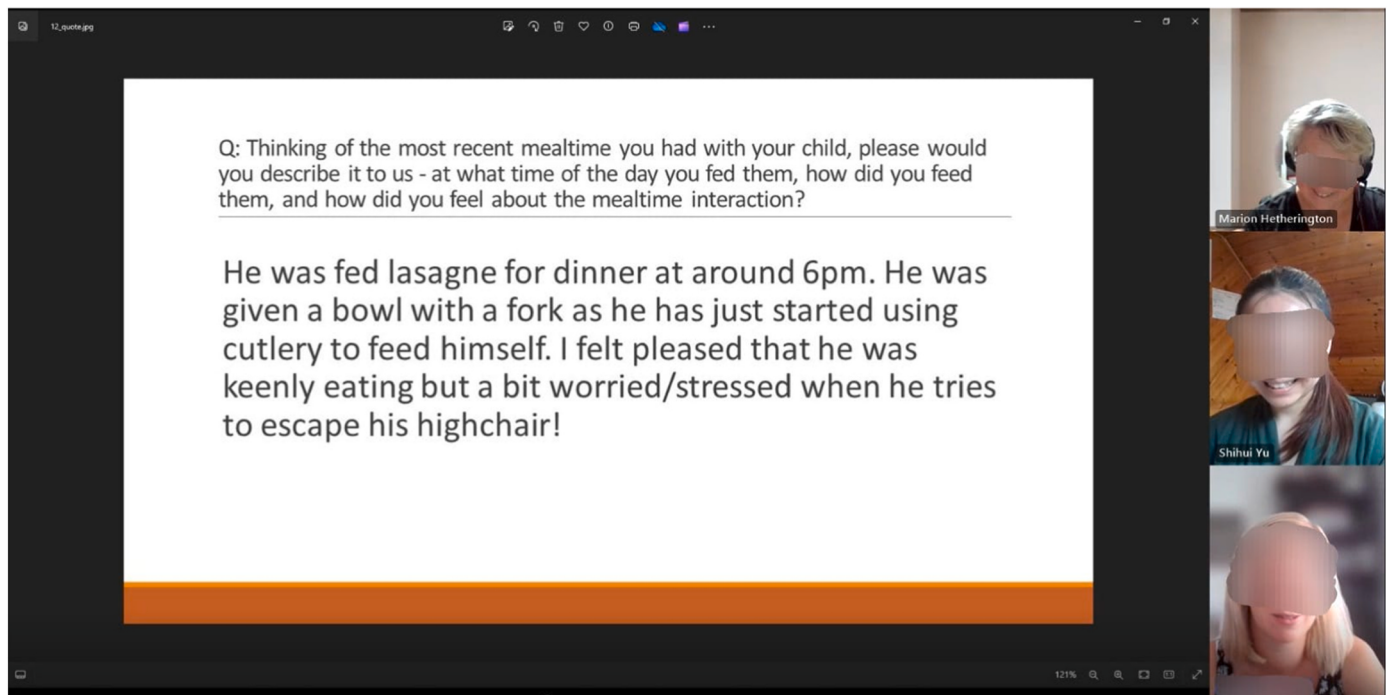


Fig. 3. Still image captured from an interview where the participant was reading the quote they had written from the previous study and discussing how their mealtime experiences had changed with time.

frank conversation, while one wants to just talk about how perfect things are" [ID 2];

"Trying to feed her was like a constant struggle" [ID 1];

"We are all neurodivergent to varying degrees ... Autism and food sensory issues play a huge part in mealtimes in our household ... It was easier when I was at home on maternity leave but since returning to fulltime work, I am out of the house so much that there's not much time for making intricate meals" [ID 3];

"Our work schedules are not conventional. Only Sunday we can all eat together ... She probably eats more processed foods than we would like, things like frozen chicken nuggets. They're supposed to be good ... Things being easy together is a big part of our mealtime. It's difficult to make full meals from scratch especially when you are eating in different times" [ID 8];

"It's incredibly frustrating when you pay for foods with your own money, make something from scratch, and then it doesn't get eaten or gets wasted ... especially with food prices being so expensive at the moment, it's just infuriating" [ID 9].

Moreover, caregivers with a child with allergies or intolerance shared specific issues for example one whose child was lactose intolerant commented: *"He was my first baby, I didn't really know that was a thing that could happen. Like a cat allergic to fish ... We didn't know what's happening with him. He would scream all day and he would be in pain a lot, we could see that"* [ID 10].

Trying new things, a child going through a fussy stage and throwing foods, and dining-out were also challenging. Additionally, a child's changing, fluid food preferences, were described as a concern. For example, *"I still find myself getting frustrated when she refuses to eat the things that we know she likes as well as that really keeps us on our toes, keeps us guessing"* [ID 1].

Caregivers observed and appreciated the independence their child showed during mealtimes such as *"he loves feeding himself"*. Some participants acknowledged that *"every child's personality is so different"* [ID 6], *"some were very easy to feed and others could have similar problems*

to what we have occasionally" [ID 1]. Positive experience of a child being a good eater was observed. For example, having a fussy child *"eats what we give to her"* and that made the caregivers *"feel good"*; another caregiver said *"she is such a good eater ... She is always waiting for my son who is fussy to finish so that she can pick off his plate"* [ID 7]. Additionally, caregivers noticed how differently their child might eat in the nursery compared to at home. One father described that his child *"might eat things that she won't eat at home ... She loves nursery and eats really well there, better than she does at home. Maybe because she's with all the friends ... The nursery has a proper chef. He makes big batches of things. It's easier and then all the kids have the same. We cannot do that at home"* [ID 8]. Even with the app where the nursery reported foods served and what was eaten by the child, two mothers particularly mentioned the app is *"handy and important"*, but they did not receive enough information: *"I don't really know, is it (his eating) better than here at home? it's quite difficult to know"* [ID 9], *"I'm always a bit dubious as how accurate the amount they recorded that he's eating there"* [ID 13].

3.4. Theme 3: Guidelines are meant to be helpful in feeding, however, they weren't

The third theme captured caregivers' experiences with support sought from outside the home. For example, reading guidelines on feeding which are freely available to all provided by the National Health Service (NHS), or asking NHS health visitors (who come to all homes in the UK following the birth of a child) for advice, and looking at posts from social media influencers on infant feeding. The information provided by the NHS and the care offered by health visitors is available to all residents of the UK (The NHS is the UK's publicly funded healthcare system, established in 1948 to provide comprehensive, universal healthcare free at the point of delivery based on clinical need rather than the ability to pay). In the present study, caregivers noted that existing resources, which are intended to be useful, were experienced as unhelpful in coping with challenges they encountered during feeding. For example, conflicting information which made caregivers feel overwhelmed.

"I had got myself a bit 'information overloaded' and there was just quite a lot of conflicting information" [ID 5];

Participants also reported complex attitudes towards social media and the additional pressure it had on their daily feeding practices, *"it is hard to justify the time and the cost to make the food (from the recipe)" [ID 3], or "some of them are a bit gimmicky ... they are just trying to make it look pretty or just for views" [ID 7].*

Social media influencers by comparison to what was experienced at home, could suggest that caregivers were not **"doing well enough"**, making social media **"the last resort"** for dealing with mealtime difficulties.

"If I decide to follow an influencer, I think it's going to put additional pressure to follow that strictly ... I feel there's enough stress without the additional pressure of following somebody on social media and doing it" [ID 1];

"I started following a couple of ladies and saw plates of food they created every day, like things made from scratch. In the morning their breakfast was like various berries and porridge with seeds on it ... To be honest, more often than not, it made me feel like I wasn't doing enough or I wasn't good enough ... How on earth does any mother do this on a daily basis and work? That was just unbelievable ... It actually made me feel worse. It seemed so fake and I thought it can't be real life ... I couldn't deal with it. So I've completely blocked that out my life because I think that was a negative influence on my motherhood journey" [ID 2].

Some stressful experiences with external resources from the NHS website or from health visitors were mentioned. For example, the NHS guidance on feeding practices; lack of support for specific problems including child being underweight, milk allergy or food sensory issues; and the ways they could have been better supported. Participants mentioned that NHS guidelines may give a good basis especially for first time caregivers. They could benefit from knowing *"what you should and shouldn't do"* [ID 11]. Whereas one mother suggested that the breast-feeding guidelines on NHS website need to be updated, *"in terms of the pressure that people feel they are under ... People should have the support to be able to breastfeed ... (NHS) need to embrace other things"* [ID 9]. Some participants pointed out that feeding guidelines served as *"one size fits all, where sometimes the circumstances change that"* [ID 13]. They acknowledged that it was important and necessary to give a bit of flexibility when following the guidelines, and to hear real life experiences.

It is worth noticing that one mother with ASD who shared their written script with the research team (rather than having an online interview) reported that all her three children have different levels of neurodivergence and food sensory issues. For her, she really struggled to find any feeding guidelines that worked for her family.

"It's difficult to get specific advice for special needs because a referral to a dietician is very hard to get. The NHS is so stretched ... General feeding suggestions have tended not to work for us in the past; it feels like we have tried everything!.. Past experience with my older children tells me that there isn't much help out there and you just have to muddle through yourself" [ID 3];

This aligned with the experience of other caregivers that resources intended to help caused additional stress:

"I couldn't really articulate and I was quite upset because the health visitor could actually come and observe a mealtime so they could see our problems. If I didn't get the advice from my own health visitor, where else could I go? What's the point in going anywhere else? ... (Besides) my child was underweight and quite a late walker. I was thinking goodness is this because she was not getting enough nutrients? They (health visitors) kept reassuring me it was all fine. But for someone to say that to me, she kept hopping on about gold top milk ... I am still concerned about our meal-times but she never asked or contacted me again. I have never had a

consistent health visitor which really didn't help me either ... It's a bit disappointing and I don't know if that's the local authority issues." [ID 2];

3.5. Theme 4: Parents do their best for better mealtimes

Parents described efforts to "do their best for better mealtimes", and this formed the fourth theme. Several different strategies and actions were described to support enjoyable and healthy mealtimes for their children. Ways to respond to their children's appetite cues and needs were described; these included ways to encourage eating, and coping strategies for dealing with challenges in feeding.

For example, sharing the same meal encouraged their child to eat more and made the mealtime much easier. Meanwhile, other approaches were mentioned such as offering a variety of foods and then offering the same food repeatedly, buffet style, and feeding through play. One mother reported that she let her child decide what to have by playing with a homemade pastry pinwheel. The use of tricks, bribery, or feeding by stealth were reported in response to challenging eating occasions. For example, *"I have to come up with ways to trick him into opening his mouth, because once he tastes them he does realise he likes the food after all"* [ID 3]. One mother noted that a lot of bribery was involved in their mealtimes because of her fussy child. *"Things like 'you eat your tea, you might get a sweetie or pudding later on', it often worked quite well"* but the success rate also varied since *"my child is getting old enough to know that she will get that anyway regardless of what happens. Also I think we are a bit of a soft touch when it comes to treats and things like that. But bribery does occasionally work as well, to get her to eat a few more spoons"* [ID 2]. A strong willingness was evident in *"getting the right guidance"* and *"doing the right thing for the right age"* [ID 13]. They appreciated feeding resources that were trustworthy and helpful, such as the NHS weaning seminar and other "structured and regimented" guidelines, which *"are backed up by research"*. Some of them demonstrated the importance of having a mealtime routine, as well as offering autonomy to their child, so that the child had control over what and how much to eat.

"I was very much trying to go by the book" [ID 2];

"I had done plenty of research ... Breastfeeding has not always been easy but I've no regrets about persevering with it! My son is now 18 months and still breastfeeding at night so we are still going strong" [ID 3];

"I'm quite keen to be quite consistent. I think that's really vital for kids" [ID 5];

"I wanted to let him lead the way. (After the experience with my first child) this time I thought 'let's do what you want to do' ... I'm just trying to remain calm during mealtimes and go with the flow, let him do what he wants" [ID 6].

The importance of caregiver's own expectation control, emotional regulation, as well as not giving additional pressure to their children during feeding was reflected in participants' frequent reference to provide a better mealtime. In particular, caregivers showed how they learned to manage the balance between what they wanted as caregivers and what their child needed in terms of eating (e.g. *"It doesn't matter as long as he's trying it ... it was more about them trying rather than the amount"* [ID 11]).

"I don't want to get worked up because that's not an appropriate reaction ... That's about my frustration of things not working out as I want them to. So I would say that I have adjusted my expectations slightly and tried to be a bit more flexible with my approach, my reaction to how she eats and what she eats" [ID 1];

"I think at the dinner table, if I'm frustrated, I have to make sure I'm calm so he will then be calm and eat ... If I'm not calm, it's not helpful for him" [ID 9];

"I used to be like 'try and eat as much as you can' with my son. He was so fussy and that kind of put him off a bit more. So now as long as my kids think they're full, that's fine. I don't try and force them to eat it, because that's not going to help anyone" [ID 7].

Caregivers were responding to and accommodating their own and their child's needs in eating, such as eating at different times due to caregivers' working schedules, cooking foods separately due to the food sensory issues of the child, eating separately as a consequence of the neurodivergence and food disgust of children with ASD, and having safe foods that they know their child would always eat. Contextual components were also mentioned by caregivers to regulate the mealtime. Some caregivers insisted that they should have a screen-free mealtime: *"I don't think that's healthy for children"* [ID 12], whereas some caregivers reported their mealtime dilemma (e.g. *"she is not eating if she is not happy"* [ID 2]) and used a screen or nursery rhyme to help their child to remain seated - *"stay sat down for longer"* [ID 4], or to *"get her to actually eat her meal"* [ID 2]. They expressed their concerns such as *"I felt like she was not engaged in any way with the food"* [ID 2], *"he has got used to having a screen when eating which isn't ideal"* [ID 4], but it worked as a successful method or the last resort to get their child to eat especially on challenging days.

It was acknowledged that working in the early years sector with lots of experience with children helped caregivers understand behaviours and communications of their own children, or having their first child contributed to less stressful family mealtimes while they had the second child based on caregivers' learning trajectory on parenting. Also, some benefit from online recipes for inspiration or for age-appropriate foods, and online peer support from social media that *"worked like a little community"* was also reported.

"I work for an eating disorder charityI'm trying not to push him to eat because I'm very aware of what that can develop into" [ID 9];

"I found social media a godsend for inspiration of what I make for mealtimes" [ID 13].

3.6. Theme 5: This conversation made me reflect on how far she/he has come

The fifth theme incorporates notions of progress in feeding. Specifically what caregivers have learned in the intervening time since the earlier study. Participants noticed changes in feeding practices, prompted by reading what they had previously written about their most recent mealtime experience one year ago (example see Fig. 3), as well as watching the short mealtime video clip during the interview (example see Fig. 4). Some spontaneous reactions of recognition were expressed from the previous statement to the current mealtime experience, some participants did not remember what they had written. For example: *"I can still relate to a large majority of this. It's funny, I don't even remember doing this"* [ID 2], *"Oh God, yes I did remember the experience. I couldn't remember how long ago. But trying to escape from the highchair was a regular thing. That's really interesting, this quote brings back some memories for me"* [ID 9]. When being invited to view the mealtime video clip, one mother immediately commented *"OK, that's cringe"* [ID 2] but with a smile. By comparing their day-to-day mealtimes to what they experienced a year ago, participants were able to illustrate to what extent their feeding strategies had changed, and how much their child had grown in terms of appetite expression, independence, and self-control in eating.

"OK, that's very interesting. I wasn't aware that it had changed, but now you told me what I said previously. There has been a slight shift. I think I'm at the point now where I'm happy that she's eating something, so even if she's just eating a little bit of everything, that's good enough for me" [ID 1];

"I think in the weaning stage maybe we didn't do as well as we could have done. With hindsight, we didn't do enough messy play and that would probably be my biggest regret from weaning ... We do still have to devote a lot of our attention to get her to eat but nowhere near what it was a year ago ... We're in a much better place that she is more open and adventurous. I do feel we made progress. It's moving in the right direction rather than the wrong direction" [ID 2];

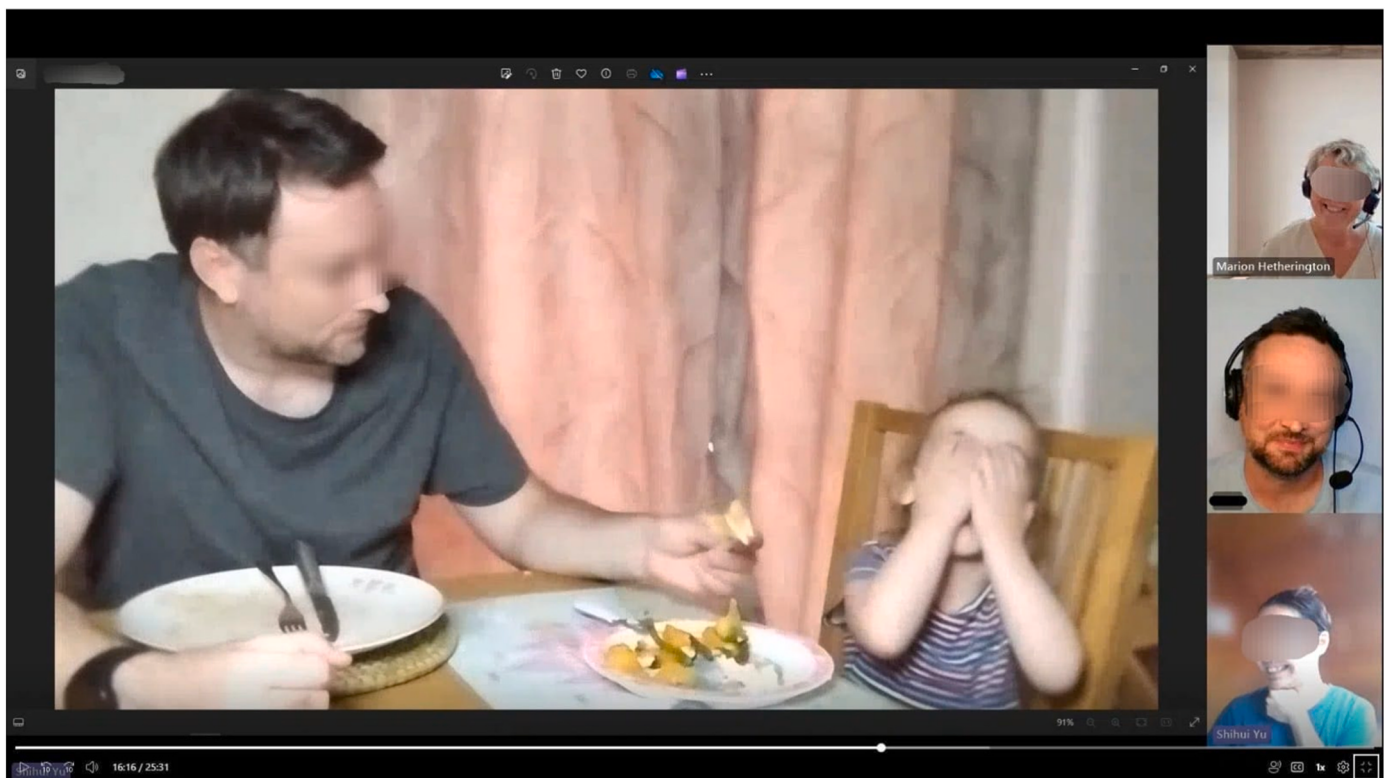


Fig. 4. Still image captured from an interview where the participant was watching the short video clip of their typical family mealtimes and noticing what was happening during the meal.

"Nowadays I don't think at this stage I've got any kind of worries or difficulties with my kid. I think it's a lot easier and more relaxed now. You can just enjoy mealtime a bit more ... I knew it was a case of time that you get a bit more confident with your child with what they can manage" [ID 12].

Observations of the mealtime interactions were reported by some participants after watching the short video clip (see Fig. 3). Since the recording was recent, participants indicated that they remembered their mealtime well and shared how they felt about the mealtime interaction with their child. A few caregivers noticed their child's activity in ways they may not be aware of: *"I've never noticed, I didn't realise she got that good at using her cutlery. It's good!" [ID 8], "I noticed how active she actually is when she's eating. You don't always see that when you are moving around in mealtimes" [ID 10].* Facilitated by provided materials during the conversation and caregivers' personal mealtime experiences, some participants talked about their learning trajectory in parenting and feeding, their feelings evoked from the reflection, and suggested that the growth was reciprocal for both the caregiver and their child.

"(In the mealtime video clip) it seems like I'm putting a little bit of pressure on her, a little bit more than I was aware of at the time ... I was trying to encourage her a bit more beyond the point where she was getting distracted. Again, I don't want to force her because that was obviously the wrong thing to do, but she just needs a little bit more encouragement each time. And I suppose we'll be a lot happier if she could eat just a bit more" [ID 1];

Two mothers particularly summarised the importance of "learning" and "reflecting" in feeding:

"This conversation certainly made me reflect on how far she has come because I think we too often reflect on the negatives about the mealtimes ... I think as parents you learn from your mistakes, and I do need to be more appreciative and grateful about the fact that she is so willing to eat ... I know it's been a journey and this conversation has really enlightened me actually on how much things have changed ... and it makes me quite proud" [ID 2];

"You need to do your own research, get the basics and then use your own judgement and instincts outside of that, go from what you are comfortable with because feeding is so nerve wracking ... It's been a lot of learning that just picked my battles with mealtimes ... Now I think I'll be a bit more relaxed with my second child, because we have been there, done that, and I know what I do" [ID 13].

A few participants also emphasised how important it was for them to learn and adapt their feeding practices and the benefits they observed in their child:

"Now I have changed my thought ... I think I have created the weird (food sensory) issue with my first child, now with my second, as long as he is eating, as long as he has a healthy weight, then I'm fine with it. I'm a lot more relaxed ... Now it is nice to watch him enjoying mealtime and thinking they interact well together, the positive relationship between them. Seeing it that way makes me think: Oh, I think we're doing the right thing" [ID 6];

"I think my first child taught me to be less controlling around feeding ... with my second, I learned to just relax, let her explore food at her own pace and it's paid off in the long run because she's got a much more various diet than my first kid will probably ever have" [ID 10].

4. Discussion

Overall, caregivers with high levels of alexithymia in this follow-up study indicated that they perceive family mealtimes as a social activity where they have the chance to enhance family bonding by sitting and eating together. Facilitated by their answers on mealtime experience for

the earlier study, participants reviewed their parenting experiences, how they had adapted their feeding practices in response to their child's developing appetitive cues, acknowledged their child's growth in temperament and improved motor skills. Participants considered their mealtimes stressful, with lots of emotional investment and challenges such as their child's food sensory issues. Coping strategies were reported as solutions to mealtime difficulties, or to accommodate their child's needs. For example, both general (e.g. the use of repeated exposure) and "tailored" techniques (e.g. the use of pastry pinwheels to encourage child engagement and fun in meal planning) were described to encourage eating. After reviewing the short video clip of their typical family mealtime, caregivers with high levels of alexithymia noticed the satiation cues of their child which were overlooked during the meal. Through reflections on their practices, participants emphasised the reciprocal learning process of the caregiver-child dyad during interactions, the reassurance of knowing that they were "doing the right thing" in feeding, and the importance of embracing their progress as mealtimes improve.

This study provided the first qualitative exploration of feeding and mealtime experiences of caregivers with high levels of alexithymia. Rather than seeking to identify challenges unique to this population, our reflexive analysis investigated how know alexithymia traits, specifically difficulties identifying and describing internal states and a reliance on external cues, influenced how caregivers with high levels of alexithymia perceive, navigate, and reflect upon their feeding practices and mealtime interactions. Findings from the previous study showed that caregivers' capacity in recognising and responding to their own satiation cues reduced the impact of alexithymia on their ability to decode their infant's hunger and satiation cues during feeding (Yu et al., 2026). Results from the present study indicated an important role of video elicitation which helped caregivers with high levels of alexithymia notice previously overlooked child satiation cues. In addition, the reflection on mealtime experiences and feeding practices fostered a sense of progress and reassurance for participants. Thus, by improving understanding and sensitivity towards their interoceptive cues, parents with high levels of alexithymia may become more aware of and engaged with their child's appetitive and affective cues. Consequently, caregivers were more likely to satisfy their child's needs, provide appropriate responses and mealtime interactions, rather than mainly focusing on food provision. In general, children can benefit from watching attentive caregivers who are teaching and modelling how to recognise and respond to internal hunger and satiation cues during mealtimes. In a study with video observations in a childcare setting, Ramsay et al. (2010) explored caregivers' mealtime communication regarding preschoolers' internal and non-internal hunger and satiation cues. Results showed that some caregivers tried to get their children to eat with an emphasis on non-internal cues, such as cueing the amount of food served and remaining without evaluating children's internal state (Ramsay et al., 2010). This may result in a detrimental effect on promoting children's sensitivity to internal cues and undermining self-regulation skills during mealtimes (Johnson, 2000).

Our findings align with a previous study in which Thompson et al. (2021) investigated parental perspectives on the ideal and the reality of family mealtimes. Parents of preschool children highlighted the importance of being together for the meal, as well as offering healthy foods to their children. Challenges in achieving an ideal family mealtime included having a fussy child, negative parental role-modelling in vegetable intake, and parental work schedules that required them to be out of the house at mealtimes. Parents reported solutions such as having flexible meal timings in response to scheduling conflicts, promoting child engagement in meal planning, and using positive role-modelling to encourage their children to "build good habits" and eat healthy foods. Overall, they considered it challenging to attain ideal family meals with conflicts between unrealistic parental expectations and child mealtime behaviours. Thus, results showed that with or without alexithymia, parents may experience similar mealtime difficulties and may employ

universal coping strategies.

Vaughn et al. (2016) suggested that decisions parents make around feeding their children can be categorised into three different practices: coercive control feeding, structure-based feeding, and autonomy-promoting feeding. Coercive control feeding is associated with parental use of controlling feeding practices such as pressuring their child to eat, whereas structure-based feeding and autonomy-promoting feeding are involved with providing children a structured and healthy mealtime environment and teaching children to have control over their own eating (Musher-Eizenman et al., 2019). In the present study, tension was identified between parental expectations of how much they wanted their children to eat, and parental desires to be child-centred in how much or what parents actually offered to their child. For parents of “good eaters” (such as ID5, ID8, and ID12), the experiences reported were often positive as the feeding strategies mainly focused on fostering child independence during mealtimes. In contrast, parents with a fussy child (such as ID1, ID2, and ID3) expressed experiences that were similar to each other in offering foods that they knew their child would like and consume. However, it usually came with additional stress and effort in getting their fussy child to “just eat something”. Similar parental feeding patterns were reported in an earlier study, where mothers “firmly believed” they knew the “right amount” to provide to their child; meanwhile, they knew or expected what their child would and would not eat (Johnson et al., 2015). Children with fussy eating are likely to display complex eating behaviours (Farrow & Blissett, 2006; Haycraft et al., 2011). While child fussiness may be transient and resolved over time (Mascola et al., 2010), it may also exist as a long-term issue for some families and cause feeding concerns and nutritional risk (Galloway et al., 2005), with coercive feeding practices or instrumental strategies involved in order to encourage or to pressure the child to eat more, as a strategy to manage difficult child behaviours (Rodgers et al., 2014).

Results from a recent cross-sectional study showed that parental active engagement in feeding is associated with structure-based feeding as well as autonomy-promoting feeding (Sherrard & Tan, 2022). In the present study, parents demonstrated their engagement through sitting at the table together during mealtimes, having conversations, and involving their child in the meal preparation. However, due to food sensory issues, having a fussy child, caregivers' working schedules, and convenience factors, parents reported that they were compelled to make different meals or separate feeding schedules from the rest of the family, which might lead to reduced parental engagement in feeding during mealtimes. Similar practices have been reported by Brannen et al. (2013) who also suggested that this may hinder the opportunity for the entire family to sit around the table simultaneously, with parents modelling appropriate eating behaviours and table manners. Parents have a significant modelling effect on their children's food intake and mealtime behaviours (Blissett, 2018). For instance, maternal modelling was associated with child increased enjoyment of food and lower fussiness (Palfreyman et al., 2015). Hence, strategies and encouragement for parental active engagement and positive role-modelling may promote better mealtimes and healthy child eating behaviours.

Research has been focused on the impact of mealtime structures on child eating behaviours. For example, minimising potential distraction in the home environment is considered an approach of structure-based feeding, as well as a key element for healthy family mealtimes (Jones, 2018). In an observational study conducted in the home setting, children demonstrated lower food fussiness where no distractions were present (such as TV) during mealtimes or where they had higher engagement in food choice or meal preparation (Powell et al., 2017). Moreover, in the present study, parents reported meal-dependent experiences, varied food acceptance rates, in addition to numerous strategies to encourage eating. Findings aligned with previous literature that child food acceptance can vary day by day; those initially rejected might be accepted later after repeated neutral exposure (Birch & Marlin, 1982). Compared to children who received rewards, those who were

allowed to explore foods were more likely to try new foods and eat them again (Birch et al., 1984). Rolls (1986) also suggested that given autonomy, children are likely to eat a variety of foods and to maintain a nutritionally adequate diet over time. In summary, with attentive and responsive caregivers, children are allowed to actively engage in the process of achieving tasks autonomously with concrete and repeated experiences during mealtimes, and “do best with feeding” eventually (Satter, 1995).

A few mothers advocated the importance of breastfeeding and indicated that although it was difficult for various reasons, they “persisted” until their child was at least two years old. One mother particularly commented that support for breastfeeding was essential and specifically needed by her. Our findings supported the previous research that longer duration of successful breastfeeding was associated with sustained social support, such as periodical follow-up contact with the physician or health visitor, delaying the return to work, working part-time instead of full-time, and being able to express milk at the workplace (Satter, 1990). However, a mismatch was reported by different parents between their feeding practices in reality and what feeding guidelines suggested (from NHS, healthcare professionals, and/or social media). Their concerns about unhelpful feeding resources and emotional strain resonated with findings from a national survey on maternal experiences in maternity care and infant feeding support in England. Mothers indicated that they had “learned the hard way” or in some way “failed” in parenting on account of inconsistent advice, and a lack of postnatal support from the organisation and staff (Redshaw & Henderson, 2012). Results across studies demonstrated maternal expectations and needs in receiving help on feeding, while professional support was not accessible or unhelpful in some circumstances, leading to additional distress for caregivers.

It is worth noting that while caregivers appreciated the convenience and peer support offered by digital resources such as social media and mobile apps, some criticized them and articulated what they considered to be the downside of social media. They described the content creators' posts as unrealistic, that they felt additional pressure to conform. One mother particularly emphasised that due to the postnatal depression she experienced and her understanding of other mental health conditions, caregivers should be aware of “the risk of tracking things via apps” and “be cautious of being rigid”. Our findings partially supported what Srivastava et al. (2022) reported in their qualitative study that caregivers considered media as “a double-edged sword”, a “nightmare” when parents sought out information relevant to breastfeeding.

In the epidemiology domain, genetic studies showed that alexithymia is not only substantially heritable (Picardi et al., 2011), but also shares a genetic relationship and aetiology with sensory sensitivity, which relates to almost all sensory domains (Yorke et al., 2025). Meanwhile, unshared environmental factors are also a major determinant for alexithymia, which may include but not limited to pathological family interactions, dysfunctional family environment in childhood, poor family expressiveness, and perceived dysfunctional parenting (Picardi et al., 2011). Furthermore, results from a qualitative study revealed that individuals with alexithymia demonstrated a less sophisticated communication vocabulary, as well as less nuanced and less vivid descriptions of interpersonal relations (Meganck et al., 2009). This might have a negative impact on the child's language development through mealtime conversations with poor interactions, as emotion words in the language processes act as critical components in children's development of emotion concepts (Hobson et al., 2019). Overall, it is of importance to offer support on feeding to caregivers who score high on alexithymia, devise effective environmental interventions to reduce alexithymic traits or promote their interoception awareness so they can enjoy their mealtimes and have healthy interactions with their children.

This study also contributed to implications for practices and intervention design. For example, findings from this study suggested that feeding support for caregivers with high levels of alexithymia should pivot away from traditional approaches that rely on emotional

introspection or the verbalisation of feelings. Instead, clinical interventions are needed to scaffold externalised reflection through objective modalities such as video elicitation, structured observation, and concrete behavioural feedback. In the present study, video-stimulated recall functioned as a vital reflective scaffold, enabling caregivers with high levels of alexithymia to retrospectively decode child cues and identify personal behavioural patterns that were inaccessible during the immediate, high-arousal mealtime environment. From a design perspective, future feeding interventions could optimise engagement by emphasising parental reassurance, longitudinal progress, and “good enough” feeding frameworks, rather than an idealised “gold standard”. Delivering opportunities to analyse observable dyadic interactions – rather than prescribing emotionally laden guidance – may accommodate reduced sensitivity to interoceptive cues, ultimately mitigating caregivers’ pressure and fostering adaptive feeding practices.

To summarise, elevated caregiver sensitivity in recognising and responding to their own appetitive and affective cues may promote their awareness of their children’s hunger and satiation cues during feeding, which consequently generates more RF practices. Future research could focus on developing training resources or interventions on feeding especially for parents with high alexithymia scores, or who are less likely to recognise and respond to their own interoceptive cues. In addition, feeding guidelines and training programmes should go beyond general resources so that parents could possibly benefit from tailored support. For example, healthcare professionals might benefit from training to support parents with alexithymia to provide structured mealtimes, to perform autonomy-promoting feeding practices, or to be “good enough”. Furthermore, parental modelling has been applied to encourage expected child behaviours during mealtimes in other research (Sweetman et al., 2011; Trofholz et al., 2018). Providing parents with guidelines and encouragement for role-modelling through mealtime interactions might serve as promising feeding strategies.

5. Strengths and limitations

The first strength is that this is a follow-up of a previous study and participants were selected based on their alexithymia scores. This allowed the further investigation of feeding experiences and mealtime interactions of caregivers who struggled in recognising and expressing their own interoceptive cues. The second strength of this study is that video elicitation and quotes from the previous study (Yu et al., 2026) were included to minimise caregivers’ recall bias, to facilitate their reflection and observation on their feeding practices and typical family mealtime interactions. However, our target sample was caregivers with alexithymia (TAS-20 scores >60). Due to the difficulties in the recruitment, for example, individuals with alexithymia found it challenging to express themselves during the interview or while facing the camera, in addition to their childcare responsibilities, we eventually had a self-selected sample with caregivers who scored high on alexithymia ($52 < \text{TAS-20 scores} \leq 74$). The second limitation is that other measurements of caregivers’ wellbeing were not included, such as Autism Spectrum Disorder (ASD), anxiety and depression, which may occur with alexithymia (Poquérousse et al., 2018). The research team was only able to know when participants revealed concurrent mental health conditions during the interview (including ASD and postnatal depression in the present study). The third limitation is that although we have collected data on children’s eating traits such as satiety responsiveness, food responsiveness, and food fussiness in the previous study (Yu et al., 2026), these quantitative child-level variables were not incorporated into the analytic process. This was due to the design of the present study as an exploratory qualitative study using reflexive thematic analysis. Additionally, another limitation is that we did not systematically collect diagnostic information about children’s developmental or feeding-related conditions. It is therefore possible that some children may have experienced specific challenges related to neurodivergence, sensory processing differences, or clinically significant feeding

difficulties (e.g., Avoidant/Restrictive Food Intake Disorder) that could influence mealtime interactions independently of parental alexithymia. Future work could explicitly examine how parental alexithymia interacts with child eating traits, child eating profiles, and/or child developmental needs in influencing their mealtime experiences. The fourth limitation is that participants all identified as White British. Therefore, findings are not generalisable to a wider population, although this is not necessarily an aim of the qualitative work.

6. Conclusion

Overall, five themes identified in the present study revealed that caregivers with high scores on alexithymia reported that mealtimes were challenging. They experienced specific difficulties beyond typical feeding challenges, such as child’s sensory needs, child weight concerns, parental control over feeding, and lack of support in feeding. Discussion with caregivers who scored high on alexithymia was enhanced by the video-elicitation and quotes from the previous study. The results showed struggles which participants were unable to solve, consequently it provided additional pressure in turn. Our findings also captured parental reflections on their child’s feeding progress, mealtime interactions, as well as how they acknowledged their identity in caregiving. This revealed how participants navigated their feeding practices and mealtime interactions according to the interplay between parental high levels of alexithymia, child characteristics (e.g. “good” and “fussy” eaters) and child needs. These views imply a person-centred approach and caregivers’ willingness to apply multiple strategies to provide better mealtimes to their child. Caregivers with high score on alexithymia may benefit from tailored support in helping them to recognise and respond to appetitive and affective cues of both themselves and their child, so to improve their mealtime experiences and interactions.

Ethical statement

Ethical approval for this study was granted by the University of Leeds, School of Psychology Ethics Committee (PSCETHS-1086).

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

CRediT authorship contribution statement

Shihui Yu: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Visualization, Writing – original draft, Writing – review & editing. **Alison Fildes:** Conceptualization, Methodology, Supervision, Writing – review & editing. **Pam Birtill:** Conceptualization, Formal analysis, Methodology, Supervision, Validation, Writing – review & editing. **Tang Tang:** Conceptualization, Methodology, Supervision, Writing – review & editing. **Marion M. Hetherington:** Conceptualization, Formal analysis, Investigation, Methodology, Project administration, Supervision, Validation, Writing – original draft, Writing – review & editing.

Declaration of competing interest

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The authors declare no competing interests regarding this research.

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Appendix A. Supplementary data

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