Food Intimacy: A Parental Perspective of Eating Behaviors in Obese Youth

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Abstract
Disordered eating behaviors are implicated in the development and persistence of obesity in childhood, adolescence, and adulthood. The purpose of this study was to provide a qualitative perspective of obese youth’s eating behaviors through the lens of their parent as they attempt to create healthy changes. An in-depth secondary analysis was conducted for the construct of food intimacy that evolved as part of a larger study investigating how parents promote health for their obese child. Seventeen parents of 10- to 14-year-old obese youth were interviewed. Themes and concepts were developed using grounded theory. Parents described child behaviors such as losing control and sneaky eating to obtain food, as well as using food for comfort, pleasure, and simply loving food. The relationship between these children and food was identified as the over-arching theme, food intimacy. This study highlights the intimate relationship these children developed with food and the powerful influence of this relationship on their eating behaviors. This suggests that prescribed interventions such as exercising more and eating less may be ineffective in certain obese children, and that more focus should be placed on investigating the relationship an obese child has with food.

Keywords
behavioral sciences, adolescence, obesity, social sciences, food behaviors

In the United States, approximately 13% of children are clinically obese (Centers for Disease Control and Prevention [CDC], 2012). Of those children who are obese, 40% to 70% will continue to be obese as adults (Reilly & Kelly, 2010). Obese children are at risk for health problems previously affecting only adults, including type 2 diabetes and cardiovascular disease. Furthermore, obese children have premature and higher mortality levels compared with lean children of similar age (Franks et al., 2010). The societal and economic burden of childhood obesity continues to grow with approximately US$14.1 billion in direct medical costs attributed to obesity in children in the United States alone (Robert Wood Johnson and Trust for America’s Health, 2013). Reducing the prevalence and alleviating the burden of childhood obesity is a priority globally (World Health Organization [WHO], 2012).

Increasingly, focus has turned to eating behaviors and disordered eating as contributors to the ongoing obesity epidemic in youth. Pasold, McCracken, and Ward-Begnoche (2013) reported that 33% of obese adolescents seeking treatment for obesity demonstrated moderate to severe binge eating. Other eating behaviors such as emotional eating in response to emotionally distressing situations such as stress and sadness have been attributed to weight gain and obesity in youth (Braet & Van Strien, 1997). More recently, food addiction has been identified as a potential contributor to obesity in youth (Gearhardt, Roberto, Seamans, Corbin, & Brownell, 2013). These studies suggest that obese youth are quantitatively identified once they have reached specific diagnostic thresholds for disordered eating sub-types that generally are identified in the research setting. This presents a narrow approach and view of food behaviors of obese youth and does not adequately recognize potentially obesogenic-eating behaviors that do not reach well-delineated psychometric cut points. Furthermore, such studies lack the depth and richness that detail the intimate relationship between food and children with disordered eating behaviors.

Qualitative studies yield vast amounts of descriptively rich data that provide the foundation from which the research question is methodically addressed and subsequently answered. Often large amounts of data are left underutilized and provide an opportunity to ask additional questions of the data set independent from the initial research aim (Heaton, 2004), particularly, when novel concepts and constructs are only partially explored and developed (Corti & Bishop, 2005; Heaton, 1998, 2004). For example, Kidd, Scharf, and
Veazie (1996) examined stress and injury in the farming environment. In their primary study, they identified patterns of decision making, health risk, and risk prioritization to avoid risk in the farming environment. Once completed, a secondary data analysis was conducted to further explore the concepts of stress and injury. Similarly, this approach provided the opportunity to further explore the construct of “food intimacy” that emerged from a larger qualitative study. In the primary study, food intimacy was defined as an intimate relationship reported by parents that signified a strong bond between their child and food, which had been previously identified in the primary study as a significant barrier for parents attempting to engage their obese child in healthy behaviors. The current study represents an in-depth analysis of the construct of food intimacy through the lens of the parent. The purpose was to describe and elucidate how parents perceived their obese youth’s relationship and behaviors with regard to food and eating.

Method

Primary Study

Classic grounded theory guided data collection and analysis (Strauss & Corbin, 1998). All parents consented to being interviewed and audio recorded. Inclusion criteria consisted of English-speaking parents/guardians who self-identified their child as overweight or obese and between the ages of 9 to 14 years. As parents generally underestimate the weight of their overweight or obese child, objective measures of body mass index (BMI) were not considered for inclusion (Lundahl, Kidwell, & Nelson, 2014). A convenience sample of participants was recruited through health care clinician referrals, word of mouth, flyers in common areas of health care practices and community settings, and local newspapers servicing the Northeastern United States.

Data collection and analytic methods for the primary study are detailed elsewhere (Laurent & Zoucha, 2014). Saturation was achieved by Interview 13 and continued for an additional 4 interviews. Trustworthiness (Lincoln & Guba, 1985) was gained by formal member checking. During data collection for the primary study, participants were asked to correct errors of fact or interpretation during the interview process to improve trustworthiness.

The construct of food intimacy was an explicit construct within the theoretical model. Institutional review board approval was obtained for this study.

Secondary Analysis

Several approaches may be used in secondary data analysis depending on the focus of the study (Heaton, 2004). This study was supplementary to the original data set, meaning our aim was to elaborate and fully develop a previously identified theoretical construct of interest (Heaton, 1998, 2004). As such, Strauss and Corbin’s (1998) classic ground theory coding paradigm and constant comparative method were used for the secondary data analysis to better understand the construct of food intimacy.

Each transcript included data detailing the child and food relationship, thus all 17 transcripts were included in the secondary data analysis. Transcripts were pooled and recoded to allow for a “new analysis” focusing on the construct of food intimacy (Heaton, 2004). However, the majority of data were generated and analyzed primarily from two open-ended questions, “Do you have any idea what may have contributed to or caused your child’s weight gain?” and “What problems or barriers did you encounter [while instituting healthy behaviors]?”

Analysis began with open coding and progressed to higher levels of abstraction in axial coding. For example, data fragments (Charmez, 2006) found in open coding, such as “would just go crazy” and “food is always on her mind,” were identified as important to the construct of food intimacy. With ongoing inductive and deductive analyses inherent to classical grounded theory, the subcategory of “losing control” emerged and described the parental perception of what food did to their child’s behavior as well as what occurred once food consumption began.

Results

Sample Characteristics From Primary Study

A final convenience sample of 17 parent participants were interviewed for this study: 3 women were single parents, 14 were married or identified a significant partner, 4 were father participants married to mother participants, and 1 parent participant was a grandmother. All parents identified their child as “having a weight problem” and between the ages of 9 and 14 years. Interestingly, no parent used the term obese when referring to his or her child. Two children were clinical overweight, and 14 children were obese (defined as body mass index [BMI] for age and gender above the 95th percentile; CDC, 2010). Only 1 parent had sought previous treatment for her child’s obesity. Further sample characteristics are detailed elsewhere (Laurent & Zoucha, 2014). Pseudonyms will be used for all illustrative quotes.

Food Intimacy

The construct of food intimacy was identified as an essential theme describing the parental perception of their child’s relationship with food. Participants described their children as using food for more than sustenance. Several concepts within food intimacy emerged from the data. Loves food, comfort eating, losing control, and sneaky eater were in vivo codes to describe the properties inherent within food intimacy. In vivo codes were used in as great an extent as possible to keep the data grounded within the words of the participants (Strauss
& Corbin, 1998). Each participant’s child did not manifest all properties and dimensions of food intimacy, and the degrees in which they did varied between children.

**Loves food.** Participants described their children as loving food. Kammie referred to her daughter as “loving food, she loves to eat. She’s like my little foodie. I mean she just has always had like—I’ve always had to slow her down, even since she was probably 3 or 4 years old.” She goes on to describe an example:

She doesn’t know this, but like the joke is—all the kids will be in one room and they’ll be playing the Wii and Maggie will be sitting with us having appetizers. She would rather be with the adults socializing with a huge emphasis on food than playing with the kids. It’s something that gives her her great pleasure.

Parents identified food as providing a means of pleasure for their child. Barb described her son’s response to food:

[He is] very much into the tactile. He’s very tactile. And I think that food is another piece of that. You figure you’re tasting it and you’re smelling it. I think that that kind of thing is very stimulating for him to have that kind of thing.

Karen confirmed that her son simply, “just likes food.”

**Comfort eating.** Comfort eating was described as eating to make oneself feel better in the context of sadness, stress, or in response to other distressing emotions. Eating did not occur in the setting of hunger and the chosen foods were typically less healthy or the food quantity was greater. Tom described his daughter “turning to food” when picked on. Similarly, Anna reported that her son, “does have a speech impediment . . . so I think he decided instead of talking, [he will] eat.”

When Joyce’s daughter is “[hurt or upset] she eats.” Her daughter always had been “thin, slender” until “family problems arose; problems in the house—and she started eating. A lot. Her behavior started changing. Isolated, depressed, not doing good in school. I took her to therapy and they said she’s a feeling eater.”

Serena felt her granddaughter was an “emotional eater” and “when there’s disappointment and stress and things going on in her life, I think she eats more.” Kylie also acknowledged that food provided “a bit of a respite for her [daughter].” Aaron did not speak specifically to the act of comfort eating per say but questioned whether depression was a contributor for his son. He said,

I don’t know if he’s eating because he’s hungry. Is it possible to be eating because of depression? I don’t know if that’s possible with younger kids at that age or—yeah, I guess it is.

**Losing control.** Parent participants reported food was a driving force for their children. For Sara, it did not matter what type of food. “It doesn’t matter if I have a bag of chips or a bag of carrots, she’ll eat them until they’re gone, regardless of what it is.” She went on to say, “She will just eat. If it’s not nailed down, she’ll eat it. Food is always on her mind.”

She’ll say to me sometimes, “I’m starving.” I’m thinking, “Mary, we just had breakfast 2 hours ago or whatever.” So I don’t think you’re starving. It’s obvious she’s not starving. I don’t know how to explain it. It’s certainly not where there’s been enough time between when she ate last to when she’s thinking she’s starving again.

Hunger or food desire was heightened within the context of sweets or junk food. For example, Barb described the following scenario:

Quite often, he’ll be, “I’m still hungry, but I’m so hungry.” And I think he picks and chooses when he’s hungry. He can leave the main meal on the plate because he’s full but then once he realizes—and we don’t usually have dessert but once there’s something else there, then all of a sudden, “I’m hungry.”

**Sneaky eater.** Disordered eating behaviors were apparent in some of the participant’s children with regard to seeking or sneaking food particularly when parents attempt to modify access or improve the healthful quality of available foods. Kammie relayed a story by which her daughter attended Bible school for the food that was served. She said,

They had this Bible study group or whatever, but really what it was is she wanted the junk food, because this woman would bring cake and cookies and pies. And I wrote to the principal and I said, you know what? I have no problem with her exploring other religions, looking into other views of the world. That’s great. I don’t think she needs to be fed while she’s doing it. And Regina came home not long after and said, “oh, yeah, we had apple slices this time.” And I went, “good.” [Her participation] slacked off after that.

Joyce described her daughter as “hustling up food” from her friend’s parents and selling her belt for food. She said her daughter “traded a brand new belt I got. I got her a brand new belt, a hot belt. Everybody wanted it. She sold it for 5 bucks at school. [She bought] food, candy, and junk at the store.”

Several participants commonly described sneaky eating by their children. Children would horde or sneak food only to be discovered at a later time by the parents. Sara called her daughter “a sneaky eater.” Kathy said about her daughter, “Tonight she’ll get out of bed and go into the freezer or fridge and literally sneak food. I’ve found frozen pizzas in her room. I’ve found half-eaten cans of SpaghettiOs hidden in corners.”

You go up to help her clean her room and there are wrappers. I mean, I said, if you are going to eat something and you don’t want us to know that you are eating it, why don’t you at least throw the wrappers in the garbage. But, it’s there. (Julie)
Sitting on the couch and putting your hands between the cushions and see how many candy wrappers come out. (Tom)

The only boy who exhibited this behavior was Barb’s son. She described him as “very manipulative” and “knows he would be limited and would not be allowed to have anymore” so he resorted to sneaking food.

**Discussion**

This study explored and illuminated the parental perspective of disordered eating behaviors of their obese child while attempting to promote healthier behaviors. Parents in this study vividly identified and detailed an intimate relationship between their child and food. Children were described as finding comfort in food, sneaking food, acting out to obtain food, and/or simply loving food.

Participants reported their child seeking solace in food at an early age suggesting that comfort eating is likely a learned and possibly reinforced behavior by parents. Intuitively, the development of comfort eating does not occur instantaneously. It is a process that requires interactions, experiences, and the influence of others as it evolves. The young age from which comfort eating appears to begin raises concerns for the indoctrination and perpetuation of such behaviors as the child ages, as well as for future health concerns. For example, Jääskeläinen et al. (2014) found that adolescents who exhibited stress-related eating were more likely to have higher BMI and use alcohol and smoke tobacco, particularly in females. Further “comfort” or emotional eating (eating is response to negative emotions) may result in loss of control eating in youth (Goossens, Braet, Van Vlierberghe, & Mels, 2009). With obese children at increased risk for multiple weight-related co-morbidities and early mortality (Franks et al., 2010), additional at-risk behaviors are of great concern.

Participants in this study described a dysfunctional and enmeshed relationship between food and their child. A comparison is drawn with that of addiction whereby thoughts and feelings for these children about food created disordered eating behaviors. Parents described their children as craving, desiring, and/or working to get food in varying degrees and along different dimensions. Food addiction has been demonstrated in obese adults (Gearhardt, Corbin, & Brownell, 2009), and evidence suggests that food addiction may be present in obese children. Gearhardt et al. (2013) reported that approximately 7.2% of obese children in a community sample exhibited eating behaviors meeting criteria for food addiction. Similarly, Pretlow (2011) found that 29% of 8- to 21-year-old individuals who participated in an interactive website for overweight teen and preteens reported being addicted to food and 37% reported being addicted to certain foods. Merlo, Klingman, Malasanos, and Silverstein (2009) found that obese children who exhibited more addictive-like eating behaviors were more likely to report other disordered eating-related attitudes and behaviors. This suggests that addictive-like eating may be a problem for a subset of obese children, share features with other disordered eating behaviors, and pose greater barriers for parents and health care providers to adequately promote weight loss and achieve optimal weight.

For several parents, attempts at modifying desirable food quality and food access were met with resistance, persistence, and in some instances, clandestine eating behaviors. Restrictive practices and increasing levels of parent control have been shown to increase disordered eating behaviors, such as eating in the absence of hunger, and have been associated with higher levels of adiposity (Sonneville et al., 2013). Similarly, Goldfield et al. (2010) found an association between parental control over food and higher levels of adiposity but did not demonstrate a relationship between parental control over feeding and sneaking or hoarding food in a community sample of adolescents. It is possible that only a small subset of obese children may demonstrate sneaking and hoarding behaviors in general and/or when parents institute restrictive feeding practices. Although this may not be relevant to the majority of obese children, such behaviors would be clinically important to the child and family.

The standard of treatment for overweight and obese children and adolescents focuses on maximizing physical activity, decreasing sedentary behaviors, and improving dietary habits (Wang et al., 2015). In the short term, such programs have been shown to assist in weight maintenance and/or weight loss. Yet, anywhere from 50% to 80% of children regain their weight in as early as 18 months (Dietz & Robinson, 1993). Weight loss interventions in the home setting are even less successful with approximately 10% of children maintaining their weight beyond 2 years (Reinehr, 2013).

There are likely several reasons for unsuccessful weight control. One plausible reason, however, is that parents are unaware or do not understand the emotional susceptibility of their child in relationship to food in times of stress discomfort and do not recognize the early compensatory response of emotional eating until noticeable weight gain is evident. In addition, children and adolescents may not be screened effectively for subclinical disordered eating behaviors by health clinicians. Adequate screening at child health care visits for disordered eating behaviors and emotional attachments to food may facilitate optimal and alternative approaches to weight management for affected children and adolescents. For example, emotion-focused family therapy (EFFT) has been found to be effective in children and adolescents with clinical eating disorders (Robinson, Dolhanty, & Greenberg, 2015). Knatz, Braden, and Bouteille (2015) have subsequently adapted a EFFT approach that assists parents in becoming an emotional coach for their child with the aim of increasing parental awareness to their child’s emotional vulnerabilities and provide adaptive strategies to reduce emotional eating. Such approaches may be more efficacious in...
weight control as well as weight maintenance than standard interventions alone.

**Limitations**

Several study limitations should be noted. The retrospective account by parents may affect the veracity of their past experiences. Height and weight were self-reported by parents and could likely be an erroneous estimation of their child’s weight. Furthermore, physical activity and psychosocial factors (i.e., anxiety, depression, stress) were not examined and would be important to consider in future studies as both physical activity and psychological well-being are important variables in weight trajectory in youth (Kubzansky, Githorpe, & Goodman, 2012; Pate et al., 2013). The construct of food intimacy was not the focus of the primary study. It was a concept that evolved as an important barrier for parents addressing health for their overweight children and may have skewed data generation and affected the secondary analysis. Furthermore, the study sample was primary White mothers from the northeast region of the United States that limits the findings to a small, homogeneous population. Replication of this study in heterogeneous populations would provide greater insight into food behaviors specific to other cultures and ethnicities.

**Conclusion and Future Implications**

Although the findings are not intended to be generalizable, this study is among the first to describe obese children’s disordered eating behaviors from a parental perspective in a community setting. This study extends the current understanding of eating behaviors in overweight or obese youth by illuminating how food affects these children on an intimate level. Importantly, current interventions of diet modifications, enhanced physical activity, and less screen time may be ineffective in “food-intimate” obese children to promote healthy weight. Thus, more research should investigate the child–food relationship and the combined psychosocial and biological mechanisms of appetitive drive. Future studies should examine the meaning of food and the construct of food intimacy through the lens of the child.

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**References**

Braet, C., & Van Strien, T. (1997). Assessment of emotional, externally induced and restrained eating behaviour in nine to twelve-year-old obese and non-obese children. *Behaviour Research and Therapy, 35*, 863-873. doi:10.1016/S0005-7967(97)00045-4

Centers for Disease Control and Prevention. (2010). *Overweight and obesity*. Retrieved from [http://www.cdc.gov/obesity/defining.html](http://www.cdc.gov/obesity/defining.html)

Centers for Disease Control and Prevention. (2012). *Childhood obesity facts*. Retrieved from [http://www.cdc.gov/obesity/data/childhood.html](http://www.cdc.gov/obesity/data/childhood.html)

Charmez, K. (2006). *Constructing grounded theory*. London, England: SAGE.

Corti, L., & Bishop, L. (2005). Strategies in teaching secondary analysis of qualitative data. *Forum: Qualitative Social Research, 6*(1), 1-27

Dietz, W., & Robinson, T. N. (1993). Assessment and treatment of childhood obesity. *Pediatric Reviews, 14*, 337-343.

Franks, P. W., Hanson, R. L., Knowler, W. C., Sievers, M. L., Bennett, P. H., & Loken, H. C. (2010). Childhood obesity, other cardiovascular risk factors, and premature death. *New England Journal of Medicine, 362*, 485-493. doi:10.1056/NEJMo0904130

Gearhardt, A. N., Corbin, W. R., & Brownell, K. D. (2009). Food addiction: An examination of the diagnostic criteria for dependence. *Journal of Addiction Medicine, 3*, 1-7.

Gearhardt, A. N., Roberto, C. A., Seams, M. J., Corbin, W. R., & Brownell, K. D. (2013). Preliminary validation of the Yale Food Addiction Scale for children. *Eating Behaviors, 14*, 508-512.

Goldfield, G. S., Moore, C., Henderson, K., Buchholz, A., Obeid, N., & Flamet, M. F. (2010). Body dissatisfaction, dietary restraint, depression, and weight status in adolescents. *Journal of School Health, 80*, 186-192. doi:10.1111/j.1746-1561.2009.00485.x

Goossens, L., Braet, C., Van Vlierbergh, L., & Mels, S. (2009). Loss of control over eating in overweight youngsters: The role of anxiety, depression and emotional eating. *European Eating Disorders Review, 17*, 68-78. doi:10.1002/erv.892

Heaton, J. (1998). Secondary analysis of qualitative data. *Social Research Update, 22*(4), 88-93.

Heaton, J. (2004). *Reworking qualitative data*. London, England: SAGE.

Jääskeläinen, A., Nevanperä, N., Remes, J., Rahkonen, F., Järvelin, M.-R., & Laitinen, J. (2014). Stress-related eating, obesity and associated behavioural traits in adolescents: A prospective population-based cohort study. *BMC Public Health, 14*, Article 321. doi:10.1186/1471-2458-14-321

Kidd, P., Scharf, T., & Veazie, M. (1996). Parent coaching model for adolescents with emotional eating. *Eating Disorders, 23*, 377-386.

Kubzansky, L. D., Githorpe, M. S., & Goodman, E. (2012). A prospective study of psychological distress and weight status in adolescents/young adults. *Annals of Behavioral Medicine, 43*, 219-228.

Laurent, J. S., & Zoucha, R. (2014). Parents addressing health for their overweight or obese pre-adolescent. *Health Behavior and Policy Review, 1*, 131-142. doi:10.14485/HBPR.1.2.5

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. London, England: SAGE.
Lundahl, A., Kidwell, K. M., & Nelson, T. D. (2014). Parental underestimates of child weight: A meta-analysis. *Pediatrics, 133*(3), 1-15. doi:10.1542/peds.2013-2690

Merlo, L. J., Klingman, C., Malasanos, T. H., & Silverstein, J. H. (2009). Exploration of food addiction in pediatric patients: A preliminary investigation. *Journal of Addiction Medicine, 3*, 26-32.

Pasold, T. L., McCracken, A., & Ward-Begnoche, W. L. (2013). Binge eating in obese adolescents: Emotional and behavioral characteristics and impact on health-related quality of life. *Clinical Child Psychology and Psychiatry, 19*, 299-312. doi:10.1177/1359104513488605

Pate, R. R., O’Neill, J. R., Liese, A. D., Janz, K. F., Granberg, E. M., Colabianchi, N., . . . Taverno Ross, S. E. (2013). Factors associated with development of excessive fatness in children and adolescents: A review of prospective studies. *Obesity Reviews, 14*, 645-658. doi:10.1111/obr.12035

Pretlow, R. A. (2011). Addiction to highly pleasurable food as a cause of the childhood obesity epidemic: A qualitative internet study. *Eating Disorders, 19*, 295-307. doi:10.1080/10640266.2011.584803

Reilly, J. J., & Kelly, J. (2010). Long-term impact of overweight and obesity in childhood and adolescence on morbidity and premature mortality in adulthood: Systematic review. *International Journal of Obesity, 35*, 891-898.

Reinehr, T. (2013). Lifestyle intervention in childhood obesity: Changes and challenges. *Nature Reviews Endocrinology, 9*, 607-614. doi:10.1038/nrendo.2013.149

Robert Wood Johnson and Trust for America’s Health. (2013). *F as in fat: How obesity threatens America’s future 2013*. Retrieved from http://healthyamericans.org/assets/files/TFAH2013_FasInFatReportFinal%209.9.pdf/

Robinson, A. L., Dolhanty, J., & Greenberg, L. (2015). Emotion-focused family therapy for eating disorders in children and adolescents. *Clinical Psychology & Psychotherapy, 22*, 75-82.

Sonneville, K. R., Rifas-Shiman, S. L., Haines, J., Gottmester, S., Mitchell, K. F., Gillman, M. W., & Taveras, E. M. (2013). Associations of parental control of feeding with eating in the absence of hunger and food sneaking, hiding, and hoarding. *Childhood Obesity, 9*, 346-349. doi:10.1089/chi.2012.0149

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research*. Thousand Oaks, CA: SAGE.

Wang, Y., Cai, L., Wu, Y., Wilson, R. F., Weston, C., Fawole, O., . . . Segal, J. (2015). What childhood obesity prevention programmes work? A systematic review and meta-analysis. *Obesity Reviews, 16*, 547-565. doi:10.1111/obr.12277

World Health Organization. (2012). *Prioritizing areas for action in the field of population-based prevention of childhood obesity*. Library of Congress. Retrieved from http://www.who.int/diet-physicalactivity/childhood/Childhood_obesity_Tool.pdf

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