Nutrición Hospitalaria

Nutr Hosp. 2013;28(6):2188-2193
ISSN 0212-1611 • CODEN NUHOEQ
S.V.R. 318

Original / *Otros*

Food choices coping strategies of eating disorder patients' parents; what happens when both mother and father work?

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Abstract

Objective: **Recently, it has been reported that food choices of relatives of eating disorder (ED) patients are not adequate having in mind a healthy model of eating habits. The aim of this study was to analyse how work conditions relate to parents' food choice coping strategies in both families with a member suffering from an ED and families with no sick members. In addition, the differences in those strategies between the two types of working parents were studied.**

Methods: **A total of 80 employed fathers (n = 27) and mothers (n = 53) of patients with an ED (n = 50) and healthy offsprings (n = 30) were interviewed. The mean age was 43.57 ± 5.69 and they had moderate incomes. Food choice coping strategies, used by working parents to integrate work and family demands, were measured by means of 22 items included in five categories.**

Results: **Considering the food choice coping strategies, ED patients' relatives show better skills than relatives of healthy offsprings do. The fact of preparing more meals at home and less fast food as main meal are good examples of those better strategies as well as to miss less number of breakfasts and lunches because of work-family conflict, grabbing less frequently and overeat less after missing a meal.**

Discussion: **The therapeutic effort to improve the food choices of ED patients' relatives, especially when both father and mother work, are a key point to improve the eating habits of ED patients, thus contributing to a better outcome.**

(*Nutr Hosp.* 2013;28:2188-2193)

DOI:10.3305/nh.2013.28.6.6840

Key words: *Food choice. Coping strategies. Work-family conflict. Work-family spillover. Eating disorders. Nutritional education.*

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Recibido: 8-VII-2013.
Aceptado: 18-VII-2013.

ESTRATEGIAS DE AFRONTAMIENTO EN LA ELECCIÓN DE ALIMENTOS DE PADRES DE PACIENTES CON TRASTORNOS DE LA CONDUCTA ALIMENTARIA; ¿QUÉ OCURRE CUANDO LA MADRE Y EL PADRE TRABAJAN?

Resumen

Objetivo: **recientemente se ha comunicado que la elección de alimentos por parte de familiares de pacientes con trastornos alimentarios no es adecuada teniendo en cuenta un modelo saludable de hábitos de alimentación. El objetivo de este estudio fue analizar de que forma las condiciones de trabajo se relacionan con las estrategias de afrontamiento en la elección de alimentos tanto en familias con algún miembro que padece un trastorno alimentario como en otras sin miembros con estos trastornos También se analizaron las diferencias en el tipo de estrategias usadas por unas y otras familias.**

Métodos: **Un total de 80 padres (n = 27) y madres (n = 53) de pacientes con trastornos alimentarios (n = 50), con trabajo extra-doméstico, e hijos sin alteraciones psicopatológicas (n = 30) fueron entrevistados. La edad media fue de 43,57 ± 5,69 años y los ingresos económicos fueron moderados. Las estrategias de afrontamiento en la elección de alimentos usadas para integrar vida laboral y familiar fueron evaluadas mediante 22 ítems incluidos en cinco categorías.**

Resultados: **Los padres y madres de pacientes con trastornos alimentarios presentaron mejores estrategias que los de hijos sin patologías. El hecho de preparar más comidas en casa y usar menos comida rápida como comida principal son algunos ejemplos de esas mejores estrategias así como presentar menos pérdidas de desayunos y almuerzos debido al conflicto familia-trabajo, presentar menor picoteo y menor frecuencia de sobreingestas tras haber perdido alguna comida.**

Discusión: **El esfuerzo terapéutico para mejorar la elección de alimentos en los padres de pacientes con trastornos alimentarios, especialmente cuando ambos trabajan fuera de casa, es un punto clave para mejorar los hábitos de alimentación de los pacientes contribuyendo ello a unos mejores resultados del tratamiento global.**

(*Nutr Hosp.* 2013;28:2188-2193)

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Palabras clave: *Elección de alimentos. Estrategias de afrontamiento. Conflicto familia-trabajo. Sobrecarga familia-trabajo. Trastornos alimentarios. Educación nutricional.*

Abbreviations

ED: eating disorders.

Introduction

Despite the present economical crisis and the subsequent big number of unemployed people, most Spanish parents are employed and the work-family conflict (time devoted to work: time devoted to family) is not yet resolved, so it may make competing demands on parents' time and efforts[1-3]. Factors like long work hours, rigid work and family schedules, and spill over of work into home lifes leave many families feeling short of time, tired, and stressed[4-6]. Marks and MacDermid (1996) have defined work-family balance as the tendency to engage fully in the performance of each role with an attitude of dedication to respond optimally to each of those roles[7].

One of those roles comprises of the efforts in regards to everything related to food. Since family work hours have increased, families are spending less time doing household tasks, including meal preparation[8-10]. As a result, some changes have arisen. On the one hand, the number of meals eaten and prepared away from home (i.e. restaurant meals, meals from cafeterias, etc.) work has increased and on the other hand (as consequence), the number of family meals eaten together has decreased[9,11,12]. Food choice coping strategies have been defined as the behavioural mechanisms through which people actively conceptualize and manage food selection in response to the work and family demands[13]. Due to the above-mentioned circumstances, many employed parents use these mechanisms. That "modern" reality makes food choices in many Western countries a relevant topic with importance for health promotion and disease prevention[14].

Poor physical and mental health has been associated with high levels of the strain resulting from work-family conflicts[15], especially among those workers with less control at work[16]. As parents play a critical role in determining the diets of their children, as meal providers and role models, pressures on parents' food choices have a great impact on the nutrition and health status of their children[17] and the same could be applied to the case of adolescents. Food choice strategies are usual habits that people acquired to select the products they eat and drink[18]. These strategies are necessary to cope with conflicting family and work roles and represent a day-by-day challenge to the food choice especially in Western countries.

Considering those families with a member suffering from an eating disorder (ED) the selection of foods is relevant. For example, foods prepared outside the home have been shown to be lower in nutritional quality than those at home[12]. In addition, less healthy diets have been positively associated with the different working conditions of the parents (e.g. 19, 20) and problems such as obesity and weight gain have been associated with specific working conditions[21-23]. Recently, it has been reported that food choices of the parents of eating disorder patients are generally not nutritionally adequate having in mind a healthy model of eating habits[24].

The aim of this study was to analyse how work situation relate to parents' food choice coping strategies in both families with a member suffering from an eating disorder and families without members suffering from any psychopathology. In addition, the differences in the food choice strategies between these two types of family were explored.

Method

Participants

A convenience sample consisting of 80 employed fathers (n = 27) and mothers (n = 53) of patients with an ED (n = 50) and healthy offsprings (n = 30) were interviewed in Seville (Spain). The mean age was 43.57 ± 5.69 and they had moderate incomes (21,000-28,000 €/year) and secondary level of education. With respect to the sons and daughters (5 and 45 respectively) of those fathers and mothers, their age ranged from 15 to 25 years old and they were receiving treatment as outpatients in an ED unit (average treatment time 8.7 ± 1.6 months). Parents of patients were interviewed during the weekly sessions of the therapeutic process of their sons and daughters. The other participants were drawn from different health insurance companies and were invited to participate voluntarily in the study. A total of 100 candidates from those companies were randomly selected, having accepted a total of 30 volunteers. Those parents of healthy offsprings had not nutritional pathologies, they were not going on diet and they were not under psychiatric or psychological treatment. With respect to ED-patients' parents they had not any history of psychiatric illnesses or ED.

Instruments

Following the study of Devine et al[4]., the food choice coping strategies used by working parents to integrate work and family demands were measured by 22 items in five categories including: 1) food prepared at/away from home, 2) missing meals, 3) individualizing meals (family eats differently, separately or together), 4) speeding up to save time, and 5) planning (Table II). Six items assessed work access (yes/no) to healthy, reasonably, priced, good tasting food, and to a microwave oven, refrigerator, and vending machines.

Procedure

The interviewing of the parents of patients was developed during the therapeutic sessions and included

Table I
Missing meals

	ED patients' parents (%)			*Other parents (%)*		
	Often	*Sometimes*	*Rarely*	*Often*	*Sometimes*	*Rarely*
Miss eating meals with family because of work	15.2	16.4	68.4	24.1	20.7	55.2
Miss breakfast due to work and family demands	4	14	82	24.1	20.7	55.2*
Miss lunch because of work	0	2	98	6.9	27.6	65.5***
Grab quick food after work	0	10.2	89.8	7.1	39.3	53.6**
Overeat later after missing a meal	0	12.2	87.8	10.3	24.1	65.5*

χ^2 test; *p < 0.05; **p < 0.001; ***p < 0.0001.

Table II
Individualizing meals

	ED patients' parents (%)			*Other parents (%)*		
	Often	*Sometimes*	*Rarely*	*Often*	*Sometimes*	*Rarely*
Different meals for different family members	4	38	58	27.6	24.1	48.3**
Family watches TV during the main meal	63.3	20.3	16.5	62.1	27.6	10.3
Eating the main meal with the whole family together	60	36	4	41.4	27.6	31**
Feeding children separately	11.4	5.7	82.9	20	30	50*

χ^2 test; *p < 0.05; **p < 0.01.

as a normal activity of these sessions. The parent who was interviewed was the primary caregiver of each patient, who normally accompanied the patient to the clinic and usually prepared meals for said patient. With respect to the healthy volunteers, an appointment was given to them in order to develop the interview. All participants were informed about the objective of the study and all of them gave their written informed consent following a protocol approved by the Institute Review Board (conforming the provisions of the Declaration of Helsinki-Edinburgh revision). Patients were receiving treatment in the Eating Disorders Unit of that Institute. None of the participants received any compensation for their participation.

Statistical analyses

Data are expressed as total number of cases and percentages due to the categorical nature of the variables. Differences were explored by way of the χ^2-test.

RESULTS

Food prepared at/away from home

Parents of ED patients prepared more meals at home than parents of healthy offsprings ($\chi^2 = 9.83$; $p < 0.05$) and they prepared less junk food as the main meal ($\chi^2 = 21.85$; $p < 0.0001$). These data are shown in figures 1-2. With respect to main meals being sourced from take-aways, restaurants and drive-throughs there were not significant differences.

Missing meals

In relation to different meals, parents of ED patients miss less number of breakfasts/week than parents of healthy offsprings ($\chi^2 = 8.86$; $p < 0.05$) and they miss less number of lunches/week because of work ($\chi^2 = 16.24$; $p < 0.0001$). Considering those indulging in fast food after work, a significant difference was found between the two groups with parents of members without pathologies indulging more frequently than parents of ED patients ($\chi^2 = 13.80$; $p < 0.001$). Finally, the fact of overeating later after missing a meal was more frequent in the group of parents of healthy offsprings than in the ED patients' parents group ($\chi^2 = 7.75$; $p < 0.05$). With respect of missing eating meals with family because of work there was not a significant statistical difference between the two groups of parents. Data are shown in table I.

Individualizing meals

Parents of healthy offsprings usually prepare different meals for different family members more frequently than parents of ED patients do ($\chi^2 = 9.46$; $p < 0.01$). Furthermore, eating the main meal with the whole

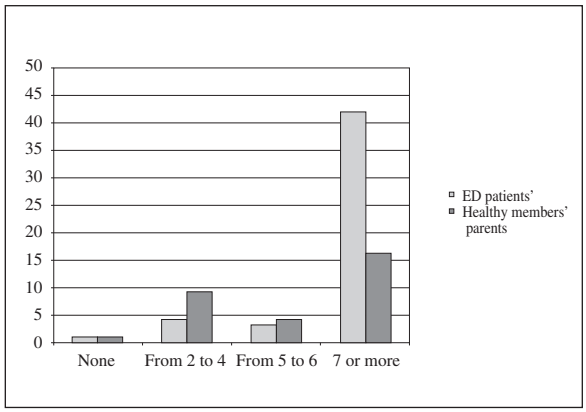

Fig. 1.—Meals per week prepared at home.

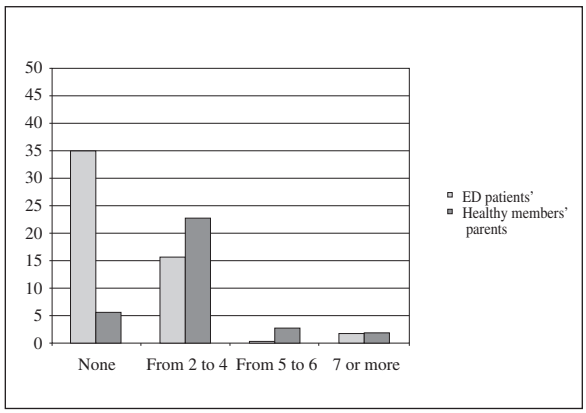

Fig. 2.—Main meals per week based on fast food.

family together is more frequent in ED patients' parents than in the other group ($\chi^2 = 11.23$; $p < 0.01$). With respect to feeding children separately, this is more common among parents of members without pathologies than among ED patients' parents ($\chi^2 = 7.74$; $p < 0.05$). There was not a significant difference with respect to the item "family watches TV during main meal". Data are shown in table II.

Speeding up

Family meals that were quick to prepare was less frequent in the case of ED patients' parents ($\chi^2 = 11.69$; $p < 0.01$) as well as eat while working ($\chi^2 = 7.38$; $p < 0.05$) and grab fast foods at work instead of a meal ($\chi^2 = 13.72$; $p < 0.001$). Taking into account the family meals including canned, frozen and boxed entrees there was not significant difference between the two groups. Data are shown in figure 3.

Planning

Considering if families cook enough for leftovers, there was not significant difference between the two groups. The strategy of packing a lunch to take to work is less common in the case of ED patients' parents ($\chi^2 = 7.54$; $p < 0.05$) as well as keeping food on hand at work ($\chi^2 = 7.63$; $p < 0.05$). With respect to cooking more on days off there was no significant difference. Data are available in figure 4.

Discussion

In general, some strategies to cope with food choices have been considered as unhealthy and causing feelings of guilt. The stress related with work-family spillover leads to choosing some type of foods (e.g. hot dogs, pizzas), which are considered less healthy for the family members than they would like to be. If working parents were relying on these types of strategies the

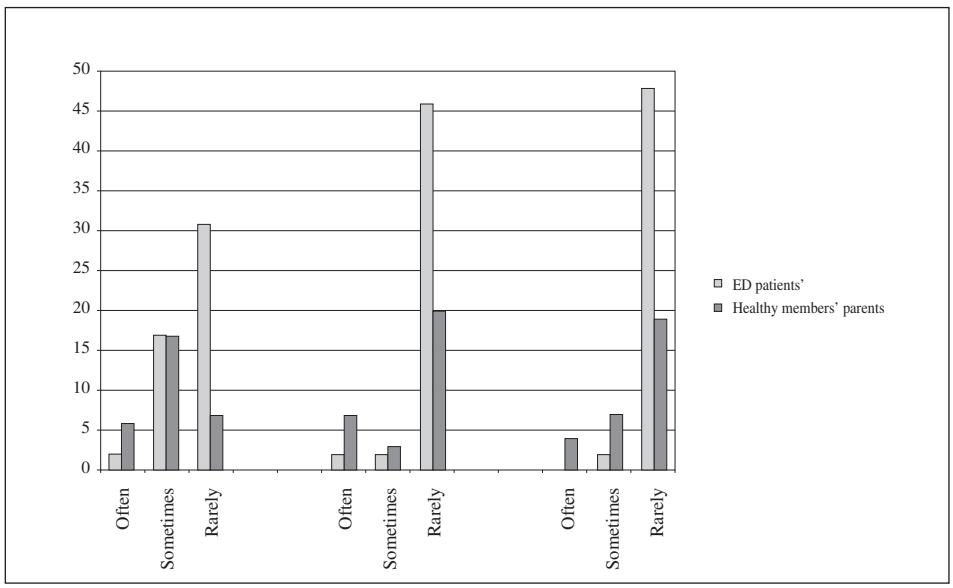

Fig. 3.—Speeding up.

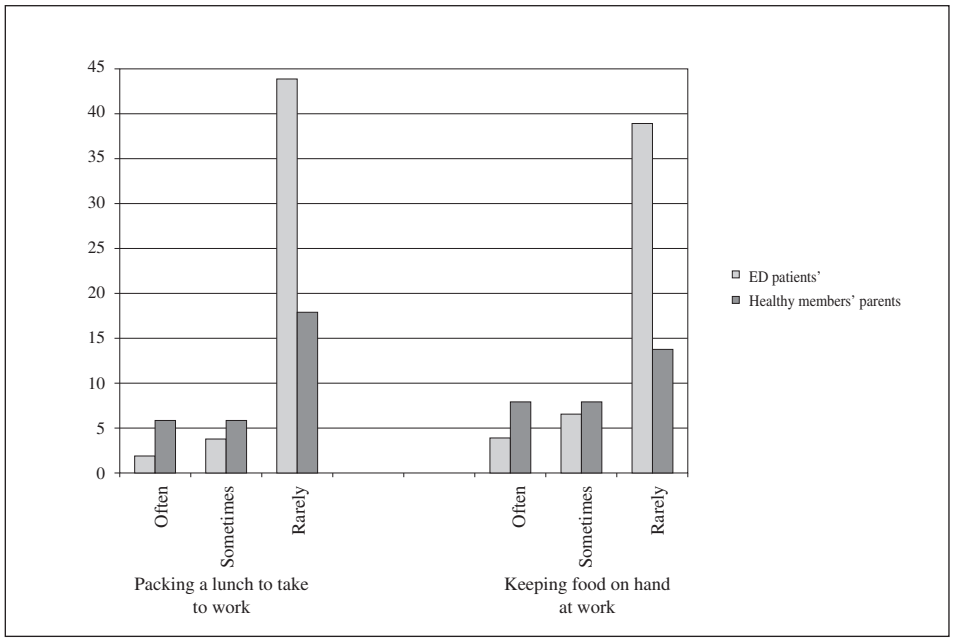

Fig. 4.—Planning.

consequent nutritional limitations would have implications for all family members, children and parents alike[14]. When parents prioritize other activities or responsibilities than food and eating, eating habits and nutritional status may be affected clearly. This seems to be the case of some families in which a work-family conflict leads to a devaluation of other family functions[25]. Some authors have pointed out that value negotiation is a basic process in the construction of food choices[26]. Many times, some strategies as meals eaten in restaurants, frequently fast foods or pizza bars are usual and valued as one of the few calm, quiet, and rewarding times of the week when everyone in the family is present and satisfied with the food. In addition this strategy permits tired parents to relax and eat with all members of the family together[14]. These strategies are a need for working parents but undoubtedly are linked with nutrition and health implications due to the habitual poor quality of meals eaten away from home. Moreover, since there is a link between family meals and the nutritional quality of children's diets, work-family spillover may have relevance for the nutritional status of children[27].

If these points are relevant to be considered in healthy children or adolescents, this relevance must be highlighted in the case of parents-working families and a member suffering from an eating disorder. In the therapeutic process of ED, weight restoration and healthy eating habits learning are key facts with prognostic implications. Usually the process of learning new eating habits involves not only the patients but also all family members (frequently working parents). And a main questions raises: Are ED patients' parents a good model to be followed by the patients? Unfortunately the answer is often no when considering the initial evaluation of the parents and patients eating habits. As a result, the nutritional education of ED patients' parents is absolutely necessary in order to improve the eating habits of the patients, and this is a gold standard when both father and mother work. There are not any reasons to consider that initially parents with children suffering from ED had better food choices coping strategies than the other participants. As a result it would be stated that the nutrition education process was successful to improve those strategies.

Recently an analysis of the eating habits among ED patients' parents has shown that in many cases they follow a hypocaloric, high-in-protein, high-in-fats and low-in-carbohydrates diet with other relevant deficits in micronutrients. The point is that this type of diet was similar among a lot of patients, as it has been noted in former studies[28-31]. This example could be an example of the effect of nutritional education of ED patients' parents with a general result: With respect to the food choice coping strategies ED patients' parents show better skills than parents of healthy members do, and these healthier skills have been acquired during the therapeutic process in which the nutritionist, the patient and the parents work together.

With respect to the preparation of meals, the fact of preparing more meals at home and less fast food as main meal are good examples of those better strategies as well as to miss less number of breakfasts and lunches because of work-family conflict, indulging less frequently and overeat less after missing a meal. Considering the fact of individualising meals, ED patients' parents prepare different meals less frequently and they usually eat the main meal with the whole family together. With regard to speeding up, ED patients' parents use less convenient food, eat less while working and grab less fast food at work instead

of a meal. Finally, among the strategies of planning, the facts of packing lunch to take to work and keeping food on hand at work are less frequent among ED patients' parents. The therapeutic effort to improve the food choices of ED patients' parents, especially when both father and mother work, are a key point to improving the eating habits of ED patients, thus contributing to their better clinical outcome.

The present work has some limitations, the small sample being one, which does not permit us to distinguish among possible differences among ED subgroups. With respect to socio-demographic characteristics, all participants had a moderate income, so considering several levels of socio-economic status, possible differences have not been explored. With regard to the gender, it would be desirable to include a greater number of fathers. Moreover, the strategies of fathers and mothers should be compared in the future. Nevertheless the ratio mothers/fathers of this study represents a realistic approach to the normal treatment environment in the ED units, where mothers are usually the main caregivers. The fact of having assessed the food choices through a self-reported way might influence the results due to a theorical stronger bias in the report of ED-patients' parents. Finally, work and family conditions need to be explored in detail in order to generalize some of the findings of this work.

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