Obese and Hungry in the Suburbs: The Hidden Faces of Food Insecurity

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What is it about those last 30 minutes of clinic?…

OUR LAST 2 patients of the day had just registered when I caught a glimpse of a husky, sulking teenage boy shuffling into examination room 2. It was the end of a long and busy day that had been filled with back-to-school checkups, and a smattering of minor "back-to-sports" injuries. Handing me a thin paper chart and keeping a thicker, dog-eared one for himself, my preceptor cheerfully said *"OK, time to divide and conquer… I'll take the older brother, Sam, why don't you see the younger kiddo, Xavier, in room 3 with his mom, Mrs. Thompson? Just a quick checkup, and don't forget to ask about a flu shot!"*

"Got it!" I replied.

During the first weeks of my intern year, I had quickly discovered how much I loved my continuity clinic. I had been placed in a suburban private practice, while the majority of my peers worked in the large hospital-based resident clinics for their continuity experience. My friends who worked in the resident clinic often chided me that while their patients had "real" needs, my patients' biggest concerns were probably whether or not they would be accepted by the elite preschool or competitive soccer team of their choice, or how to cope with the crushing disappointment of having to wait until their 17th birthday for a new car. At first, I had defended the diversity of my more affluent suburban patients, then I had tried to legitimize their stressors as being just as important to them as those of their less fortunate peers but, finally, I quietly accepted the notion that I had "easy" patients and looked forward to my weekly escape to the suburbs.

Standing outside room 3, my mind drifted to thoughts of my dinner plans later that evening with friends at a new restaurant we had been dying to try. It was still warm enough that we'd be able to sit outside on the sprawling patio overlooking the river and also finally cool enough that sitting outside would actually be enjoyable. As visions of the coming meal flitted around my brain, my stomach growled and I glanced quickly at the chart in my hands, *"11 year old boy… No medical problems… his mother expressed concern about preventing excess weight gain due to older brother's struggle with obesity…"* As my preceptor had said, just a checkup and flu shot. I would be able to make it to dinner on time without any problem.

I entered the examination room to find Mrs. Thompson, a well-dressed, pleasant-appearing woman who immediately introduced herself. She nudged her son, Xavier, who was engrossed in his hand-held video game, instructing him to say hello. Never moving his eyes from the screen in his hands, he shrugged his shoulders and jerked his chin toward me, in obligatory recognition of my presence, muttering something vaguely resembling "hello," and quickly returned to his game. Remembering the nursing notes highlighting Mrs. Thompson's concern about Xavier's weight, I noted to myself that although he may have had a few extra pounds, he was decidedly "normal" in appearance, especially for a growing periadolescent boy, and his weight and body mass index, although increased from his last visit, were not concerning. We sailed through the history and physical examination, both of which were unremarkable. Xavier had a tonsillectomy when he was 6 years old and, with the exception of an occasional cold in winter and a few stitches after a mishap with a tree branch the previous summer, he had been a healthy kid.

When I finished, I gathered my stethoscope and Xavier's chart and, with one hand nearing the door handle, asked if they had any additional questions. Mrs. Thompson casually mentioned her concern that Xavier had been gaining weight, making me realize that although I'd addressed her concern in my head, we hadn't actually discussed it. Moving back toward the examination table from the doorway, I reviewed Xavier's growth charts with Mrs. Thompson. I explained that her son's recent weight gain was normal for his age, and he was securely at a reasonable percentile for weight, height, and body mass index. Mrs. Thompson seemed unconvinced, perseverating on the rate of her son's recent weight gain, his voracious appetite,

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and his family history of obesity, and so, while resting the chart back onto the table, I asked more about Xavier's diet, exercise, and daily routine. Seeing that Mrs. Thompson herself was obese and remembering the substantial silhouette of her elder son, I began discussing my general diet and exercise recommendations for families struggling with weight. At one point in our conversation, I asked how often the family eats outside the home, or eats fast food. Mrs. Thompson quickly replied *"Oh no, we don't eat out. Never, not at all. We can't afford that."* I restated my question, asking again about fast food, still assuming that this family must get many of their excess calories by eating out, and Mrs. Thompson repeated herself insisting *"We don't eat fast food either. We don't have that kind of money."*

Something about her answer struck me. Many of the patients I see disclose eating fast food frequently, and typically justify their choices by stating "*fast food is cheaper and easier than cooking at home*." I had even begun to believe such statements considering the area's grocery prices and the busy lives of the community's children and their families. I find myself constantly discussing, educating, and negotiating healthier options with many patients and families, regardless of their socio-economic status. In my experience, it sometimes seemed that those families who had the least ate outside of their home the most often.

My recent Advocacy rotation had opened my eyes to the reality that, in addition to worsening nutrition and the rise in childhood obesity, an increasing number of families are suffering from food insecurity, a problem that is often quite difficult to assess. So, I probed a little further, asking Mrs. Thompson if her family had enough food at home, half expecting her to dismiss my question, while also hoping she would not become defensive. At that time, I was still apprehensive, afraid of offending a patient by assessing their food security, but there was something about my conversation with this family that made me feel I had to ask. So I did. I simply asked her if they had enough food at home to make it to the end of the month. Mrs. Thompson looked at me cautiously, with a mixture of surprise and suspicion, and then burst into tears. *"No,"* she gasped. "*We don't. I'm so sorry. I'm so embarrassed.*" Xavier shifted uncomfortably on the examination table where he was still seated. He was staring intently at his hands, which had been left empty since his mother had taken away his video game before I examined him. He wrung his hands around one another and glanced at me briefly. When we made eye contact, his eyes darted back to his fingers, where he began nervously digging at his cuticles with his fingernails. I moved from where I had been leaning against the examination table next to Xavier and slowly sat down next to Mrs. Thompson, who was now shaking with tears. I said nothing, giving her time to regain her composure (and myself time to choose what to say next). As her sobs subsided, I asked her to tell me more. She was a single parent, had recently lost her job, and was now in school full-time while also working at her required work activity to ensure she would continue to receive cash assistance. She told me the family relied on food stamps for groceries, and although their allotment typically lasted for only the first half of the month, they somehow were usually able to just get by. Recently, however, her food stamps were cancelled, admittedly due to her misunderstanding of the complicated renewal process, and this had made the past 3 months exceptionally difficult because during the summer months the boys were not receiving free breakfast and lunch at school. She noted that providing 3 meals a day to 2 hungry boys was proving to be nearly impossible.

Listening to her story, I was horrified to learn about the reality of her struggle. Our residency program's Advocacy course included a visit to our local public benefits agency. During this visit, I witnessed the difficult, time-consuming, and often convoluted process of obtaining federal and state assistance experienced by local underserved families. We also visited our city's largest food bank, an organization whose mission is to eliminate hunger by helping families bridge the gap left by inadequately-funded federal and state benefit programs. Mrs. Thompson had visited one such food bank but admitted she was too embarrassed to go anywhere else.

Hunger in suburban families is often overlooked, but recent data have emphasized that suburban food insecurity is present and growing. In 2010, 6.2 million suburban households were classified as food insecure and an additional 2.3 million households demonstrated very low food security.[1] Estimates suggest nearly half of clients served by food banks live in rural or suburban areas.[2] Although patterns indicate that the southern and western regions of the United States are disproportionately impacted, no region remains unaffected. In Ohio alone, 16.4% of families meet criteria for food insecurity making it one of 9 states that fare worse than the national rate of 14.6%.[3,4]

There is a common association between hunger and poverty, but unemployment is an even more important predictor of food insecurity.[5] Suburban unemployment is a growing problem, and the rising number of unemployed suburban families is likely to be accompanied by rising food insecurity. Of particular relevance to the field of pediatrics, both households with children as well as single parent households are both at increased risk of becoming food insecure.[5] The bottom line is staggering; food insecurity affects over 16 million children in the United States.[6] Thus, all practicing pediatricians are seeing food insecure patients, but are we recognizing them?

Another common misconception is that food insecure individuals will be underweight due to insufficient caloric intake. Instead, multiple studies have linked food insecurity as an underlying factor of excess weight gain in children although the strength of such an association remains controversial.[5,7–9] Many factors likely contribute to this phenomenon, such as the predominance of low quality, high calorie foods in the diets of food insecure individuals. Behavioral factors also play a role. For example, food insecure individuals may resort to binge eating when food is available as their food insecurity may call into question the time and place of the next available meal.[9] For Mrs. Thompson, the reality that she

and her son were overweight did not change the fact that they did not have reliable access to food.

Growing awareness of food insecurity and the fact that Mrs. Thompson's family shares the same struggles with many of their neighbors does nothing to fill her empty kitchen. Instead, the increasing demand for federal, state, and local assistance is rapidly depleting supplies and straining agencies at all levels. That evening, I worked with my preceptor sharing the information and resources I had learned during my Advocacy rotation, to provide appropriate contact information for Mrs. Thompson and her sons to gain urgent access to food. We also provided contact information for legal assistance to resolve the food stamp interruption and obtain other benefits. Despite our efforts, however, I felt deeply inadequate, frustrated that at that moment I could really only offer validation, reassurance, and a list of community resources.

That evening I sat quietly at dinner, as my friends chattered around me. Typically I am an animated member of our little group, delighting in the dramatic story-telling of our often bizarre and crazy days as interns. This time however, I sat quietly. My friends didn't seem to notice I was lost in thought, as I remembered my squirming young patient and how he must have ached to escape that examination room, how he winced upon witnessing his mother's confession in the doctor's office, and how he must have felt so torn upon hearing her speak. That image of Xavier had seared itself into my mind, pushing waves of guilt over me as I attempted to choose my entrée. I felt panicked and nauseous as I thought of how easily Mrs. Thompson's and Xavier's food insecurity could have gone unnoticed. If I had not asked, if I had not chosen to probe a little deeper to assuage the nagging feeling in my own gut, how long would they have gone hungry? In addition, I questioned whether I had really done enough and whether I could have done more. How many other families had I seen who were struggling with the same problem, and I had failed to ask? I struggled to understand how such a dichotomy could exist in modern day America, feeling both immensely thankful that I have always had ample access to food, but also deeply saddened that there are people in my own community who can't afford bread and milk.

I wish this was a rare story, a single account of a terribly unique situation. I realized that night, and even more so since, that in contrast, the painful reality of hunger in our country is that it is pervasive, and yet often also invisible. I've known that, as a physician, it is my responsibility to provide a safe, unassuming, and supportive environment in which I encourage my patients, young, old, thin, overweight, wealthy, or impoverished, to seek assistance, advice, and relief. I realized the day I met Mrs. Thompson and Xavier that it is also my responsibility to ask the difficult, awkward questions; the questions whose answers I may be afraid to hear or even be unsure of how to address. These are the questions that also have the potential to allow a family to finally reveal their heaviest burden. To me, allowing my patient's most basic needs to remain unmet by simply failing to ask those difficult questions makes the art of managing complex disease seem so much less important.

Today, several months and many patients later, I still try to carry Mrs. Thompson and Xavier's experience with me into each examination room. Their story is now accompanied by the stories of additional families, each reminding me of the importance of taking the time to assess the very basic needs of each family I meet. I am still frustrated that I can rarely resolve such complicated situations, and a pang of guilt often lingers when I indulge in an expensive meal or throw away leftover food. However, those feelings also serve as reminders that as a physician, I am in a position to provide both an avenue for disclosure as well as important resources for relief to struggling families. To me, making a commitment to assess food insecurity with each patient I encounter is a step toward changing the outcome for the families and children I serve.

REFERENCES

1. Coleman-Jensen A, Nord M, Andrews M, Carlson S. Household food security in the United States in 2010. In: Service USDoAER, ed. Volume September 2011.
2. Cohen R, Mabli J, Potter F, Zhao Z. Mathematica Policy Research. Feeding America. Hunger in America 2010. Arkansas News 2010. February 2010.
3. America F. Map the meal gap interactive food insecurity map. Available at: http://www.feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap.aspx. Accessed December 2011.
4. DeNavas-Walt C, Proctor B, Smith J. Income, poverty, and health insurance coverage in the United States 2007. US Census Bureau. 2008. Available at: http://www.census.gov/. Accessed December 2011.
5. Nord MA, Carlson S. *Household food security in the United States*. Alexandria, VA: Department of Agriculture ERS, ed; 2009.
6. USDA. Measuring U.S. Household Food Security. 2005. Available at: http://www.ers.usda.gov/AmberWaves/April05/DataFeature. Accessed January 22, 2010.
7. Casey PH, Simpson PM, Gossett JM, et al. The association of child and household food insecurity with childhood overweight status. *Pediatrics*. 2006;118:e1406–1413.
8. Rose D, Bodor JN. Household food insecurity and overweight status in young school children: results from the Early Childhood Longitudinal Study. *Pediatrics*. 2006;117:464–473.
9. Dubois L, Farmer A, Girard M, Porcherie M. Family food insufficiency is related to overweight among preschoolers. *Soc Sci Med*. 2006;63:1503–1516.