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A qualitative study of motivators and barriers to healthy eating in pregnancy for low-income, overweight, african-american mothers

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Abstract

Poor diet quality is common among low-income, overweight, African-American mothers, placing them at high risk for adverse pregnancy outcomes. We sought to better understand the contextual factors that may influence low-income African-American mothers' diet quality during pregnancy. In 2011, we conducted semi-structured interviews with 21 overweight/obese, pregnant African Americans in Philadelphia, all of whom received Medicaid and were eligible for the Supplemental Nutrition Program for Women, Infants, and Children. Two readers independently coded the interview transcripts to identify recurrent themes. We identified ten themes around motivators and barriers to healthy eating in pregnancy. Mothers believed that consuming healthy foods, like fruits and vegetables, would lead to healthy babies and limit the physical discomforts of pregnancy. However, more often than not, mothers chose foods that were high in fats and sugars because of taste, cost, and convenience. Additionally, mothers had several misconceptions about the definition of healthy (e.g., "juice is good for baby"), which led to overconsumption. Many mothers feared they might "starve" their babies if they didn't get enough to eat, promoting persistent snacking and larger portions. Living in multigenerational households and sharing resources also limited mothers' control over food choices and made consuming healthy foods especially difficult. Despite the good intentions of low-income African-American mothers to improve diet quality during pregnancy, multiple factors worked together as barriers to healthy eating. Interventions which emphasize tasty and affordable healthy food substitutes, address misconceptions, and counsel mothers about true energy needs in pregnancy may improve low-income, African-American, overweight/obese mothers' diet quality.

Keywords

Pregnancy; Diet quality; Low-income; Motivators; Barriers

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The study was conducted in Philadelphia at Temple University.

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Introduction

Diet quality in pregnancy is a strong determinant of maternal and infant health.¹ Poor diet quality may result in micronutrient deficiencies that predispose to neural tube defects, preterm birth, and infants born small for gestational age.^{2,3} Additionally, reduced fruit and vegetable intake, along with increased consumption of energy dense, fried foods have been linked to excessive gestational weight gain,⁴⁻⁶ increasing risk of diabetes in pregnancy, hypertension, and complications at delivery.⁷

Both income and pre-gravid weight status have been shown to be important predictors of diet quality in pregnancy.⁸⁻¹³ Evidence suggests that low-income, overweight and obese mothers consume less vegetables, iron, and folate and more fried potatoes, juice, whole milk, and high-fat biscuits/muffins than their normal weight pregnant counterparts.^{8,11} Previous investigators have speculated that cost, palatability, and food availability among low-income, obese mothers may be significant drivers of energy dense and nutrient poor choices.¹¹ However, few studies have explored factors influencing diet quality in pregnancy from the perspectives of these high risk mothers,¹⁴⁻¹⁸ and these investigations are limited by a lack of focus solely on dietary intake, little data about motivators and barriers to healthy eating, and scant recommendations for intervention planning. With prevalence rates of obesity among low-income women exceeding 50%,¹⁹ and the highest rates among those self-identifying as African-American, a better understanding of the contextual factors and beliefs that impact low-income African-American mothers' eating habits in pregnancy is urgently needed.

The objective of this study was to understand the perceptions of low-income, overweight and obese, African-American mothers about diet quality in pregnancy, specifically focused on what facilitators and barriers exist to eating healthy. Identifying these perspectives is critical for developing effective interventions to improve low-income African-American mothers' diet quality. We used qualitative research methods because they are ideally suited for understanding how an individual's frame of reference and social context influence health-related behaviors.²⁰

Methods

Study design and participants

We conducted semi-structured individual interviews with pregnant African-American participants in 2011. One of the study authors (A.A.K.) recruited mothers from the waiting room of a single university-affiliated outpatient prenatal care clinic in Philadelphia, PA, which served primarily Medicaid-insured patients. We restricted enrollment to those mothers who self-identified as African-American, were at least 18 years of age, and received Medicaid (income proxy). We included mothers of all gestational ages, but tried to oversample mothers in early pregnancy (first or second trimesters), as dietary quality during this period is especially critical for fetal development and maternal antenatal health.^{17,18}

Of the 49 mothers screened for eligibility, we excluded 9 mothers who were under 18 years of age, 10 who did not self-report African-American race/ethnicity, and 1 who was disinterested, leaving 29 mothers scheduled for interviews. We completed 24 individual interviews, as 5 mothers did not show on their scheduled interview day. For this analysis, we additionally excluded participants with pre-pregnancy body mass indices (BMI) under 25 kg/m² (n=3), as these mothers were few in number and at low risk for poor diet quality in pregnancy.^{8,11} Thus, 21 pregnant participants were included in this analysis. Each participant provided written consent and was compensated for time/travel with \$50 in cash. The Temple University Institutional Review Board approved the study protocol.

Data collection

Interviews were conducted by one of the study authors (S.J.H.), a general internist with nearly 10 years of clinical experience working with low-income, African-American women. The interviewer was white and was not involved in providing health care to the subjects. Interviews were held in a private office near mothers' prenatal clinic; only the interviewer and participant were present for the 60 to 90 minute discussion. The interview guide and prompting questions were developed by the authors and informed by prior research in this area, including previous qualitative studies about eating habits among African-American women.^{21,22} All study questions were pilot tested for clarity among a convenience sample of two African-American mothers.

Questions were divided into two broad categories: 1) eating behaviors and 2) beliefs about eating in pregnancy. Sample behavior questions included: "How has your eating changed now that you're pregnant?"; "Do you prepare your meals or eat out?"; "Do you do the food shopping for you and your family? How do you decide what to buy?" Sample belief questions included: "Do you think your diet is healthy now?"; "What might get in the way of eating healthier?"; "Do you feel like you have control over what you eat and the amount you eat?" Specific probing questions, such as "Can you tell me more about that?" or "Can you help me understand that better?" were used to clarify participant responses and narrow the discussion. Sessions were audio-recorded and transcribed verbatim.

At the time of their interview, participants were also asked to complete a questionnaire assessing demographics, food security (using the short form of the US Household Food Security Module),²³ pre-pregnancy weight, and height.

Data analysis

Using principles of grounded theory,²⁴ two of the authors (N.R.R. and S.J.H.) independently coded the data to identify recurrent themes contained within the text of the interview transcripts, selecting participant comments that served as examples of each theme. Atlas.ti software (version 6.1, 2010, ATLAS.ti GmbH, Berlin, Germany) was used to assist with data coding and management. The first three interviews were used to develop a coding template. The remaining interviews were coded independently by the two authors applying the coding template, which was modified as the analysis proceeded. The two reviewers met regularly to assess the level of concordance regarding themes and their supporting comments, discuss emerging or new themes, and check for completeness of the codes. Coding disagreements were discussed until consensus was reached, with transcripts regularly revisited for context.

Results

Participant characteristics

The majority of mothers were in their first or second trimester of pregnancy ($n = 15$, 71%) and multiparous ($n = 16$, 76%). Mean age was 23.8 ± 5.0 years (range 18–37 years) and mean pre-pregnancy BMI was 32.0 ± 6.3 kg/m² (range 26–41 kg/m²). Approximately one-third ($n = 7$, 33%) had not completed high school and nearly half ($n = 10$, 48%) were unemployed. While 19 (90%) mothers reported they were single, all participants lived with other adults or children (average number of persons in the home was 2.6). Food insecurity was present in 7 (33%) mothers. Despite that all mothers were eligible for the Supplemental Nutrition Program for Women, Infants, and Children (WIC), just over half ($n=11$, 52%) were enrolled in WIC at the time of the interview.

Themes

We consolidated related themes and then separated them into two categories that emerged from patterns within the data: 1) motivators of healthy eating (n=2), and 2) barriers to healthy eating (n=8). Themes and representative quotes supporting each theme are summarized below and in Tables 1 and 2.

Motivators of healthy eating—Mothers shared that they were especially motivated to make healthy food choices during pregnancy in order to have a healthy baby (**Theme 1**). Compared to their eating habits prior to pregnancy, most mothers reported that healthy eating was now a higher priority. *“Now I’m not eating a lot of greasy foods... (Before pregnancy) I wouldn’t say I didn’t care, but I got another life growing in me, so I don’t want to jeopardize my life and the baby’s life.”* Specifically, mothers tried to make food substitutions, consuming less soda, chips, fast foods, and candy because *“there’s no nutritional value in them,”* and instead ate more fruits, vegetables, yogurt, and reduced-fat milk which were *“good for baby”*.

Not only did mothers acknowledge that fatty, fried or fast foods weren't good for the baby, but physical symptoms such as heartburn, which tended to be amplified during pregnancy, also led to decreased consumption of these unhealthy foods (**Theme 2**). *“I like baking (instead of frying). I don’t want heartburn. I don’t want my stomach to feel like sharp pains to where I’m really, really hurt in the middle of the night. I don’t wanna be so gassy.”* Many mothers reported making efforts to eat food that made them *“feel (physically) good.”* *“I feel healthier (now). My breathing is better, my vision is better...I just feel healthier.”*

Barriers to healthy eating—Taste and cost were already powerful influencers of food choices prior to pregnancy and appeared to continue to strongly affect many of these mothers during pregnancy (**Theme 3**). Taste preferences weighed heavily on mothers when making food choices. For most mothers, even if they knew a particular food item was “healthy” and therefore good for the baby, if the food wasn't palatable to them, they would not eat it. *“They got this (unhealthy food) on sale and I’m gonna buy it because I don’t want to taste that nasty, healthy taste.”* Taste seemed equally as important, or even more important, than baby's health in motivating many mothers' food choices.

Several mothers perceived healthy eating to be more expensive. Cost and taste converged when mothers described hesitation to try new foods because they couldn't be sure if they or their families would like the taste, citing the potential waste too high a cost. *“When I’m in the supermarket, it’s too risky to buy it (healthy food) and then get it home and nobody likes it... I wanna try these different things, but I’m just so afraid to spend my money on it and then no one wants it.”* Additionally, mothers shared that they occasionally purchased healthy foods, like fresh fruits and vegetables, but they couldn't afford to eat them daily. *“I don’t like buying them (prepared salads) too much, ‘cause I think they’re kind of expensive. Sometimes I don’t have money to spend.”*

Overall, the participants in our study lacked resources such as reliable transportation and nearby grocery stores, making convenient corner stores, filled with mostly high-calorie, nutrient-poor options, a favorite choice (**Theme 4**). Since the majority of mothers did not have cars and used public transportation to get around, frequent grocery shopping was uncommon. *“I don’t drive. So, when I get to the store, I have to go shopping for the entire month, because getting on the bus to go get groceries, it’s too much.”* Smaller purchases were typically made at nearby corner stores or small grocers in between larger monthly trips. *“(I go to the corner store) definitely every day... The supermarket, I would say once every two weeks. Depending on how fast we eat the food.”* Trips to the corner store were typically for just a few items such as, *“chips or doughnuts, cake, water ice, stuff like that. We go*

mostly every day. When you go to the (corner) store, you just see so much stuff that you want, and then you just get it."

Most mothers reported fluctuating food supplies which also discouraged healthy eating (**Theme 5**). Many reported living in large, multi-generational households. *"It's me, my mom and her boyfriend, my sister and her boyfriend, my little brother, my cousin, and my grandma (that live in the house)."* They also frequently reported sharing resources (food stamps, WIC benefits) out of necessity. *"I give my mom my Access card; she goes shopping. She spends all the food stamps every month - say, six or seven hundred for food at her house."* Sometimes this led to competition over preferred food items. Mothers who lived with their own mothers, older sisters, or even grandmothers often reported less control over their food choices, both in shopping and cooking, especially for family meals where fried foods were most common. *"She (mom) makes most of the decisions. We get the same thing every time we go shopping."* *"She (grandmother) ate the whole thing. I was upset about it... She just ate the whole pack within a few days! Oh my goodness. I couldn't believe it and I couldn't even say anything to her."* While mothers would sometimes have healthy foods, healthy options were not consistently available for many. *"When it gets close to the end of the month it (healthy food) always seems to run out, and then she (mom) has to scrape up money for food."*

Many mothers were not in the habit of eating regular meals and endorsed persistent snacking throughout the day, which increased during pregnancy because of intense cravings or to control nausea symptoms (**Theme 6**). *"I don't decide; I just eat whatever I crave for."* Additionally, taste, convenience and fatigue also influenced mothers' meal patterns (e.g., choosing to snack over preparing a meal). *"Lunch is probably a juice or soda and chips or candy."*

Pregnancy-related fatigue and sleepiness inhibited cooking, and thus, discouraged healthy eating (**Theme 7**). *"Before I got pregnant, it was like the day was my thing; I was just up doing stuff... especially when it came to cooking. But now, I barely get off the couch."* Several mothers reported improved energy as the pregnancy progressed, but others still weren't able to return to cooking. *"At the beginning (of pregnancy) I was real tired. Felt like doing nothing. I was lazy. I wouldn't cook nothing - I'd rather buy it."*

Several misunderstandings about what defines "healthy" were revealed during the interviews which were additional barriers to healthy eating (**Theme 8**). Juice was a favorite for most mothers, who felt like this beverage was a healthy option. Several mothers preferred fruit-flavored drinks or ginger ale, citing them as good for mom and baby. *"I think my Clear Fruit™ drink is healthy because it's got the kiwi strawberry and that stuff."* Some mothers inaccurately labeled high-calorie meals as snacks, depending on fullness, timing or utensils needed. *"(A snack is) like a burger, some fries. I just don't consider it lunch yet. It don't really fill me up."* *"(A snack is) something simple; it isn't a whole plate that I have to eat with a fork."*

Mothers expressed that they didn't want to deprive or "starve" their babies, promoting excessive food intake and poor diet quality (**Theme 9**). Almost all mothers shared the belief that eating too little could harm the baby, but few realized the dangers of overeating during pregnancy. *"For me... with the baby, it's like the food is not even going to me. It's like it's going straight to the baby, so... I just be hungry."* In particular, mothers seemed to connect hunger and cravings or baby's movement to specific food-related needs. *"If she's moving, then it's like, 'okay, well maybe she wants something'. When she moves, it's like, 'maybe I'm hungrier than I feel. Maybe she needs something special'."*

Family pressure to eat influenced mothers, often in a negative direction (**Theme 10**). *“My family says eat as much as I want. And just keep eating, ‘Cause it’s good for the baby.”* Some well-intended advice may have contributed to larger, more frequent meals for some mothers. *“My mom is like, ‘you’re not eating right. You can’t just eat cereal or a granola bar. You need to actually make breakfast. Make eggs, pancakes, grits, and give her (baby) bread so that she’ll be full’.”*

Discussion

Despite the good intentions of low-income, overweight/obese, African-American mothers to improve diet quality during pregnancy, multiple factors worked together as barriers to healthy eating. These included cost, palatability, and food availability, along with several factors unique to pregnancy: fatigue/sleepiness, family pressure to eat, and feelings that baby could not be deprived. Most mothers wanted to eat healthy foods for their babies, but lacked knowledge about what defined “healthy”, and thus, routinely made nutrient poor food choices. Additionally, living in multigenerational households and sharing resources (food stamps, WIC benefits) limited mothers' control over food choices and made consuming healthy foods especially difficult.

Our findings are consistent with several other studies exploring diet quality/quantity in pregnancy among low-income women.^{14,16,18} Mothers in these studies similarly believed that eating healthy foods was good for baby's health, yet cravings and palatability seemed equally as important, or even more important, in driving many mothers' food choices. Misconceptions about what is “healthy” and easy access to energy dense, nutrient poor foods were also significant barriers to healthy eating. Like in our study, family members and friends posed major obstacles to healthy eating in these investigations, both in controlling food cooked at home and in encouraging mothers to “eat for two.” However, we did not find that stress or depression were strong drivers of increased food consumption, differing from Paul *et al.* and quantitative papers on the topic.^{14,25} Instead, for the few women who spoke about the topic, depression and stress seemed to be more of an anorexiant than a food stimulator (data not shown). Our findings that food access, availability, and cost negatively influenced diet quality also differed from the Paul *et al.* paper,¹⁴ which may in part reflect our solely urban, African-American, overweight sample (compared to Paul's mixed race, mixed BMI, mixed urban and rural population) and the fact that only half of our sample took advantage of WIC benefits at the time of their interview (since data suggest that WIC participation does lead to improved diet quality).²⁶

Given that low-income, overweight/obese, African-American mothers had many more barriers than motivators to healthy eating in pregnancy, lifestyle interventions need to be particularly sensitive to these barriers. For example, to overcome mothers' lack of eating schedule in pregnancy, intervention messages could focus on tips for decreasing impulse purchases (e.g., create a shopping list to ensure that healthy foods exist at home) or encourage planned meals/snacks through texting (e.g., texting moms reminders about what/when to eat at scheduled mealtimes). Additionally, it may be helpful to focus intervention messages on the motivators of healthy eating, empowering mothers to find healthy food substitutes that are good for baby and also reduce the physical discomforts of pregnancy. Since family members are also primarily motivated by “what is best for baby”, involving family in discussions around food is essential to encourage improvements in low-income mothers' diet quality.

While qualitative research has several strengths, including the use of open-ended questions in order to develop new hypotheses, there are limitations to studies using these methods. Only a small number of similar participants are typically recruited, and thus, results cannot

be generalized to other populations. In our study, we focused solely on low-income, urban, overweight/obese, African-American mothers, who were recruited from one prenatal clinic, limiting our generalizability to mothers of higher-income, normal or underweight BMI, rural surroundings, or different racial/ethnic groups. However, results are meant to provide greater depth about a particular group or topic that can be used to develop interventions for that specific group.²⁷

Conclusions

Our qualitative study among low-income, overweight/obese, African-American mothers uncovered many more barriers to healthy eating in pregnancy than motivators of healthy eating. These barriers may explain the large proportion of low-income African-American mothers' with poor diet quality. Interventions aimed at overcoming obstacles to healthy eating may improve diet quality in pregnancy, and thus, lead to improved outcomes for both mothers and their babies.

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Table 1
Low-income, overweight, African-American mothers' motivators of healthy eating in pregnancy

Themes	Representative quotes
1. Healthy mom means a healthy baby	<p>22 yo,^a overweight, nulliparous: "When I eat, I'm making conscious decisions. I try to think about the healthiest thing to eat and I'm eating better now. I want to eat salads. I feel better when I eat good, and I want to eat good because I want her (my baby) to get nutrition, too."</p> <p>18 yo, overweight, nulliparous: "I used to eat eggs, bacon, home fries for breakfast, but it's a lot of grease and oil. Now, I just don't wanna eat it...I think it might be bad for the baby. (But after I deliver my baby), I'll be back to my old ways."</p> <p>32 yo, overweight, multiparous: "I'll make my own lunch. I'll bring soup or something cooked from the night before. Or I usually go and get a sandwich...lunchmeat...I get wheat bread, cheese, mustard, lettuce, tomatoes... If it's not good for my baby, it's not good for me."</p>
2. Physical symptoms, like heartburn and nausea, inhibit unhealthy food intake	<p>22 yo, overweight, nulliparous: "(I used to eat) a lot of processed foods, fried foods, but now, I can't even take fried foods. I'll have heartburn for hours, and it's just horrible."</p> <p>20 yo, obese, nulliparous: "If I eat, like, fried chicken. Fish too. It'll scare me. I'll get this really bad heartburn, so I'll just stop for a couple of days and not eat like that."</p> <p>21 yo, obese, multiparous: "I'm slowing down with the soda. I'm drinking more juice or water than soda, now.... (Because) It blows you up real, real big (from gas), and the acid... Yeah, soda and the greasy foods, like the fried chicken, that'll do it, too."</p>

^a
year-old

Table 2
Low-income, overweight, African-American mothers' barriers to healthy eating in pregnancy

Themes	Representative quotes
3. Taste and cost are strong drivers of food intake	<p>27 yo,^a overweight, nulliparous: "I tried Crystal Light and the diet drinks, but they had a weird taste. A lot of diet drinks are disgusting to me. I don't drink diet drinks."</p> <p>27 yo, overweight, multiparous: "I might call my mom, 'I want this. I got a taste for this'. And that's mostly the Lay's potato chips and cream cheese. I got to have that in the house. I cannot run out of that at all."</p> <p>32 yo, overweight, multiparous: "I really have to stretch it (food stamps). Because my son, he'll want something. You know kids. So I try to make sure I have what he needs... Sometimes I do get less for myself. I'm not complaining about it because as long as he's happy, everything's fine."</p>
4. Limited access to healthy food, but easy access to unhealthy food	<p>31 yo, obese, multiparous: "I don't get to the market that often. I go maybe twice a month. Maybe. So it's stuff like fruit, as quick as it's in the house, it's gone. So it's there a couple of days tops. There's nothing in the neighborhood. So I actually don't get it (fruit) as often as I'd like."</p> <p>22 yo, obese, multiparous: "At school I don't bring my own lunch, so I buy fast food. During lunch time. There don't be that many places around to get healthy food."</p> <p>21 yo, obese, multiparous: "The supermarket is good. But the corner store - when you're out and the corner store's right there, you just want something to snack on. I mean, if the corner store was a whole mile, two miles from your house, you would be like, 'no, I'm not going there'. But it's right there. It's 15 steps and you're there."</p>
5. Food supply fluctuates each month	<p>22 yo, overweight, nulliparous: "My brother, he's like, 'if you don't want me to eat your stuff, just tell me'. And I told him. I said, 'these Nutri-grain bars are mine'. And then he'll just eat all my stuff like, 'oh, I forgot, I didn't know'. So I try to hide them...but then they call me stingy."</p> <p>20 yo, obese, nulliparous: "When I get to the end of the month, I'll probably still have some food, and I'll be like, 'I don't want that stuff no more. I want something new'."</p> <p>26 yo, obese, multiparous: "We (household with cousin and cousin's children) all share. We all get food stamps and we shop together. Her kids is kind of picky, so I just buy what I want and tell everybody, 'don't eat it'. And she just buy what she need, and we just go equal shares on all other stuff."</p>
6. Lack of meal schedule persists in pregnancy	<p>19 yo, overweight, multiparous: "I could just sit there and eat snacks and not eat food. It depends on how I'm feeling."</p> <p>22 yo, obese, multiparous: "I've never been a person that ate breakfast, lunch, and dinner. Probably just lunch and dinner."</p> <p>21 yo, obese, multiparous: "I just want something to put in my stomach while I watch TV... (I'm not hungry) most of the time, no. Just eating 'cause it's there."</p>
7. Pregnancy-related fatigue and sleepiness inhibit cooking	<p>20 yo, obese, multiparous: "When I get tired, I eat more of the fast food. 'Cause it's more of, 'I'm not cooking tonight, we're going to find something to eat outside'...a Chinese store, a pizza store. Or something quick, like a TV dinner."</p> <p>37 yo, obese, multiparous: "I don't have a lot of energy. I'm used to, you know, working, cleaning. Even before pregnancy, like cleaning around the house. It's like I can't do nothing now... I can't stand for long. I don't like to cook no more. Nothing."</p> <p>26 yo, obese, multiparous: "After I eat, I'll just be tired... Before I got pregnant, I never was tired after I ate, I'd just go outside and run around, but it's like the baby's like, 'okay, I'm going to sleep', so I should just rest."</p>
8. Misunderstanding about what defines "healthy"	<p>22 yo, overweight, nulliparous: "I actually was mad because I bought Juicy Juice, and that's baby juice, and somebody decided to drink it. And I didn't want to make a big scene about it because we all pitch in. It's like, 'why my Juicy Juice? Out of everything?' I will be like that for the healthy foods."</p> <p>26 yo, overweight, multiparous: "I used to drink a lot of soda, but I cut that back a while ago. And now the soda I drink is ginger ale. There's an added benefit, 'Cause it's ginger ale. And cola's just sugar."</p> <p>27 yo, overweight, multiparous: (Favorite snack-potato chips dipped in cream cheese) "Do I think it's healthy? Yeah, 'cause I don't get sick with it. I think it's light and it don't have that much fat in it."</p>
9. Mothers don't want to deprive their babies	<p>25 yo, overweight, nulliparous: "Sometimes I wanna eat one plate. Sometimes I wanna eat more than one...I can't control it, it comes from the baby."</p> <p>27 yo, overweight, multiparous: "I'm not gonna starve my baby 'cause that's just selfish."</p> <p>20 yo, obese, nulliparous: "I would crave for something, but it's not only me craving for it. The baby craves for it, too. So the baby wants fried chicken, I'm like, 'oh well'. I can't turn the fried chicken down, because if I eat something healthy, I might throw it up because the baby don't like it."</p>
10. Family and friends pressure mothers to eat	<p>25 yo overweight, multiparous: "Sometimes if I don't have an appetite, he's (husband) like, 'just eat something'."</p> <p>22 yo, overweight, nulliparous: "She (mom) gave me the portion. I was like, 'whoa, this is a lot'. She was like, 'oh, you're eating for two! It's not that much'."</p> <p>37 yo, obese, multiparous: "My boyfriend tell me, 'eat, eat, eat'. He always cooking or bringing me food... I never say, no."</p>

^a year-old