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THE PLACE OF DIETARY PRACTICES IN THE LIVES OF OLDER WOMEN

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THE PLACE OF DIETARY PRACTICES
IN THE LIVES OF OLDER WOMEN

ABSTRACT OF DISSERTATION

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in the Graduate School at the University of Kentucky

By
Lisa Marie Curch

Lexington, KY

Director: Dr. John F. Watkins, Associate Professor of Geography

Lexington, KY

2002

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ABSTRACT OF DISSERTATION

THE PLACE OF DIETARY PRACTICES
IN THE LIVES OF OLDER WOMEN

Studies have supported the benefits of positive dietary behaviors in preventing or reducing morbidity and extending longevity, as well as the psychosocial function of dietary practices for quality of life. Research is needed though on the dietary behaviors of elders in general and older women in particular, for whom gender affects lifelong dietary patterns. Health behavior theory has typically focused on psychological factors, to the neglect of sociocultural processes. This investigation utilized a life course perspective, enhanced by social interactionist elements, to address aspects of development and change in behavior neglected by health behavior theories, such as temporal dimensions and social contexts.

Using primarily an ethnographic approach centered on in-depth narrative interviews of 18 older women residing in a retirement community, this study explored how social milieu influences the development and progression of dietary behavior throughout life, the potential of life course transitions to modify dietary behavior, and how the retirement community environment shapes current dietary behavior. The interviews probed current dietary experiences and practices, as well as constructed histories of dietary behavior. Through the use of coding techniques and thematic analysis, themes and concepts that emerged from the data were organized for further analysis.

Four levels of influence on dietary behavior were identified: 1) person factors, including psychological and physiological processes; 2) interpersonal relationships and social interaction;
3) social roles and statuses; and 4) contexts, particularly environmental, community policy and political economic contexts. Analysis additionally revealed four major food-related themes in the lives of the women: dietary morality, dietary wellness, dietary sociability and dietary duty.

Interpretation of the findings, in terms of lifelong social experiences, the impact of relationships, roles and transitions, and structural characteristics of the retirement community that constrain or facilitate dietary practices, contributed to the development of a theoretical model. The research findings and model of life course influences on the nature of dietary behaviors of older women provide a more holistic understanding of dietary practices of older women and have implications for future research and practice, particularly as related to quality of life issues.

KEYWORDS: Dietary Behavior, Life Course, Older Women, Retirement Communities

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THE PLACE OF DIETARY PRACTICES IN THE LIVES OF OLDER WOMEN

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DISSERTATION

Lisa Marie Curch

The Graduate School
University of Kentucky
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Dedicated to Christopher Curch
For his love, support, and ability to make me laugh
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Chapter One
Introduction

Colonial Square¹ is an independent living retirement housing community in the heart of Kentucky, and the residence of about two hundred older people, who all have a wealth of personal experiences and unique life stories from which much can be learned. Eighteen women who make a home in the physical place called Colonial Square opened up their lives to me and allowed me to explore the sociocultural place of food and eating in their lives. I probed social contexts and influences on their dietary actions of the past, present and future, and examined how daily life at a retirement community structures current dietary behavior. One theme in their stories was magnificently apparent: Food and eating are much more than bodily nourishment.

This insight in and of itself is not a profound revelation. What the lay public has long known, and scholars have also recognized, is that food practices contain multiple sociocultural meanings, functions and implications. Lupton (1996, p. 7) purports that a social science perspective on food and eating considers what it means in the context of a culture, and argues that the practices surrounding the foodways of people (food acquisition, preparation and consumption) may be governed by biological needs, but “these practices are then elaborated according to cultural mores.” Dietary behavior, therefore, is much more complex than traditional nutritional or biological perspectives might portray.

It is this very nature of the social aspects of dietary behavior that renders it so fascinating a topic for study. Personally, I have greatly enjoyed food for as long as I can remember. One of my early memories is a happy one of my grandparents, my parents and myself at a Red Lobster restaurant, and I recall the extremely satisfying taste sensation of Alaskan snow crabmeat dunked in melted butter. I have vague impressions of the setting – dimmed lighting and a candle in a red holder are about all I can conjure up – but the delight in that crabmeat is clear, as is the attention that my zealous love for seafood brought me. As the story goes, a pound of crab legs were ordered for me, and to the astonishment of my grandparents, as a little three-year-old girl, I ate every bite, cleaning those leg shells out (and I still love seafood). Fast forward to almost

¹ Colonial Square is a pseudonym, to protect anonymity and confidentiality.
twenty years later, and as a new bride, I am dismayed at my new husband’s lack of food safety awareness. How could he possibly use the same cutting board for cutting up raw chicken and chopping vegetables, without fully sterilizing the board in between? Was he crazy? Perhaps he thought I was. I became cognizant that not everyone learned the same food practices as I did growing up, and that apparently having two parents who were in the medical field produced a heightened consciousness of bacteria lurking in foodstuffs. My husband is now very careful, particularly with raw meat, though he may be just as motivated to avoid my consternation as he is to practice food safety.

Seven years later, and knowing firsthand the impact of early life experiences and life transitions such as marriage on foodways, I found myself in the midst of doctoral research, attempting to more fully understand social impacts on dietary behavior across the life course. Appreciating that the female gender traditionally is responsible for providing nourishment for others, I talked with older women about their past and present experiences, seeking to address three research questions:

1. How does the social milieu (particularly familial) shape dietary behaviors, affecting the development and maintenance of behaviors throughout life among elderly women?

2. How do life course transitions, especially changes in residence and familial states (e.g. marriage, widowhood, child bearing and child launching) potentially modify dietary behaviors?

3. How does the retirement community environment shape current dietary behaviors of older female residents?

These questions guided the in-depth life history narratives (including “food history” narratives) that I collected from the eighteen older women at Colonial Square. These narratives and participant observation notes provided the data for my qualitative analysis. I chose qualitative methodology for the research because of its capacity to elicit issues of context and meaning, and to gain the perspectives of the women, in their own voices.

From the stories of the women, important perceived influences on their dietary experiences surfaced, and the nature of their current dietary experiences were related. Themes regarding the women's relationships to food and eating emerged, and their approaches can be
broadly categorized as dietary morality, dietary wellness, dietary sociability, and dietary duty. I primarily utilized a life course research framework to understand current and past influences on dietary behaviors of older women, but I also integrated symbolic interactionism, and drew from social cognitive theory, social support perspectives and ecological models. I developed a conceptual model of influences on dietary behavior of older women out of the research findings, which furthers our understanding of how social theories and perspectives such as the life course perspective and symbolic interactionism can inform theorizing about health behavior in general and dietary behavior in particular. Therefore, a more holistic picture of dietary behavior of older women was pieced together through illumination of meaning, context and sociocultural mechanisms of influence.

The following sections of this chapter begin by briefly addressing why the study of health behavior, and especially dietary behavior, of older adults and social influences on health behavior over the life course is a worthy investigation. Included next is a short section on possible outcomes of such research, and Chapter One ends with an outline of the remaining dissertation.

Health Behavior, Dietary Practices and Aging

The study of the health behavior of older adults is a relatively recent area of research, although the last twenty to thirty years have seen a steady increase in our basic knowledge (Ory, Abeles & Lipman, 1992). It is an important area for research because of the significant impact that a host of behaviors and habits exert on health and well-being. According to the U.S. Department of Health and Human Services (USDHHS, 2000), behavioral and environmental factors are responsible for 70 percent of all premature deaths in the United States. Many of the leading causes of death (e.g. heart disease, cancer, stroke, diabetes) and other chronic illnesses affecting older adults (e.g. hypertension, osteoporosis) can be attributed, at least partially, to health-related behaviors such as smoking, dietary and exercise practices. Prior to the late 1980s, however, it was thought that behavioral factors did not matter in later life, and that changes in later life could not reverse any damage that had already been done (Kaplan, 1992).

Recent research has shown that altering behaviors and maintaining healthy behaviors can influence morbidity and mortality even into advanced ages (Fries, 2000; Kaplan, 1992). Healthy People 2010 (USDHHS, 2000) has noted significant health benefits for older adults who improve
health behaviors, and has strongly encouraged such improvement. According to Wilcox and King (1999, p. 287), the bulk of evidence shows that appropriate health behaviors “can prevent or control many chronic diseases and can reduce functional disabilities that increase with age. These behaviors also can lead to significant enhancement of the quality of life and general well-being of older adults.” The International Longevity Center (2000) reported that it is never too late to improve health through a healthy lifestyle, and that the risks involved with unhealthy behaviors cannot be out-lived. Evans and Cyr-Campbell (1997) even suggested that some physical age changes (e.g. reduced muscle mass) are not age-related at all, but the result of health behaviors (e.g. amounts and levels of physical activity).

Despite the shift in thinking about older adults and health behavior, there remains a relative lack of basic knowledge about the health behaviors of older adults. We do know that older adults in general appear to follow healthier lifestyles. In the Alameda County study (Berkman & Breslow, 1983), more people age 75 and older reported practicing all seven of the positive health behaviors studied (concerning diet, physical activity, sleeping, alcohol use, and smoking) than in any other age group. However, various patterns of health behavior practices of older adults have been found (e.g. Rakowski, Julius, Hickey & Halter, 1987; Walker, Volkan, Sechrist & Pender, 1988). Walker (1997) observed that the heterogeneity of older adults extends to their health behavior practices, and although many follow healthy lifestyles, many do not. Kaplan and Strawbridge (1994) remarked that the heterogeneity of the older adult population supports the importance of behavioral and social factors as they influence health in later life. Genetic and biological factors certainly play a role in the health of an elder, but behavioral and social processes are critical. As Kaplan and Strawbridge (1994, p. 59) explained:

In the case of genetic factors, the behavioral and social environment provides the context that determines the expression of these factors. Even more importantly, behavioral and social factors may dynamically interact with biological processes to determine the health of the elderly.

Particularly lacking is knowledge about the meanings associated with behaviors, social contexts of behaviors, and factors that determine, stabilize and change behaviors over time. Much research and theory on health behaviors of adults in general has focused on cognitive and
psychological processes, such as motivation, beliefs, efficacy, and locus of control (Bennett & Murphy, 1997). This tendency is further evident in studies of older adults’ health behaviors, too. The sociocultural and temporal aspects of health behavior in later life have not been adequately addressed.

Detailed examinations of actual health behaviors of older adults, and the foundations of such behaviors, are needed. Furthermore, situating the health practices of older adults within social and historical contexts, as well as the individual’s personal and family histories, may reveal a more holistic view of the behaviors studied. Constructs such as self-efficacy, locus of control and beliefs are commonly found in the literature (e.g. Grembowksi et al., 1993, Huck & Armer, 1996, Rakowski & Hickey, 1980). Yet Nowicki’s (1996) demonstration of the effects of the Depression on one older woman’s dietary behavior, and O’Brien Cousins’ (2000) illustration of the effects of marital and societal contexts on elder women’s physical activity, both confirm the existence of a bigger picture regarding factors affecting the health behaviors of older adults.

As for specific health behaviors, research has implicated dietary behaviors as particularly relevant for physical well-being of older adults. The physiological benefits of a nutritious diet seem to be well known to both the scientific community and the American public. Diet is a factor associated with five of the ten leading causes of death: coronary heart disease, atherosclerosis, stroke, diabetes, and some types of cancer (Institute of Medicine, 2000; Wilcox & King, 1999). Eating habits are also a factor associated with some chronic diseases, such as osteoporosis (Institute of Medicine, 2000; White & Ham, 1999). Obesity is a common nutritional problem that affects older adults, but nutritional deficiencies are also of much concern (Institute of Medicine, 2000; White & Ham, 1999).

There is further evidence that dietary behaviors could contribute to psychosocial well-being. Positive health behaviors in general can help maintain physical functioning, prevent morbidity and disability, and ameliorate the effects of disease, and thus become a strategy for an older adult to preserve his/her independence (Evans & Cyr-Campbell, 1997; O’Brien Cousins, 1998). As noted by Amarantos, Martinez and Dwyer (2001) and Drewnowski and Evans (2001), good nutrition and dietary behaviors can also greatly impact an elder’s quality of life. All of the authors highlighted that research commonly attempts to evaluate dietary practices, interventions and programs in terms of the classic biomedical endpoints: mortality and morbidity. The concern
emphasizes the lowering of mortality rates and reducing the risk of disease and illness. Certainly this is important, especially reducing morbidity, since even a small change in morbidity can have a large impact on quality of life. As Morley (1995, p. 63) pointed out, the “impact on quality of life of a 95-year-old who does not fracture a hip when falling because of nutritional (calcium and vitamin D) and exercise interventions is immeasurable.”

Yet, as Amarantos et al. (2001) alternatively pointed out in their work, quality of life is more than mortality rates and goes beyond reducing morbidity and optimizing function, and they contended that quality of life also involves life satisfaction and mental well-being. They called attention to a gap in quality of life research, in that nutrition and dietary practices have not been included among influential domains. Drewnowski and Evans (2001, p. 89) asserted that “such factors as perceived mastery and control, enjoyment of the diet or satisfaction with exercise programs may be as important to quality of life as is reduced plasma cholesterol or increased grip strength.” Indeed, some researchers, in discussing disease prevention and health promotion related to diet, have warned that certain dietary changes may not be worth considering because they offer relatively little benefit, and may do more damage to the older adult if the change renders eating and meals less enjoyable for the elder, which in turn could lead to nutritional repercussions (Morley, 1995).

The potential for economic consequences is another consideration. Though not thoroughly tested, it has been proposed that improved nutritional status and healthy dietary practices could ultimately save a substantial amount of money for consumers, the government and health care organizations in terms of health care costs (Frazão, 1999; Leigh & Fries, 1992; Stearns et al., 2000).

Social Aspects of Health and Dietary Behavior

Investigation of social contexts, such as family and gender, is needed in health behavior and aging. Family experiences and family life transitions have been shown to affect dietary behavior (Backett & Davison, 1995; Devine, Connors, Bisogni & Sobal, 1998). But such experiences and transitions have neither been examined in depth, nor have they been studied in later life or as earlier determinants of dietary behavior in later life. There is little work, for example, examining the impact of widowhood or caregiving in later life on dietary behavior,
or how experiences in childhood may have been carried throughout life. Devine et al. (1998) have demonstrated that past life course events and transitions have an impact on the fruit and vegetable choices of adults. Of the work that has been conducted specifically on the influences of life transitions, with some exceptions (e.g. Rosenbloom & Whittington, 1993), such research has generally focused on transitions in early adulthood (about ages 18 to 40).

Backett and Davison (1995), Kemmer, Anderson and Marshall (1998) and Umberson (1987) demonstrated that changes in family status might cause health behavior change for younger adult age groups. Some research, including that of Louk, Schafer, Schafer and Keith (1999), has compared different family stages from young to old, but such research does not adequately address possible cohort effects, alternative family structures, nor possible reasons for why being in a different family stage should result in altered behaviors.

Nor do such life stage approaches consider how experiences and preferences extend and are modified across the life span in terms of gender. Women comprise the majority of the older adult population, have more chronic illnesses, and generally attend to the health, and dietary, matters of their families. Differences in health behavior practices among men and women begin to appear at young ages, and there may be differences in meaning associated with health behaviors (Leventhal, 2000). Women also have been subject to certain societal expectations and stereotypes regarding particular health behaviors (O’Brien Cousins, 1998; Verbrugge, 1990).

Though the social aspects of dietary behaviors are less frequently mentioned in the health literature, they might have powerful meanings associated with them, and may be very important for psychosocial quality of life for older adults. Sidenvall, Nydahl and Fjellstrom (2000) interviewed older women about the meaning of food and cooking. Being able to cook for someone else and to give meals and food as gifts were acts associated with feelings of comfort, intimacy and joy. If the gift giving aspect was lost, as it often was for the widows who lived alone, the researchers found that the meaning of cooking also disappeared, and “thereby a risk of lost self-esteem as well as declining nutritional intake arose due to meal skipping” (Sidenvall et al., 2000, p. 421). As illustrated by the authors, social aspects of food are related to personal meaning and other intrapersonal dimensions, such as self-esteem. One can easily argue that the inclusion of social aspects of dietary practices is very relevant and important for both physical health outcomes and psychosocial quality of life.
Theoretical Needs and Outcomes of Research

Gochman (1997) stated that basic research in health behavior that establishes sound theoretical foundations would improve the effectiveness of health promotion and education efforts. Prohaska, Peters and Warren (2000) have similarly contended that health care professionals need to have appropriate theory and information available to them, in order for intervention strategies to be most effective when used with heterogeneous and diverse groups, such as older adults. In addition to improving health promotion and education efforts, basic research might also provide health care practitioners with more insight into their clients’ reasoning and circumstances surrounding behaviors, and therefore might be able to provide more person-centered and tailored care and recommendations for their clients.

Health policy and government initiatives could be better informed by a more contextual understanding of sociocultural influences on health behaviors, such as policy that is concerned with health promotion and education and preventive health care. But there are other policy implications, particularly in terms of economics and costs. As previously mentioned, some evidence suggests that positive health behaviors (e.g. healthy eating habits) can lead to decreased costs in medical care and treatment, while negative behaviors (e.g. smoking) can increase expenditures (Stearns et al., 2000).

As discussed earlier, much of the discourse on outcomes of dietary behavior centers on such physical health-focused results. Economic savings to the government and consumers are sometimes invoked, but more often the biomedical endpoints of morbidity and mortality are discussed, in terms of delaying mortality and reducing morbidity. Nutritionists, clinicians and other health professionals seek to intervene in individuals’ health behavior performance and modify habits for the sake of physical health, a worthy intent to be sure, but one that falls short because quality of life is about more than physical health; it is also about psychosocial well-being and overall quality of life.

Outline of Dissertation Chapters

The next chapter, Chapter Two, provides background material, covering literature in later life nutrition and dietary behavior, social aspects of dietary behavior over the life course, and theoretical foundations of this research. Chapter Two demonstrates how this research fits
into the existing literature and therefore, its significance. Chapter Three outlines the methods used to conduct this research. Chapter Four provides a detailed picture of Colonial Square, and an overview of the participants; presenting appropriate background information on these women and the place where they now live, assists in a fuller understanding of the stories they told. Chapters Five and Six review findings from analysis of those stories. Chapter Five presents perceived lifetime influences on current practices, and present food and eating experiences at Colonial Square. Chapter Six presents four themes running in and out of the lives of the women, focusing on one particular participant who exemplifies each theme, and comparing the experiences of other participants. Chapter Seven offers a discussion of my interpretations of the findings, how the findings relate to the research questions and previous literature, and presents a conceptual model of dietary behavior of older women. The chapter ends with conclusions made from this study, including its implications and applicability regarding future research and practice issues.
Chapter Two
Background and Significance

Relevant research on health and dietary behaviors comes from varied and sometimes rather disparate literatures. Information for this dissertation, for example, draws at least from the areas of gerontology, health behavior (which includes health promotion and health education), nutritional sciences, biomedical sciences (including nursing, public health, and medicine), psychology, geography, anthropology, and sociology. Most of the literature reviewed in this chapter relates to aging and older adults, although some research regarding earlier stages of life are included as required by the life course nature of this study. Because of the scope of this review, the chapter is divided into three parts. Part I covers nutrition in later life and dietary behavior of older adults. Part II reviews social contexts of dietary behavior over the life course, including the influences of gender, family, social roles and transitions, social support, and environment. Part III addresses conceptual and theoretical foundations of health behavior and of this research.

Background Part I: Nutrition and Dietary Behavior in Later Life

An understanding of the complex elements of food preferences and dietary behaviors requires grounding in physiological processes and the role of nutrition in aging. Such factors, as they interact with psychological and social dynamics, have ramifications with respect to the dietary actions of older adults. Therefore in Nutrition and Aging, I review physiological age changes with nutritional implications, nutrition in health and illness, nutritional requirements of older adults, nutritional risk factors for older adults, and provide a brief note on nutrition and women. With this background in place, in Dietary Behavior and Aging, I continue with an overview of dietary practices of older adults, and what is known about how elders actually behave in relation to food and eating. This section also highlights dietary issues particular to older women.
Nutrition and Aging

Nutrition and aging is a growing area of study, particularly as more is discovered regarding the role of nutrition in health. Fiatarone Singh and Rosenberg (1999, p. 81) remarked that the focus in nutrition and aging has changed and “expanded beyond the prevention of poverty and undernutrition to the critical role of diet and nutritional factors in successful aging and the prevention of declining function and disease associated with age.” But first, it is important to know what physical changes are associated with age that have nutritional implications, because such changes can affect an elder’s nutritional status and dietary behaviors.

Age-Related Physical Changes and Nutritional Implications

One area of dramatic physical change, and change that is most apparent to others, is in body composition. In general, older people tend to lose body water, and lean body mass (sarcopenia) and bone (osteopenia) (Fiatarone Singh & Rosenberg, 1999; Rolfes, DeBruyne & Whitney, 1998; White & Ham, 1999). Although many textbooks and articles state that older people gain body fat (adipose tissue), Morley (1995) contended that his research and other studies show that, particularly for women, a small increase in body fat after age 40 is maintained until about age 70 to 75, after which body fat percentage declines. Some of these changes in body composition are due to changes in hormonal activity, decreased physical activity, inadequate calcium and vitamin D intake, excess alcohol, sodium and protein, and in some cases, undernutrition or catabolic diseases processes (e.g. congestive heart failure, chronic obstructive pulmonary disease or chronic infections and inflammations). The results of such changes in body composition are low basal metabolic rate, low energy requirements, higher risk of micronutrient deficiencies, higher risk of glucose intolerance, increased risk for immune dysfunction, increased risk for fractures, and increased risk of diseases such as diabetes, cardiovascular disease and hypertension. These changes also affect storage and metabolism of medications, as storage and concentration of fat-soluble and water-soluble medications may increase.

The gastrointestinal system also undergoes some changes with age (Rolfes et al., 1998; White & Ham, 1999). The intestinal wall loses strength and elasticity with age, resulting in decreased gastric motility. Decreased lactase activity and decreased secretion of gastric acid occur with age. Consequences of such age changes are decreased absorption and bioavailability
of nutrients, and higher risk of constipation and atrophic gastritis. The liver decreases in size, blood flow, and drug-metabolizing enzymatic activity. These changes result in decreased albumin synthesis and poor or delayed metabolism of certain drugs (White & Ham, 1999). Changes in the renal system cause reduced excretion of metabolites and drugs (White & Ham, 1999).

The central nervous system may influence dietary intake through regulation of sensations of hunger, thirst and satiety (Fiatarone Singh & Rosenberg, 1999). The number and function of brain receptors that affect appetite decline with age in animal studies, though the evidence in humans is uncertain. There is also speculation that changes in the sleep cycle, which often lead to poor sleep quality, insomnia and daytime drowsiness, may impair an older person’s ability to access and prepare a healthy diet (White & Ham, 1999).

Sensory changes include losses in the sense of taste and smell (Fiatarone Singh & Rosenberg, 1999; Rolfes et al., 1998; White & Ham, 1999). A decrease in the number of taste buds and papilla on the tongue alter taste threshold, and reduce the ability to detect sweet/salt, therefore increasing the use of sugar and salt. A decrease in the number of olfactory nerve endings alters the smell threshold and reduces palatability, which may cause reduced food intake. Also relevant are changes in vision and hearing (Fiatarone Singh & Rosenberg, 1999). Poor eyesight can affect the visual aesthetic of food, and make the activities involved in meals difficult (e.g. getting to stores, shopping for food, reading labels, counting money, preparing food). It may be more difficult to detect spoiled food, visually and by smell. Hearing loss may impact the enjoyment of social aspects of meals, especially if it becomes difficult to carry on conversations with mealtime companions.

Although not necessarily changes related to physical aging, oral health problems can affect the nutrition of older adults (Rolfes et al., 1998; White & Ham, 1999). Only 10.5% of Americans are edentulous, but the prevalence of tooth loss increases with age, as does the prevalence of gum disease (White & Ham, 1999). Dentures, even those that fit well, are less effective in mastication. Conditions that cause difficult, painful or inefficient chewing can cause choking and/or result in decreased or modified food intake, in which the older adult limits food selections to only foods that are soft. This is not necessarily a problem unless food groups
are eliminated and variety is restricted, resulting in nutritional deficiencies and/or decreased enjoyment of food and meals.

*Nutrition in Health and Illness*

The term malnutrition has no set clinical definition and has been used to refer to a number of deficiencies and excesses (Institute of Medicine, 2000). Two disorders commonly considered to be forms of malnutrition are obesity and undernutrition. The *Merck Manual of Diagnosis and Therapy* (Beers & Berkow, 1999, para. 1) states:

Malnutrition results from imbalance between the body’s needs and the intake of nutrients, which can lead to syndromes of deficiency, dependency, toxicity, or obesity. Malnutrition includes undernutrition, in which nutrients are undersupplied, and overnutrition, in which nutrients are oversupplied.

Obesity is more prevalent than undernutrition and is the most common nutritional disorder in older adults, although its incidence decreases after the age of 75 (Chernoff, 2001; Institute of Medicine, 2000). It is a risk factor for premature death and disability, and is associated with an increased risk specifically of heart disease, diabetes, osteoarthritis, hypertension, stroke, some cancers, and respiratory impairment (Chernoff, 2001; Institute of Medicine, 2000). However, it is suggested that for older adults the need for weight loss should be determined on an individual basis, as there is some evidence, albeit inconsistent, that being overweight (even moderate obesity) protects against mortality, because of a metabolic reserve function, and against hip fracture (Chernoff, 2001; Institute of Medicine, 2000). Weight loss is regularly used to define undernutrition, but a history of weight loss from middle age to late adulthood may really be more important than an actual low body weight (Institute of Medicine, 2000). Being underweight has been associated with increased mortality in older adults (Tayback, Kumanyika & Chu, 1990). Undernutrition is much less prevalent among older adults in general, but is considerably more common among hospitalized patients.

Regarding immune function, Walsh (2001) asserted that poor nutrition is the leading cause of immune deficiency in elderly people, as adequate nutrient intake has been deemed
critical to immune function (Fiatarone Singh & Rosenberg, 1999; Walsh, 2001). It has been speculated that an age-related increase in susceptibility to infection and certain cancers is related to decline in immune functioning: “Protein malnutrition, zinc deficiency, vitamin B-6 deficiency and inadequate antioxidant intake, all conditions for which the elderly are at greater risk, may negatively influence the function of the immune system and thereby risk of infection” (Fiatarone Singh & Rosenberg, 1999, p. 87).

Vascular-related diseases include heart disease (e.g. coronary artery disease, atherosclerosis, ischemic heart disease, congestive heart failure) and hypertension. There has been a steadily growing body of work on the relationships between dietary fat, cholesterol and heart disease, which has lead to recommendations that reducing fats and cholesterol in one’s diet can prevent and treat heart disease (Chernoff, 2001; Institute of Medicine, 2000). One of the newest nutritional dimensions to be studied regarding vascular disease and aging is homocysteine (Fiatarone Singh & Rosenberg, 1999), a nonprotein-forming sulfur amino acid. Recent studies indicate that moderate elevations of homocysteine associated with aging increase the risk of vascular disease, in both men and women. Homocysteine metabolism is regulated by vitamins, such as folate, vitamin B-6 and vitamin B-12, and a response to folate therapy among older adults suggests that a sub-clinical vitamin deficiency may be in part the cause of higher levels of homocysteine.

Additionally, antioxidants have been recognized as potential nutritional factors in vascular disease. There appears to be a strong relationship between vitamin E and beta carotene intake in both the prevention and treatment of vascular disease (Chernoff, 2001; Fiatarone Singh & Rosenberg, 1999). Vitamin E intake has been associated with reduced mortality from ischemic heart disease, and improved circulatory function and walking ability in people with intermittent claudication (Fiatarone Singh & Rosenberg, 1999).

Hypertension is a common problem among older adults, and untreated hypertension is associated with an increased risk of stroke and cardiovascular disease (Institute of Medicine, 2000; Morley, 1995). There are several dietary approaches that have been shown to lower blood pressure, including reduced sodium intake, weight loss, reduced alcohol consumption, increased potassium intake, and adopting overall healthy dietary patterns (Institute of Medicine, 2000). Morley (1995) advised against severe sodium restriction for adults whenever possible, because:
1) it can result in unpalatable food and consequently lead to the development of malnutrition; and 2) it can lead to severe postural hypotension.

Fiatarone Singh & Rosenberg (1999, p. 88) described some of the nutritional interactions that can affect the central nervous system (CNS), noting “no other organ system of the body depends more minutely on its nutrient supply than the CNS.” The CNS requires glucose and almost all essential nutrients for adequate brain function and maintenance. It is possible that mild sub-clinical deficiencies contribute to some decline in neurocognitive function with aging, and that antioxidants play a role in the control of neurodegenerative diseases in older adults. Homocysteine may again play a role, as some evidence has suggested that moderate elevations in homocysteine are related to declines in neurocognitive function in older adults (Fiatarone Singh & Rosenberg, 1999).

Bone and joint health is affected by nutritional factors. One of the most common diseases associated with aging, and a major cause of morbidity among women, is osteoporosis (Morley, 1995; Rolfes et al., 1998). Adequate calcium and vitamin D intake may both prevent and treat osteoporosis. Osteoarthritis is a prevalent type of arthritis, and has a known nutritional link, in terms of being overweight (Rolfes, DeBruyne & Whitney, 1998). Weight loss is important for overweight people with osteoarthritis, in part because the extra weight puts stress on weight-bearing joints; however, weight loss has been found to relieve pain in the hands as well, which are not weight-bearing joints.

There are a number of other nutrition-related conditions and diseases affected by nutritional factors. Many of these are common and important disorders among the elderly population, and include diabetes, chronic renal failure, some cancers, macular degeneration and cataracts (Fiatarone Singh & Rosenberg, 1998; Institute of Medicine; Morley, 1995).

**Nutritional Requirements of Older Adults**

In light of the physical aging changes and nutritional issues in health and illness, the nutritional requirements of older adults should be addressed. There is some difficulty related to establishing nutritional needs of older adults, and setting dietary standards for older people (Bidlack & Wang, 1995; Rolfes et al., 1998; Weddle & Fanelli-Kuczmański, 2000; White & Ham, 1999). White and Ham (1999, p. 144) remarked, “The nutritional needs of older persons
are difficult to quantify due to ‘physiological diversity and heterogeneity’ and the prevalence of chronic disease.’ Older persons take different medications (for different chronic conditions), which will impact nutrient needs. Rolfes et al (1998) pointed out that people start out with different ways of handling nutrients, the effects of which become magnified over time; for example, an individual may not have regularly consumed vegetables throughout life, and in old age may have an associated set of nutritional problems. Finally, there just is not the data available to know what elders’ requirements are and thus make clear, accurate recommendations. Bidlack and Wang (1995) suggested that different subgroups of older adults have different nutrient needs; for example, independent, community-dwelling elders will have needs different from older adults in long-term care facilities. The researchers warned, however, that there is not enough data to identify specific nutrition needs of subgroups, but that caution should be used in making generalizations to the entire older adult population.

Therefore, the requirements identified in the literature are for healthy elderly people and often extrapolated from the requirements for younger age groups. There is some contradiction in the literature regarding the appropriateness of using the requirements for middle-aged adults for older adults. In the 1980s, some researchers concluded that the nutritional needs of healthy older adults do not differ from those of younger adults (Bidlack & Wang, 1995). Studies in the 1990s began to produce research that indicated that although nutritional needs of older adults appear to be similar to the needs of middle-aged adults in general, there was evidence that for some nutrients, older adults have different needs (White and Ham, 1999). The most recent position statement of the American Dietetic Association on nutrition and aging declared “research has shown that older adults do have specialized requirements for a variety of nutrients because of aging effects on absorption, utilization and excretion” (Weddle & Fanelli-Kuczmarski, 2000). For example, Vitamin A requirements actually decrease with age, because with age there is increased absorption of this nutrient. Consequently the Recommended Dietary Allowance for Vitamin A may be too high (Rolfes et al., 1998; Weddle & Fanelli-Kuczmarski, 2000).

Many people are familiar with the concept of Recommended Dietary Allowances (RDAs), which are defined as “the levels of intake of essential nutrients that, on the basis of scientific knowledge, are judged by the Food and Nutrition Board to be adequate to meet the known nutrient needs of practically all healthy persons” (National Research Council, 1989, p. 10). The
last set of RDAs came out in 1989, and the RDAs for elders were within the set for people aged 51 and older, as there was insufficient data at the time to make separate recommendations (Guigoz, 1995; Weddle & Fanelli-Kuczmarski, 2000). However, Dietary Reference Intakes (DRIs), a new reference system, are replacing the previous RDAs, and consist of four levels of intake values: Estimated Average Requirements, RDAs, Adequate Intake, and Tolerable Upper Intake Limit (Weddle & Fanelli-Kuczmarski, 2000; White & Ham, 1999). The DRIs at least divide adults over age 50 into two groups, 51 to 70 years and 71 years and older. The DRIs are being released for specific nutrients as their levels are established. The American Dietetic Association recommended that the 1989 RDAs are the best guide for nutrient intake for those nutrients with unavailable DRIs (Weddle & Fanelli-Kuczmarski, 2000).

DRIs for older adults have been established for a number of nutrients, including vitamins A, C, E, and K, and the elements boron, chromium, copper, fluoride and iodine (National Policy and Resource Center on Nutrition and Aging, 2001). DRIs have also been established for the nutrients essential for the maintenance of bone health and for the B-complex vitamins and choline, which are briefly reviewed to illustrate some of the specific needs of older adults (White & Ham, 1999). Acknowledging that osteoporosis is a major health risk for both women and men, calcium levels were set higher and according to maximum retention of body calcium, with the value for those 51 years and older at 1200mg/day – this is higher than the RDA. Vitamin D is necessary for the body to efficiently use calcium, and for men and women aged 51 to 70 years, the recommended intake is 400 IU and for those over 70 years, 600 IU. White and Ham (1999) recommend that higher doses of vitamin D may be needed for elders with limited exposure to sunlight (such as institutionalized elders) or for whom there is evidence of osteomalacia or osteoporosis.

Older adults also require greater intakes of folate and vitamins B-6 and B-12 than the RDAs, to prevent some decline in cognitive function (particularly memory), reduce the risk of coronary heart disease and possible prevent some hearing loss (Weddle & Fanelli-Kuczmarski, 2000; White & Ham, 1999). The DRI value for folate (51 years and older) is 400µg/day, vitamin B-12 (51 years and older) is 2.4µg/day, and vitamin B-6 (51 years and older) is 1.5µg/day (excessive doses of vitamin B-6 increases the risk of developing progressive, crippling neurological damage) (White & Ham, 1999).
It seems to be generally agreed in the literature that adults should meet their nutrient needs as much as is possible through food consumption, and that the best way to do so is to eat a variety of foods (Fiatarone Singh & Rosenberg, 1999; Rolfes et al., 1998; Weddle & Fanelli-Kuczmarski, 2000). The balanced diet concept still reigns as the recommended way to achieve good nutrition, and perhaps has been the one constant in all the years that researchers and the government have attempted to establish exactly what the nutritional needs are for the population. It is conceded that supplementation can be useful, especially for those for whom food selection is limited, and those who either cannot or do not consume adequate amounts of nutrients (Fiatarone Singh & Rosenberg, 1999; Weddle & Fanelli-Kuczmarski, 2000). Bidlack and Wang (1995) reviewed studies that show increased vitamin intake can improve nutritional status. Although older adults in general do not seem to be at risk for toxicity, the authors indicated that there should be concern for those elders who take high doses of vitamins. I address the use of vitamins and supplements by elders in the section on dietary practices of older adults.

Nutritional Risk Factors for Older Adults

A variety of issues can impact the nutritional status of an older adult, and put the elder at risk for malnutrition and concomitant problems. These issues can be grouped into physical, psychological and social factors. As reviewed in the previous section, there are a number of physiological changes that can affect nutritional status, and potentially put an elder at nutritional risk. Related physiologic factors include acute and chronic conditions, functional status, alcohol/drug use and medications use (Read & Schlenker, 1993; Rolfes, DeBruyne & Whitney, 1998; Schoenberg, 2000; Taylor & Polan, 1998; White & Ham, 1999; Wilcox & King, 1999; Wylie, Copeman & Kirk, 1999). White and Ham (1999) postulated that a chronic disease or condition often results in either a prescribed or self-imposed modified diet, which is frequently limited in variety and nutrient intake. The authors advised monitoring unintentional weight loss or signs of malnutrition in conjunction with acute or chronic illness. As far as functional status, physical disabilities and frailty can hinder shopping and food preparation. Excessive alcohol and drug use can affect nutritional status, as malnutrition is a common problem among those who abuse these substances. Use of medications and polypharmacy further affect nutritional status. As referred to previously, age-related changes in metabolism may affect drug absorption and the effects of a
drug, and conversely, medication interactions may affect metabolism and appetite. Additionally, food and nutrients have the capacity to alter the effects of medications.

Psychological factors that are associated with nutritional problems include bereavement, depression, mental illness and other emotional or cognitive impairments such as dementia and memory loss (Read & Schlenker, 1993; Rolfes, DeBruyne & Whitney, 1998; White & Ham, 1999; Wilcox & King, 1999; Wylie, Copeman & Kirk, 1999). Decreased nutrition may be a grief reaction. Alternatively, grief may cause some temporary cognitive difficulties, such as disruptions in memory, confusion and disorganization, that lead to poorer nutrition. Depression and mental illness often are associated with undernourishment as a result of decreased food intake caused by changes in appetite, lower self-esteem, lack of motivation, negativity and disregard for good nutrition, all of which lead to a loss of interest in food. Other impairments, such as dementia and memory loss, can interfere with the ability to make choices, to shop and prepare food, and even to remember to eat appropriately.

There are several key social factors that can affect nutritional status, such as social isolation, living arrangements, and socioeconomic levels and resources (Rolfes et al., 1998; Schoenberg, 2000; Taylor & Polan, 1998; White & Ham, 1999; Wilcox & King, 1999). White and Ham (1999, p. 138) noted that older adults who have limited social contact and interaction “with family, friends and neighbors at an individual level and who are unable or unwilling to access social support systems on a broader level may experience decreased food intake, lack of appetite, and limited motivation to shop and prepare meals as a result.” Isolation may additionally contribute to loneliness. Loneliness can alter eating habits, and tends to have a negative impact on food intake and nutrition, with the lack of mealtime companions playing a role (Walker & Beauchene, 1991; Wylie, Copeman & Kirk, 1999). An older person’s living arrangements, such as living alone, may contribute to isolation. Living alone, therefore, because of a possible lack of mealtime companionship, may result in poorer nutrition. It is important to remember that isolation and living alone do not always entail loneliness (or lack of meal partners), and thus changes in dietary behaviors could result from the preferences and subjective interpretations of the older adults in such situations.

Socioeconomic factors such as income (either low income or a fixed income combined with inflation) and educational levels may affect nutrition and dietary behavior (Rolfes et al.,
Poverty and low income can keep older adults from purchasing the foods needed for an adequate diet. Lower levels of education can affect whether older adults can adequately meet their nutritional needs, through a lack of nutritional knowledge and/or exposure to a variety of foods.

Finally, one aspect of diet and nutrition often not considered is fluid intake. Adequate fluid intake could be a problem for older adults, placing them at greater risk for dehydration (Rolfes et al., 1998; Taylor & Polan, 1998; Weddle & Fanelli-KuczmarSKI, 2000). Dehydration can result in increased risk for urinary tract infections, constipation, fecal impaction, pneumonia, pressure ulcers, cognitive impairment (including confusion and disorientation), functional decline and death. Inadequate fluid intake can be due to various factors. Older people seem to physiologically be less sensitive to the sensation of thirst. They may not be able to obtain enough fluids. Older adults may consciously not drink enough, because it may be difficult to get to a bathroom or to prevent having to get up so much at night. Older adults who have lost bladder control or fear incontinence may be afraid to drink too much. Increased arthritic pain from numerous trips to the bathroom may also cause a conscious reduction in fluid intake. Because of a decrease in total body water, even mild stresses (e.g. fever, hot weather) can bring on rapid dehydration.

Nutrition and Women

Wilson and Kaiser (1995, p.183) stated “The significance of gender differences in nutritional maintenance remains relatively unexplored as few studies have concentrated on the specific needs of women.” However, nutritional factors and requirements for women may be different from those of men. Wilson and Kaiser offered possible reasons for such gender differences, especially for older women, such as variation in the female hormone profile with age, increasing tendency toward obesity, and the consequent development of impaired glucose metabolism.

Morley (1993) reviewed major nutrition-related differences between older men and women. One of these differences is in body composition; older women have a higher body mass index and lower waist-to-hip ratio than older men. Older women as compared to younger women reduce their food intake less than older men as compared to younger men. However,
cases of anorexia nervosa have been reported among older women. Most of them have histories of the condition as teenagers and consistently restricted their weight throughout life, but some develop it for the first time in old age, in which case it is designated as anorexia tardive. Another difference is that in older women, total cholesterol levels increase with age, but cholesterol levels that are optimum for survival are more prevalent among older women than among older men.

Osteoporosis is a significant physical condition for older women (Morley, 1993; Wilson & Kaiser, 1995). Following the onset of menopause, women experience an accelerated and dramatic decrease in bone density. The significance of osteoporosis lies in the established association with an increased risk for bone fractures. Inadequate intake of calcium and vitamin D affect bone density and increase the risk for osteoporosis, but ingestion of caffeine and alcohol may also increase the risk (Wilson & Kaiser, 1995). Diabetes is a condition that is more common among women under the age of 65, however after age 65, diabetes becomes more common in men (Morley, 1993). Morley (1993) contended that 16 percent of women older than 65 years of age have diabetes, yet over half of them have not been diagnosed.

Gender is apparently an important characteristic to consider when studying nutrition and aging. It can also be important to consider in the study of dietary behavior and aging, the topic of this next section.

**Dietary Behavior and Aging**

Many of the previously described factors considered to affect nutrition in older adults, such as the physical changes and nutritional risk factors, do so through the alteration of an older adult’s dietary behavior in ways that may adversely impact food and nutrient intake. However, regarding our understanding of the dietary behavior of older adults, Wilcox and King (1999, p. 300) observed “more is known about the health benefits of good nutrition and the nutritional needs of older adults than is known about actual dietary behaviors and how to modify dietary habits.” The literature on dietary behaviors of older adults is modest, but has been developing since the late 1970s. This section reviews research on dietary behaviors of older adults, and some general food- and eating-related patterns of elders, in terms of the foodways of older adults (i.e., food acquisition, food preparation, and food consumption), eating out, and the use of vitamin and mineral supplements. Research pertinent to social aspects of dietary behavior in late adulthood,
such as gender, family, later life transitions (e.g. retirement, caregiving, widowhood), social support and living arrangements/place (e.g. age-segregated environments), are reviewed in Part II of the Background and Significance, which specifically addresses social contexts of dietary behavior throughout the life course.

In current American scholarship on dietary behavior, a large portion of the work has come out of departments of nutrition and schools of public health and medicine, which often produces a definite slant in the focus and goals of the research. The implications and applications of the research are often envisioned as preventing disease and improving health promotion/nutrition education and intervention programs for older adults, so that American elders can be healthier and avoid nutritional risk, and professionals can “assist them in making wise food choices” (Briley, 1994, p. S22). Such researchers and practitioners have good, but often biomedically oriented, intentions. It seems that only very recently have some researchers begun to mention implications of research on nutrition and dietary behavior for psychosocial quality of life (Amarantos et al., 2001; Drewnowski & Evans, 2001).

Two groups of American researchers in particular have established a body of literature on adults and eating, advancing such study in the United States. One group is out of the Division of Nutritional Sciences at Cornell University. They have conducted a number of qualitative studies in New York State on the dietary behavior of adults in general and older adults in particular, focusing on topics such as food choice processes and fruit and vegetable trajectories, and have attempted to incorporate social science perspectives, especially a life course perspective, in nutrition research. The second group is out of the School of Medicine at Wake Forest University, lead by Quandt and colleagues. This latter group’s focus has been on the dietary practices of older adults in the rural South (Kentucky and North Carolina). They have reported on several topics, such as food security, meal patterns, food gift giving, nutritional risk, gender factors, and nutritional self-management strategies of widows and widowers. They also have applied a life course perspective to some of their work. The life course perspective and pieces from these two groups relevant to a life course perspective are addressed in the third part of the Background and Significance, which reviews theoretical foundations. I address other findings from these research groups both in this section and in Part II, social aspects of dietary behaviors.
Food Acquisition

Read and Schlenker (1993, p. 298) remarked, “Food shopping can be a recreational or leisure time activity for the healthy older person with available transportation or a problem for the physically disadvantaged.” Shopping for food can be an enjoyable activity for older adults (Bonnel, 1999), and it has been noted that shopping trips can be an important avenue for social contact (Read & Schlenker, 1993), though some older adults simply view shopping as a task that must be accomplished (Bonnel, 1999). For those whose physical capacities are not what they once were, such as frail elders or oldest-old, shopping can be problematic. Problems when shopping include having to lift heavy items, difficulty getting to items on high or low shelves, failing eyesight (affecting ability to read labels), and depending on a walker or cane (which interferes with pushing a cart) (Read & Schlenker, 1993). Some no longer shop for groceries themselves, and have come to rely on others to purchase what they need (Bonnel, 1999).

Another aspect of shopping that can create problems is getting to the store in the first place. For older adults who no longer drive, access to grocery shopping translates to reliance on others (neighbors, friends, family, paid help), dependence on public transit and transportation services and/or walking, each of which poses possible difficulties (Read & Schlenker, 1993). If an older person relies on others, they are limited in when, where and how much to buy. The same limitations occur when transportation services are used, and with walking. In nice weather, walking allows more control over when the older person shops, but in inclement weather, walking may not be an option. In the north, where sidewalks may be covered with ice and snow, walking may not be possible for several days in a row (Read & Schlenker, 1993).

Sidenvall, Nydahl and Fjellstrom (2001) studied the experiences of older Swedish women, aged 64 and older, in managing food shopping. Their analysis revealed some differences among age groups and family situations, although in general all the women shopped according to familiar routines. Younger participants were more interested in buying new products. Women who shopped with their husbands were more flexible in going to different stores, but the oldest women, who lived alone, preferred their usual local store. One of the shopping problems expressed by the oldest participants was a loss of strength. Furthermore, the oldest women and those living alone purchased ready-to-eat food as one way of reducing food preparation work.
Sidenvall et al. (2001) found that, economically speaking, the women balanced food expenditures against their capacities for preparing food items. Schlettwein and Barclay (1995), using data from the Survey in Europe on Nutrition and the Elderly: A Concerted Action (SENECA), found that food budgeting problems of older adults were associated with increased shopping problems, along with decreased dietary intake and poor self-perceived health. Gallo and Boehm (1978) discussed food purchasing patterns of older Americans, comparing them to other age groups. At the time, older adults comprised 12 percent of the population, earned 10.5 percent of the income, but spent 13 percent of all money spent on food. About 22 percent of their income was spent on food, and they spent more on fresh fruits and vegetables, and less on red meats, diary products, beverages and prepared foods than did younger age groups. Other research has noted that older households, as compared to younger households, spend a larger portion of their total income on food, but aggregate food expenditures of older adults have declined, as possibly retirement and subsequent changes in total income influence the amount of money spent on food (Read & Schlenker, 1993). Given the focus on households though, a likely factor causing differences in aggregate household spending is household size, as younger households generally include children and thus are larger in size than older households.

Another way for older adults to acquire food is through food sharing and receiving gifts of food. Quandt, Arcury, Bell, McDonald and Vitolins (2001, p. 146) purported that the international food security literature “has long recognized that food sharing can play a significant role in nutritional well-being,” and they examined the meaning of food sharing among rural older adults and how giving and receiving food gifts can be a mechanism by which nutritional well-being of rural older adults is enhanced. The researchers found that these elders believed that receiving food gifts contributed to their food security, alleviating food shortages and preventing hunger. The food gift received most often was garden produce, which contained some of the nutrients in which the older adults’ diets were deficient. For these older adults, the gifts tide them over when times get lean: “Reminiscent of the past when crops might fail or a household’s provider might be injured or ill, neighbors and kin come to the rescue at contemporary times of shortage – e.g., the end of the month when Social Security or pension income runs out” (Quandt et al., p. 157). However, not all older adults receive food gifts, the amount of food received varied greatly, and sometimes the gift was not something the elder could or would eat. Additionally,
Quandt et al. found it more realistic to view food sharing as a process of redistribution within the community that eliminates potential food waste, than to see it as a means to alleviate hunger. Nevertheless, adult children who stock an elder’s home with groceries or neighbors who share the bounty of their garden sometimes provide the means by which older adults acquire food in addition to, or instead of, their own shopping, and “may augment a diet limited by income and functional status” (Quandt et al., p. 145).

**Food Preparation**

Once food is acquired, it generally needs to be prepared for consumption, usually in the form of meals. Food preparation practices are not a common topic of dietary behavior research on older adults. What few studies there are about such preparation show that older adults use a wide array of strategies and approaches, some of which are different from younger age groups. Sometimes, as in Sidenvall et al.’s (2001) study of older women, older adults purchase pre-made foods to reduce the amount of preparation work. The researchers also examined the management of cooking by older Swedish women, finding that cooking strategies utilized familiar routines, and younger participants were more interested in trying new recipes.

Bonnel (1999) investigated older women’s perceived challenges and strategies for meal management, which includes meal preparation or making alternative arrangements for meals. She identified types of meal management transitions for the independently-living women, some of which related to cooking strategies, and described various approaches to fixing meals (Bonnel, 1999, p. 44):

Some women still cooked because they enjoyed it, it kept them busy and they liked to share. Others wanted to cook but had to make modifications because of pain or weakness. For others cooking was very difficult and done only when Meals on Wheels did not deliver.

The participants used strategies generally to make cooking easier, advising the preparation of extra food and freezing it to be reheated, the use of frozen vegetables (because they do not need to be cut up, do not spoil, and do not have to be opened with a can opener), and the use of microwave ovens, although this was felt by some to be a poor substitute for cooking. A
functional environment for meal preparation was important to the women, who made their kitchen spaces as functional as possible, for example, by leaving out frequently used cooking equipment, or as one woman did, using a narrow ironing board for a place to sit and prepare food.

Brombach (2001a) reported on the meal patterns of older women in Germany. Her findings in some ways reflect aspects of German culture, such as the regular consumption of cheese and sausages for breakfast. She discovered that some of the women, who were not originally from the town where the research was conducted, continued to prepare and eat certain dishes from their region of Germany, indicating some stability in the life course regarding food consumption. Beyond culture specific issues, her findings also suggested that meals have an important role for structuring the day, and that social and cultural factors influence the kinds of foods prepared and consumed and the timing of meals, functioning then as a part of an individual’s regional and cultural identity.

An aspect of food preparation, about which little is known, is the use of food safety practices by older adults. Gettings and Keirnan’s (2001) attempted to fill this gap, using focus groups of older adults (N = 74, 12 percent male) in order to identify the practices elders use to cook, cool and thaw foods when preparing meals at home. The researchers detected both “appropriate” (safe) and “inappropriate” (unsafe) food safety habits of the participants. These habits were on the whole similar to those found in studies of the general population, but included additional, and previously unidentified, appropriate and inappropriate ways of handling food, as well as some practices identified in the general population, but not used by the older adults in the study. According to Gettings and Kiernan, eight percent of the participants had been diagnosed with a food safety illness at some time in their life.

With a few exceptions (e.g. Gettings & Kiernan, 2001; McDonald, Quandt, Arcury, Bell, & Vitolins, 2000), much research on food preparation has focused on older women. This is likely due to the fact that the majority of the older adult population is comprised of women, who, single or married, are primarily responsible for food preparation. Most older men are married, and it is their wives who prepare meals.
Food Consumption

A number of studies have been conducted to understand the beliefs and attitudes that older adults hold regarding food and eating, assuming that such psychological factors influence food selection and consumption (e.g. Cluskey, 2001; International Food Information Council, 2001; Matheson, Woolcott, Matthews & Roth, 1991; Rainey, Mayo, Haley-Zitlin, Kemper & Cason, 2000; Schlettwein & Barclay, 1995; Sharpe & Mezoff, 1995; Yen, 1995). The International Food Information Council (2001) discussed an exploration of the attitudes that shape food choices of older Americans, suggesting that the most common values used by older adults to make food selections are sensory perception, convenience, social considerations and physical well-being. They additionally noted that health concerns and medical conditions have a greater impact on food choices as people get older. Rainey et al. (2000) examined attitudes, beliefs and practices specifically of older rural women, and similarly found that health conditions influenced food choices. Other themes in their research included food preferences based on taste and childhood familiarity. McKie, MacInnes, Hendry, Donald and Peace (2000) investigated beliefs and practices of Scottish elders, but found a disparity between stated beliefs and actual consumption behavior, as practices were affected by social factors such as access to food and the cost and quality of foods. They additionally investigated attitudes specifically towards nutrition information and advice, uncovering high levels of skepticism regarding the reliability of nutrition information and advice; the older adults in the study often contrasted changing and conflicting advice with personal experiences (of themselves and others they know).

Shifflett (1987; Shifflett & McIntosh, 1986–1987) examined a unique psychological process, the perception of time, and its relationship to food use. In exploring connections between elders’ views of the future and changes in food habits, Shifflett and McIntosh (1986–1987) found that older adults with a positive view towards the future changed food habits in positive ways, whereas those with no future plans or a negative future perspective reported more negative changes in their food habits. Men were more likely than women to hold positive future perspectives and positive food habits. Shifflett (1987) reported additional analysis indicating that certain past experiences (e.g. perception of the nature of illnesses, quality of life decisions, or reduced income), in conjunction with a negative or positive future time perspective, led to different degrees of compliance with special diets.
According to Wakimoto and Block (2001), one of the earliest studies to characterize actual food consumption patterns of older adults in the United States was in 1985 by Fanelli and Stevenhagen. Their investigation, based on analysis of data from the 1977 to 1978 Nationwide Food Consumption Surveys (NFCS), included adults aged 55 and older, broken down into the age groups 55–64, 65–74, and 75 years and older. They found no significant differences between men and women or among the three age groups, concerning foods routinely consumed. The most frequently mentioned foods were whole milk, white bread, coffee and sugar. The most frequently reported fruits were orange juice and bananas, and the most commonly used vegetables were tomatoes, potatoes and lettuce. The most frequent protein-rich foods mentioned were eggs and milk. Wakimoto and Block (2001) also cited Popkin, Haines and Patterson’s 1992 report on dietary changes of older adults, based on cross-sectional data from the 1977–1978 and 1987–1988 NFCS. The researchers found changes that included shifts from use of high-fat to low-fat milk and milk products and from high-fat beef and pork to low-fat chicken and fish.

Patterson, Block, Rosenberger, Pee and Kahle (1990) used data from the second National Health and Nutrition Examination Survey (1976–1980) to report specifically on the fruit and vegetable consumption of Americans. The proportion of those consuming the recommended number of servings of fruit and vegetables was higher among older as compared to younger adults, but fewer than half of older adults ate the recommended servings of fruit, and fewer than one third of older adults ate the recommended servings of vegetables. Older men consumed an adequate number of servings of vegetables more than women (including potatoes), but women were more likely than men to consume adequate servings of fruit. These findings are congruent with Johnson et al. (1998), who examined fruit and vegetable consumption among older adults in the United Kingdom, in both urban and rural areas. Their results showed that less than half of the respondents ate the recommended five servings of fruit and vegetables a day, although the rural sample had a higher percentage than the urban sample, 51% and 37% respectively. Independent predictors of higher fruit consumption were higher social engagement score, not smoking, female gender and a higher social class, and for higher vegetable consumption were younger age and not smoking.

Wakimoto and Block (2001, p. 75) concluded that cross-sectional studies on food patterns of older adults in general show “that older people are less likely to consume red meat, whole
milk, and other fatty foods than younger people, and are more likely to consume fruits and vegetables than are younger people.” They felt this contention was also supported by longitudinal data, including data from the Baltimore Study on Aging, and stated “it appears that these changes in desirable directions may be larger among older than younger persons, and are larger and more consistent among older women than older men” (Wakimoto & Block, 2001, p. 75).

Food consumption of older adults has also been studied in terms of meal patterns and meals consumed. The most common pattern for older adults is to eat three meals a day: breakfast, lunch and dinner (Read & Schlenker, 1993). Breakfast is a particularly popular meal with older adults (Read & Schlenker, 1993), and some researchers have specifically investigated breakfast consumption of older adults. Morgan, Zabik and Stampley (1986) examined breakfast consumption patterns and dietary component intakes of older adults, using data from the 1977–1978 NFCS. The findings showed that skipping breakfast was an important contributor to dietary inadequacy, and the authors concluded that eating breakfast, especially cereal with milk, tremendously enhances the nutritional quality of the diets of people aged 50 years and older. In trying to understand the significance of breakfast consumption, Smith (1998) studied the relationship between breakfast cereal consumption and intelligence in older adults in England. Those who ate breakfast cereal every morning scored higher on tests of intelligence and reading than irregular breakfast eaters.

Limited work has been conducted regarding fluid intake and the consumption of beverages. Adams (1988) compared fluid intake of institutionalized and noninstitutionalized older adults, finding that time patterns of intake were similar for both groups, with almost no intake at night and the highest intake in the afternoon. However, the noninstitutionalized elders had a higher mean daily fluid intake, and water made up a higher percentage of their daily intake. Fetto (2000) discussed patterns of beverage consumption among Americans, finding that in general, consumption rates of many beverages decreased with age. However, those aged 50 years and older drank more than twice as much hot coffee or tea than those aged 18–24 years. The 50 years and older age group was also the most likely to try a new drink because someone recommended it to them.
**Eating Out**

Eating out (i.e. consuming food away from home) is a way to acquire and consume food without the work of preparing the food. Eating out has become a standard foodway for many Americans, and older adults consume their share of food outside of the home as well, although research indicates that they are less likely to eat out than the rest of the American population. According to Wakimoto and Block (2001, p.74–75), among adults in the United States, “calories from foods obtained and eaten away from home are highest among those aged 20 to 29 years (approximately 37% of energy for men and 34% for women), and lowest among those aged 70 years and older (approximately 16% for men and 11% for women).” Although these figures could also included food and meals eaten at the homes of friends and family, it still suggests that older adults are much less likely to eat out, or purchase/consume meals away from home. Paulin (2000) found that three out of four families in which the reference person was under the age of 65 reported an expenditure for eating out, but less than two out of three families with a reference person aged 65 to 74 and about half with a reference person 75 years or older reported an expenditure for eating out. The overall results indicated that adults aged 65 and older were less likely to buy meals away from home.

The fast food phenomenon has become a symbol of American culture, and although they may be less likely to patronize fast food restaurants, older adults will go to such establishments. Read and Schlenker (1993) cited research indicating that fast food businesses are increasingly attracting an older market, and that in 1989, McDonald’s restaurants did 30% of their business with people over 59 years of age. Reynolds, Kenyon and Kniatt (1998) investigated fast food experiences among older adults, and reported on factors that influence older adults to eat fast food. Older men were more likely to go to fast food restaurants than older women, and lunch was the preferred primary meal bought at a fast food restaurant. Factors that were most influential included convenience, speed of service, low cost, price promotions and coupons and lack of time to prepare meals.

**Vitamin and Mineral Supplementation**

One particular dietary practice that has gained attention and popularity in recent years is the use of vitamin and mineral supplements. Although the effects of supplementation
are inconclusive, many elders take vitamins and minerals on a regular basis. In fact, a larger proportion of older adults than younger people consume supplements (Subar & Block, 1990; Slesinki, Subar & Kahle, 1995). Chernoff (2001, p. 49) stated that vitamin and mineral supplementation by older adults “is generally self-prescribed and is frequently not associated with any medical conditions,” but is begun by older adults because of the desire to prevent disease and to be responsible for their own health care.

Daniel, Houston and Johnson (1995) reviewed studies published between 1980 and 1994, and made several conclusions regarding dietary supplementation among older adults. The studies indicated that about 30 percent of older adults used supplements daily, and 60 percent had used supplements in the past two years. The vitamins and minerals taken most often were multivitamins, vitamin C, vitamin E, and B complex vitamins. The use of supplements was not consistently associated with age or marital status, but was associated with high socioeconomic status and residence in the western United States. Physical activity was positively associated with supplement use, but smoking and caffeine consumption were negatively associated with supplement use. Vitamin and mineral supplement use seemed to be most prevalent among affluent older adults who practice a wide variety of health behaviors.

Being female and Caucasian was also associated with supplementation (Daniel et al., 1995). Women generally take more supplements than men do. Almost 39 percent of white women aged 64 to 75 and almost 35 percent of white women older than 75 consumed supplements (Subar & Block, 1990). Additionally, white women are more likely to use supplements than African-American and Hispanic women (Morley, 1993).

Overall, influences on the foodways of older adults have been put into three main categories: physiological, psychological, and sociocultural (Briley, 1994; Read & Schlenker, 1993). Physiological factors include almost all of those described before as affecting nutrition, and also include physical activity and food intolerances (e.g. allergies). Psychological influences include factors such as those previously discussed, beliefs, values and attitudes, as well as others such as self-esteem, knowledge, loneliness, bereavement, mental alertness, food preferences (including food aversions), food faddism, stress and symbolism of food. Social factors involve dimensions such as age, socioeconomic status, education, daily schedules, leisure time, issues of access, and others mentioned earlier (gender, social support, familial situations, later life
transitions, living arrangements, and environment). However, social factors such as period and cohort influences have not been well accounted for in some of the literature when distinguishing between younger and older adults. It is the social contexts of food and eating that are examined in the next part of the *Background and Significance*, with a focus on those latter aspects of gender, family, transitions, social support, living arrangements and environment.

**Background Part II: Social Aspects of Dietary and Health Behavior**

Many of the important questions about food habits are moral and social. How many people come to your table? How regularly? Why those names and not others? There is a range of social intercourse which is based on food … (Douglas, 1984, p. 11)

This part of the *Background and Significance* examines literatures on various social aspects of health behavior, continuing the focus on dietary practices, and highlighting certain contexts that are relevant to the research reported on in this paper. The first social aspect considered is gender, a powerful social construction present from birth to death, and in constant interaction with how and why we act, including dietary actions. Although I specifically address gender in this first section, it is a theme running throughout all sections.

The second section examines social relationships and transitions throughout the life course, particularly as they relate to family. A lifelong social context of health behavior, and the earliest one, is the familial milieu. Family members teach us how to brush our teeth, that vegetables are good for us whether we like them or not, to look both ways before we cross the street, and many other useful practices to keep us healthy and from harm. These practices also maintain and reproduce social organization and cultural norms, as we learn what one should and should not do in our referent social and cultural groups. This section first reviews literature on families and dietary practices, in general. I then consider specific research pieces on health and dietary behavior at particular stages early in life, i.e., childhood, adolescence and young adulthood. For many people, not too long after transitioning to young adulthood, the individual takes on new family statuses related to marriage and parenting. Transitions typically occurring in later life are retirement, widowhood and caregiving, and I assess literature on the impact of
these social changes on an individual’s dietary and health behavior. Finally, social support is an important and much discussed factor affecting health behavior in general and dietary behavior in particular, and so this section on social relationships and transitions ends in a review of literature on social support in this area.

The third section briefly examines environmental contexts of dietary and health behaviors, focusing on the aspect of living arrangements of older adults, and various age-segregated communities where many older adults reside. This part of the Background and Significance concludes with a brief address of the moralistic aspects of food and eating, as such factors have powerful implications for the way people eat, and feel about eating.

**Gender as a Life Course Context**

*Gender, Health, and Health Behavior*

It has been well established that women have higher rates of morbidity as compared to men, women live longer than men, and women use health services more than men (Coreil, Bryant & Henderson, 2001; Leventhal, 2000; Rieker & Bird, 2000). The phrase “gender gap in health” refers to such health-related discrepancies between the two sexes (Coreil et al., 2001). Verbrugge (1990) has asserted that the health disparities found between men and women (particularly women’s greater morbidity in later life) largely reflect psychosocial factors, particularly women’s lower rates of employment and women’s comparative lifelong lack of vigorous physical activity. Her research has suggested that “controlling for a wide array of social factors makes sex differences in health narrow and often vanish statistically” (Verbrugge, 1990, p. 175), and Verbrugge therefore promoted women’s involvement in productive roles and increased aerobic activity as means to enhancing older women’s health. Courtenay (2000) has also asserted that social factors and health behaviors contribute to the health-related differences between genders. Courtenay proposed a relational theory of men’s health from a social constructionist and feminist perspective in an effort to explain the differences. He suggested that health beliefs and behaviors are a means of demonstrating masculinities and femininities, and that health behaviors are used in daily interactions in the social structuring of gender and power.

The treatment of women by health researchers and professionals in the not-too-distant past created a “gender gap” in knowledge about health and health behavior. As Coreil et al.
(2001, p. 105–106) noted, “Only in recent years we have begun to learn much about health-related differences between men and women, largely because up until the 1990s, women were systematically excluded from medical research.” It was long thought that being female was a protective factor against heart disease, but research recently has shown that being female has a positive effect only up to middle age, after which such an influence disappears, and a number of older women develop heart disease (Chernoff, 2001). There is also research demonstrating that women are treated less aggressively for certain diseases, such as Ayanian and Epstein’s (1991) research on the differences in the use of procedures on men and women hospitalized for heart disease.

There is evidence that gender differences in health behavior may develop at young ages (O’Brien & Bush, 1997). For example, Farrand and Cox (1993) found that among a sample of nine- to ten-year-old children, girls reported a higher number of health behaviors than boys. Cohen, Brownell and Felix (1990) found that among schoolchildren, girls more often reported choosing healthful foods than boys, although girls also reported more smoking and less exercise than boys. Brustad (1996) uncovered emerging gender differences between boys and girls regarding physical activity, in which boys expressed more favorable attitudes towards physical exertion and a greater liking of exercise than girls. Brustad suggested that from a relatively young age, vigorous physical activity is regarded as more appropriate for boys than for girls.

In adolescence and early adulthood, girls often use various dietary practices as a means for attaining or maintaining slimness, while many boys use exercise and increased caloric intake as a means of bulking up their physique (Leventhal, 2000; Trowbridge & Collins, 1993). Leventhal (2000) proposed that these behaviors may persist throughout life for women, but may decline for men as they age. Morgan et al. (2001) explored gender differences among correlates of physical activity in adolescents. Girls reported lower physical self-perception and less enjoyment of physical activity than boys, which is consistent with Brustad’s (1996) findings among younger children. Also, boys reported more opportunities to do things outside and to join sports teams than girls.

Gender differences in behavior among adolescents may also be associated with gendered behavior in the family. In exploring intergenerational transmission of health behaviors and lifestyles, Wickrama, Conger, Wallace and Elder’s (1999) study of adolescents’ and their parents’
health risk behaviors revealed gender moderating effects on health-risk lifestyles within the family unit. Their analysis indicated that the father’s health-risk lifestyle affected only sons’ health-risk lifestyles whereas the mother’s health-risk lifestyle only affected daughters’ health-risk lifestyle.

These early influences, combined with societal factors, could become manifest at the other end of the life span, in late adulthood. O’Brien Cousins (2000) interviewed older women about physical activity, in which the women acknowledged the benefits of physical activity, but had major concerns underlying their resistance to exercise (e.g. it can be unsafe). O’Brien Cousins speculated that possible reasons for their concerns and resistance include a lack of experience with fitness activity, social devaluation of older women’s physical recreation, and internalized stereotypes about age and gender; these are similar to Verbrugge’s suggestions. As mentioned above, Leventhal (2000) had suggested that dietary practices related to appearance might persist throughout life, though Waldron (1997) cited data indicating that there are smaller gender differences in dieting (to lose weight) among older adults and proposed that health motivations related to dietary practices are more important in later life than appearance motivations. However, cases of older women with anorexia have been documented, and though these women usually have histories of anorexia, for some, it is a first time occurrence (Morley, 1993). These findings in older women provide support for the notion that it is important to understand women’s worlds and perceptions when studying health behaviors.

*Gender, Gender Roles, and Health Behavior*

Social and gender roles can be influential in the development and shaping of health behaviors. Waldron (1997) identified several hypotheses regarding gender differences in health behavior, focusing on the contribution of gender roles to differences. One hypothesis is that differences are primarily due to two complementary aspects of gender roles, specifically men’s greater propensity for risk-taking and women’s greater health concerns. A second hypothesis is that multiple social and biological factors, including gender roles, influence differences in health behavior. Another hypothesis, the convergence hypothesis, concerns trends in gender differences in health behavior, and proposes that as male and female roles become more comparable, then gender differences in health behavior decrease and may even be eliminated, as Verbrugge
(1990) proposed. An alternative hypothesis predicts varied trends in gender differences in health behavior, because there are many different influences on health behavior.

Waldron (1997) concluded, however, regarding the first hypothesis, that gender differences in risk-taking and health concerns contribute to gender differences in some types of health behaviors, but has little influence on other types. Research has shown some support for more risk-taking among men, which may be related to, for example, higher rates of heavier drinking and accident-related behavior of males, but Waldron cited additional research that health concerns seem to have reduced smoking among men at least as much as, if not more than, among women, and have little to no effect on gender differences in dieting and exercise. Waldron contended that there are other effects of gender roles, and that some health behaviors actually can be seen as part of gender roles in that the behaviors are more common and socially acceptable for one gender than for the other. For example, heavy drinking and involvement in competitive sports might be considered part of the male gender role in some social groups, for whom such activities are associated with toughness and masculinity and are therefore more socially acceptable for men. Similarly, dieting might be part of the female role for young women in some social groups, reflecting concern for appearance and society’s contemporary beauty ideal. Regarding trends in roles and behavior, Waldron concluded that the bulk of evidence does not support the hypothesis that gender differences have decreased as male and female roles have become more similar, but speculated that changing gender differences in employment might have had indirect effects on gender differences in some behaviors, such as smoking. Waldron suggested that it appears the trend toward increasing labor force participation for women contributed to the decrease in social disapproval of women’s smoking, and thus is a cause for decreased gender differences in smoking.

Researchers have examined social roles of women, such as employment, as related to dietary and health behavior. Devine and Olson (1992) found that women described work as a major barrier to healthy eating because of the demands on their time and energy. Devine and Sandström (1996) investigated associations among women’s social roles, their nutrition beliefs and dietary fat avoidance practices among Danish women, based on the findings from Devine and Olson. Devine and Sandström interpreted their findings as evidence that the social roles themselves did not influence fat avoidance behaviors, but the nutrition beliefs associated with
particular roles did have an influence. They found that employment was positively associated with fat avoidance, but only among women who perceived few barriers to healthy eating. Perceived social support for healthy eating was positively associated with fat avoidance among women who were not employed, but no such association was found with women who were employed.

Increased labor force participation is an example of how roles for women have changed over historical time. Bowers (2000, p. 23), in examining how changing roles of women affect dietary practices and patterns, stated:

One of the most important developments affecting America’s eating habits in the past 100 years has been the evolution of new roles for women (and men), as more women have entered the workforce and families have become smaller. New technologies and changes in gender relationships have both played a role.

Haines (1996) specified perceived social roles as a major factor impacting the eating patterns of women, referring to research that has attempted to identify role expectations and how conflicting role expectations might influence dietary behavior (for example, behaviors arising from conflicts between the role of working woman and “the good mother”). Findings from studies led Haines (1996, p. 110) to deduce: “Because women would prepare and consume a different mix of foods if they were not balancing multiple roles, this suggests that some level of role confluence may be needed if women are to be expected to successfully consume a healthy personal diet and also meet family needs and expectations.”

Haines (1996) also referred to Lewin’s work in the early 1940s on food and eating behavior. Lewin (1943) developed the concept of the gatekeeper role in his channel theory of how and why food gets to the table in the home. The gatekeeper concept reflects the perception that women control the flow of goods, including food, into a household. Food gets to the table through “channels,” such as the store, the garden and the refrigerator; the woman as gatekeeper controls the selection of channels and the foods that go through them. Haines noted that, in contrast to the era when Lewin conducted his research, contemporary research has shown that now that more women are employed, husbands are more involved in meal planning, food preparation, and in
making nutrition decisions and family health goals, although women still retain the majority of nutrition and food roles in a family.

McIntosh and Zey (1998) offered a sociological critique of Lewin’s work and conclusions. They agreed that there is an impression that women control food within a household, but based their critique on a “seeming disjunction between the expectation that women control food decisions and the limited reality of such control” (McIntosh & Zey, p. 131). McIntosh and Zey reviewed other research on particular elements of domestic roles that they believe ensure men ultimately control food decisions, including men’s control over family finances, women’s obligations to produce a harmonious family life, and women’s deference toward men’s food preferences.

Mennell, Murcott and van Otterloo (1992) addressed the place of food in the division of labor in the home. The authors remarked that men do cook at home, but this is something men can decide to do, whereas women generally have no option. Men assist or fill in when the woman is unable to cook (due to illness, for example), but no matter how competent the man may be as a cook, he does not often take over preparation of the main meals. Adler (1981) stated that men’s cooking is generally limited to special occasions, such as a summer cookout or pancakes on a Sunday morning.

Schafer and Schafer (1989) examined gender roles as related to food roles and tasks in families. The researchers interviewed couples in various family life stages (young families, maturing families, middle-age empty nest families and retirement families) and found that the couples, in all stages, generally agreed that food selection and preparation should be under the woman’s purview. The couples reported that the wives primarily conducted all the food-related activities, with only a little help from the husbands, and with little to no marital conflict over the equity of role expectations and performance. Husbands in the younger life stages did do slightly more cooking than those in later stages, but were not more involved in food selection. Additionally, the younger wives thought that the husbands should be more involved in food-related chores. The authors felt that this might “reflect a sensitivity by younger families to changing gender-roles of women and the need for husbands to share more of the responsibilities of household tasks,” or alternatively it could “reflect the bargaining of couples who have been
married longer, by which adjustments have been made in various role behaviors to produce equity” (Schafer & Schafer, 1989, p. 123).

Even though older families professed to have more traditional expectations regarding wives and food-related chores, husbands in the older retired families tended to be more involved in food shopping and food purchase and budget decisions. Schafer and Schafer (1989) speculated that this was due to greater time availability of retired men for household and food-related tasks. They stated that their data indicate “that the gender-role changes in contemporary American society have not resulted in major food-role restructuring by men and women studied” (Schafer & Schafer, 1989, p. 124). Yet, their findings on older families suggest that either: 1) there are gender role changes associated with a retirement transition in contemporary older families, 2) the older couples are reflecting some societal change in gender roles, and/or 3) some food-related tasks are perceived as more female than others (shopping and food purchase decisions are related to finances, and therefore are perhaps considered to be less feminine activities). Simply because the older men had more time does not mean they would perform the tasks if they truly believed that such chores were “women’s work.” They would likely need to believe that these are acceptable things for men to do. Or this is an example of how beliefs are not always associated with actual practices.

Brown and Miller (2001) had somewhat different findings than Schafer and Schafer (1989), when over ten years later, they reported on their investigation of the influence of gender role preference on food chore responsibilities among young couples with young children. Gender role preference (GRP) was defined as representing an individual’s “degree of preference for the rewards and costs that arise out of the gender stratification and division of household labor” (Brown & Miller, p. 1). For couples who have egalitarian GRP, household roles and tasks are interchangeable between the sexes, and for couples who have traditional GRP, the women is assumed to be responsible for all to most of the domestic work. Transitional couples are those in between the two extremes. Brown and Miller recruited couples in which the wife was no older than age 40 and they had one child under age 6, and interviewed couples who were transitional and who were egalitarian. Their findings demonstrated that in transitional couples, after children were born, food chores that had been shared were transferred to the wife, based primarily on the husband becoming the main breadwinner, and justified by the wife based on her superior
skills, time and duty. Egalitarian couples, however, used three different strategies to handle food chores after children were born. The first strategy was role reversal, in which the husband did all of the shopping, most to all of the cooking and all or shared clean-up after meals. The second strategy, called trading off, involved one doing the majority of the shopping, the other doing the cooking, and whoever did not cook, usually cleaned up. The third strategy was sharing roles. These couples switched off shopping, cooking and cleaning, so that each did part of all food chores. Brown and Miller found mostly transitional couples, with a number of egalitarian couples, suggesting that over a decade after Schafer and Schafer’s (1989) study, there perhaps have been some gender role changes for younger generations.

Gender is obviously influential as an aspect of family life. Family members teach children, starting at a young age, how girls and boys should behave, as well as model gender-specific behavior and gender-associated roles such as mother, wife, father, and husband. There is much evidence that social relations within families are gendered (Rossi & Rossi, 1990). There continues to exist different expectations for women and men in households and families. For example, as mentioned, men provide assistance with food chores, but women still are mainly responsible for food preparation and food-related tasks, despite their increased labor force participation (Haines, 1996; Kemmer et al., 1998; Schafer & Schafer, 1989). The topic of social and familial relationships and related roles and transitions, as influences on health behavior, is the focus of the next section.

Social Relationships and Transitions Across the Life Course

As food is used to create and maintain social relationships, it plays a very important role in primary groups of family and household in which individuals pass through their life cycle. The consequences of social positions in family and household for the production, distribution, preparation and consumption of food and meals form an important topic of research. (Mennell, Murcott & van Otterloo, 1992, p. 91)

There is a significant body of research on food, dietary practices and social relationships in the health behavior literature, but also in the general anthropological and sociological
literatures. The focus is commonly on the family, typically conceived of as a nuclear family with children, and on practices at home, although some research on children has examined practices at school. The anthropological and particularly sociological literatures on dietary behavior appear to be dominated by European (particularly British) and Australian scholarship. It is well beyond the scope of this review to examine all the anthropological and sociological literatures on food and eating, but those who are interested can find it summarized in Mennell et al. (1992) and Beardsworth and Keil (1997). Classic and oft-cited works on social aspects of food and eating can be found in Charles and Kerr (1988), De Vault (1991), Douglas and Isherwood (1979), Mennell (1985), Murcott (1982), Lévi-Strauss (1970), Lupton (1996), and Warde and Hetherington (1994). Valentine’s (1999, p.492) assessment of the evidence of such studies is that “food plays an important part in the production of ‘family’ identities and in the negotiation of gender relationships within the homes.” Beardsworth and Keil (1997, p. 96) reflected that such research on food and families has shown that “while eating patterns reflect family processes, at the same time, family relationships and family boundaries are expressed and reinforced by the day-to-day routines of provisioning, preparation and consumption.”

Charles and Kerr’s (1988) research on food and families is one of the most widely referenced studies on the subject. Their research involved interviews and food diaries with 200 women with young children in northeast England. One of the key findings was the emphasis on the concept and importance of a “proper meal.” A proper meal is one based on freshly cooked meat with potatoes and vegetables, and is a meal eaten together as a family. Charles and Kerr proposed that this concept is fundamental to the identity of the family and it’s well-being, and represents the family as a cohesive social unit, a “proper family.” Another key finding was the deference of the women when cooking to the tastes and preferences of their husbands, even over the children. Charles and Kerr concluded that women have responsibility without authority in relation to food and food preparation, given the economic dominance of their husbands and their prioritizing of their husbands’ preferences. This supports McIntosh and Zey’s (1998) contentions regarding the power of women in families related to the gatekeeper role for food. Research on families in the United States by De Vault (1991) produced findings similar to Charles and Kerr. De Vault interviewed thirty households in and around Chicago, also finding that women bore almost all of the responsibility for food work, and that Americans also have a notion of
a proper meal, though it is of course different in its content than the British version. De Vault also supports McIntosh and Zey, as she viewed the seeming autonomy of women in household operations as obscuring the fact that they essentially do what they perceive will please and accommodate others in the family.

Charles and Kerr’s (1988) research was conducted in the 1980s, however, and though it offers valuable insights, it could now be considered a study of the 1980s family, rather than today’s family. Kemmer et al. (1998) showed that the newly married/cohabitating women in their study were less deferential to their husbands’ food preferences when preparing food than the women in earlier studies such as Charles and Kerr’s. They suggested that newer cohorts of young women considered their own food preferences more so than in the past.

Family life is subject to changes over historical and individual time. As Baranowksi (1997, p. 200) pointed out, noting societal changes in family structure and family relationships, “What can be said about families and diet at one time may not be true of them at another,” and the same likely can be said of other health behaviors. Kemmer et al.’s (1998) findings, when compared to Charles and Kerr’s (1988) findings, support this point. The composition and structure of a family can take many forms and go through changes over an individual’s lifetime. These family transitions are critical periods that usually instigate or are accompanied by other changes in an individual’s life. Thus, the familial milieu for health behavior changes over time, and so there may be differential influences of family on behavior, depending on the change and/or the behavior. Rimal and Flora (1998) discussed how family roles and position in the family structure may affect health behaviors, giving the example of how the health behaviors of a 19-year-old living in a household as a child will be different from those of a 19-year-old living in a household as a parent.

**Childhood and Youth**

O’Brien and Bush (1997, p. 49) asserted that “Childhood is now coming to be perceived … as a critical period in the overall development of the individual for the acquisition of appropriate health behaviors and the assumption of a healthful lifestyle.” The authors argued that understanding influences on children’s health behavior is important because the “stability seen in many health behaviors by the time of adolescence shows that the health behaviors an individual
exhibits as an adult are determined, in many ways, during childhood” (O’Brien & Bush, 1997, p. 49). Researchers are discovering that there may be long-term consequences from actions taken and behaviors acquired in childhood and adolescence, such as the development of obesity (Cowell & Marks, 1997; O’Brien & Bush, 1997). Family provides an important and fundamental context for children in which behaviors are learned, established and developed (or are not learned or developed), with parental influence as a major factor in the process.

For children and adolescents, parents generally are assumed to be the predominant family members of influence, and much of the research on familial influence of health behavior in childhood and youth focuses on the parents. Little work seems to have addressed other family members, or even fictive kin, as influences on health behavior and experiences. In an exception, Lau, Quadrel and Hartman’s (1990) study of influences on young people’s health behaviors, which found family to be a very important influence, defined family to include siblings as well as parents. Lupton’s (1994) work on adult memories of childhood food-related experiences clearly indicated that other family members besides the parents may be an influence. Grandparents and other older relatives were remembered as indulging their young grandchildren, nieces, and nephews with treats (usually sweets) that the children were not normally allowed to eat at home. These treats became associated with special times and kindness from the older family members.

Pratt (1973, 1976) conducted now classic work on how child-rearing styles affect children’s health behavior. Pratt found a particular parenting style, which she named the energized family, to be associated with the highest levels of positive child health practices. In energized families, parents allowed their children to have a high degree of autonomy and used reasoning as a disciplinary strategy, rather than automatically punishing. They fostered the child’s assumption of responsibility, including for health practices. Children of authoritarian parents were not as likely to practice positive health behaviors.

Two of the main mechanisms through which parents are presumed to affect their children’s health behaviors are through direct modeling and socialization (Baranowksi, 1997; Tinsley, 1997), although Lupton’s (1994) study implied that parental social control may also be a mechanism (social control is generally studied among adults and health behavior – e.g. Umberson, 1992). The evidence for role modeling effects is inconsistent, as regular patterns of correlations between the parents’ behavior and children’s behavior have not always been
demonstrated (O’Brien & Bush, 1997). Kimiecik and Horn (1998) found no role modeling effect for physical activity, and similarly, Sallis et al. (1993) found no correlation between parents and children’s physical activity. However, Lau et al. (1990) found direct modeling to be a very important avenue of influence of parents on their children’s health behavior, and Yang, Telama and Laakso’s (1996) study of Finnish schoolchildren and their parents also showed a relationship, with children of active parents more likely to participate in sports than children of passive and single parents.

It could be that there are other important factors that need to be present in addition to modeling. Factors such as the availability of activities (to some extent controlled by the parents), and parental support have been shown to be important in children’s physical activity participation (Alpert, Field, Goldstein & Perry, 1990; Pate et al., 1997; Sallis et al., 1993). This seems to support socialization and social control mechanisms for parental influence on children’s health behaviors. It is also possible that role modeling will have differential effects depending on the behavior.

Socialization processes for children’s health behaviors appear to have more consistent support. Brustad’s (1996) study of urban schoolchildren’s physical activity found that parental socialization processes, such as parental encouragement and parental enjoyment of physical activity, had a significant effect on a child’s perceived self-efficacy in physical activity and attraction to physical activity. Sallis, Taylor, Prochaska, Hill and Geraci (1999) found that one of the variables that reliably determined the level of physical activity in children and adolescents is physical activity as a family value. Rimal and Flora (1998) examined socialization processes for children’s dietary behavior and how family, specifically parents, influences such behavior. The researchers also examined children’s influence on their parents’ behavior, noting that research on this direction of influence was lacking. They found that children who ate healthy food at home, tended to eat healthier foods outside of the home as well, suggesting that parental influence on food consumption extends to situations in which they have little direct control. Also, healthy behaviors of adults were associated with the same healthy behaviors of their children, suggesting a modeling effect for dietary behaviors. This, along with the previous mentioned inconsistent evidence for role-modeling effects drawn from studies of physical activity, implies the possibility that role modeling effects might differ depending on the behavior.
Health behaviors continue to develop in adolescence. Misra and Aguillon (1999) examined the health behaviors of rural youth, finding that those who exercised also had better diets, and that adolescents with social and leadership traits were more likely to have healthy behaviors. As children become adolescents, peers begin to gain ground as important influences on health behavior (Hover & Gaffney, 1988), but parents still retain a prime position as an influence on their children’s health behaviors. Cowell and Marks (1997) noted that family nutritional behavior has traditionally been considered one of the most important external variables to consider in explaining adolescent dietary patterns. The previously mentioned study by Wickrama et al. (1999), which investigated whether parents’ health-risk behaviors (e.g. poor diet, lack of exercise, smoking, excessive drinking and inadequate sleep) influenced adolescents’ health-risk behaviors, also explored whether intergenerational transmission occurs through direct transmission of specific behaviors, a general health-risk lifestyle, or both. Their results indicated that parents’ behaviors did influence their adolescent children’s behaviors, and that transmission of health-risk behaviors occurred at both the lifestyle factor level and the unique component level.

Young Adulthood

The transition from adolescence to adulthood presents opportunity for change in health behaviors. Pavis, Cunningham-Burley and Amos (1998) interviewed young people in Scotland who were beginning the transition from school to employment, training or further education (this traditionally occurs a couple of years earlier for Scottish youth than for American youth). The researchers considered how health-related behaviors, such as smoking and alcohol consumption, are related to this transition to adulthood. They noted that their respondents explained changes by contextualizing their practices, emphasizing their new social positions and other changes taking place in their lives. The behaviors were strongly associated with the behaviors of friends, the use of leisure time and changes in disposable income.

Lau et al. (1990) used a longitudinal data set to explore sources of stability and change in young adults health beliefs and behaviors concerning alcohol use, diet, exercise, and wearing seat belts. They found that there is substantial change in health behaviors during the first three years of college, and that peers have a strong impact on the degree of that change, consistent with
Pavis et al. (1998). But they also found family socialization to still be very important for young adults, in fact much more important than peers as sources of influence. The researchers asserted that their data, along with previous analyses in their program of research, suggest a gradually increasing parental influence on their children’s health behavior while the children are living at home, and the persistence of that influence at least through the college years. Lau et al. (1990, p. 255) proposed a “windows of vulnerability” model:

The *windows of vulnerability* model predicts that parental influence on children’s health beliefs and behavior generally will persist throughout life unless the child is exposed during certain critical periods to important social models whose health beliefs and behavior differ from those of parents. At these critical periods, individuals are particularly open to socializing agents other than the parents. Three distinct life stages seem particularly likely to be “periods of vulnerability.” The first is adolescence … A second vulnerable period is the time when grown children leave home and begin to live on their own … A third vulnerable period is the point at which children set up a home environment with a significant other (typically when they marry).

While this model is appealing, it is curious that they did not consider other phases of life as particularly likely to be critical periods. For example, having children is another period of life that is likely to affect health behaviors; children may influence their caregivers’ health behavior, as indicated in Rimal and Flora’s (1998) work. It seems shortsighted to assume that influences will persist throughout life unless exposed to other influences during critical periods, and then only suggest phases earlier in the life course as particularly likely to be periods of vulnerability. The model further neglects the significance of losing agents of socialization, other mechanisms of influence (e.g. social control, social desirability) and any meaning associated with behaviors (e.g. cooking as a gift to others).

Pliner (1983) investigated family resemblance in food preferences, also by questioning college students and their parents. Pliner found significant correlations between children and their parents, and suggests that the similarity between parents and children are due to imitation and frequency of exposure to certain foods. The study also demonstrated patterns
of sex differences, where children more closely resembled same-sex parents, which also was found in the Wickrama et al. (1999) study. Pliner further speculated that similarity is found, not necessarily because the parents influence the children, but possibly because children’s preferences also influence their parents’ preferences.

Lupton’s (1994) work used college students as well, but the students ranged in age from early twenties to middle-aged. Her study explored why individuals adhered to certain eating habits and avoided others though analysis of childhood memories of food. Lupton found that the memories were strongly linked to family relationships, and characterized by emotional themes of control, disappointment, security, happiness and belonging/not belonging. The parent-child relationship in many of the memories was typified by a power struggle related to the eating habits of the child. This struggle often centered on the discourse of “good” food versus “bad” food, in which the parents defined good food as vegetables, meat and milk and bad food as sweets and junk food. Lupton noted, however, that “ ‘Bad’ food was associated not with bad feelings, but with feelings of being indulged and loved” (1994, p. 681), and with out-of-the-ordinary events, such as birthday parties. “Good” food was often the problematic food for the participants, and was associated with conflict and feelings of physical revulsion. For Lupton, this food morality explains why “bad” food habits persist despite the efforts of health educators, who usually use a rational, common sense approach to health educating. Moral meanings of food and eating are addressed further in a later section.

For Lupton (1994, p. 682), the study demonstrated that dietary behaviors “are formed as a process of socialization throughout early childhood and adolescence, culturally reproduced from generation to generation, and are also the product of individuals’ experiences with social relations connected with food events.” Lupton (1996) later contended that childhood patterns of dietary preferences and practices never completely disappear; childhood experiences are always reacted to, consciously or not, and often lead to the acceptance or rejection of certain foods, based on those experiences.

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1 Lupton does not indicate a specific age range or an upper age grouping to give an approximation of what ages might constitute middle-aged.
Family Statuses and Transitions: Marriage and Parenting

Sometime during or after young adulthood is when individuals typically make transitions in their family life course, marrying and becoming parents. Kemmer et al. (1998) examined the changes that took place in the eating habits and food-related activities of 22 Scottish couples (ages 19 to 33) when they made the transition from single to married or cohabitating, and thus living together. The researchers interviewed the men and women separately, and interviews were carried out about three months before and three months after they moved in together. They found that the couple felt eating together had symbolic importance in “setting up home,” and tried to have the main meal together in the evenings. Shopping and eating patterns took on more formalized and routinized patterns than before they were married/cohabitating. The women were mainly responsible for buying and preparing food, but only in a small majority of the cases. Where food purchase and food preparation were shared, so was food choice. Health did not seem to be a significant issue, though women were more likely to make an issue out of eating and health. In general, there was much negotiation and adaptation in food choice and eating patterns after marriage/cohabitation, but the researchers did not identify any significant gendering of power over food choice among the couples studied. More often women influenced men, although this was not the only direction, and when the women did, it was to take care of her husband/partner as well as herself, and so she took on the traditional role of nurturer in the relationship.

Umberson (1987, 1992) examined family status as it impacts health behaviors and explored social control as a mechanism of influence on health behavior. Umberson (1987) speculated that the family relationships of marriage and parenting provide external regulation as well as facilitate self-regulation of health behaviors. Using a national sample, Umberson examined the relationships of marital and parenting statuses to a variety of health behaviors (e.g. diet, sleep, stress/conflict management, substance use). The findings indicated that marriage and the presence of children in the home deter negative health behaviors. Based on these findings, Umberson suggested that family roles promote the social control of health behaviors.

Umberson (1992) then focused specifically on gender and marital status, to explore how social control can explain mortality rate differences between the unmarried and married, and why marriage seems to be more beneficial for men than women in this regard. Analysis of national panel survey data revealed: 1) marriage was associated with substantially more
efforts to control health for men than for women; 2) those who attempted to control the health of others were more likely to be female than male; 3) there was some support for a social control mechanism among the married; 4) the transition from married to unmarried was associated with an increase in negative health behaviors; and 5) the transition from unmarried to married seemed to have little effect on health behavior (the only effect found was a reduction in alcohol consumption for women). Umberson conjectured that the seeming lack of change in health behavior in the transition from unmarried to married may be because those who get married usually have been involved with each other for some period of time before marriage, and so their regular health habits may be largely unchanged by official entry into marriage.

However, it may be possible that Umberson (1992) is missing something. Her findings are not consistent with the findings of Kemmer et al. (1998), who did find changes in eating practices and food-related activities. Umberson conducted a quantitative study using national survey data, and used indicators of health behaviors such as body mass/relative obesity, number of drinks and cigarettes, hours of sleep, and how often physical activity is engaged in. Kemmer, Anderson and Marshall conducted a qualitative study by interviewing couples before and after they got married or began cohabitating. They used a semi-structured interview technique, covering core topics, but allowing the participants to talk in their own way about the topics, and to raise issues on their own. They discussed food choices and food-related activities, as well as perceptions of changes.

A discussion of food choices and related topics will more likely reveal changes in quality-related aspects of dietary behavior, and reasons for those changes. Calculations of changes in body mass or relative obesity, though a common proxy used for assessing dietary patterns (Grzywacz & Marks, 1999; Kaplan et al., 1987; Paffenbarger et al., 1994), reveal nothing more than whether the person has lost or gained weight, and is considered obese or not. However, changes in weight could be due to factors other than the person’s diet (e.g. weight lost from physical activity or weight gained from a decrease in physical activity). If changes are the result of dietary behavior changes, it does not uncover what those changes in behavior actually are and how those changes came about. Interestingly, consistent with Umberson’s (1987, 1992) studies, there is some evidence for a social control mechanism of influence for family on health behavior from the women in Kemmer et al.’s (1998) study, in that the women consciously and purposively made efforts to improve their husbands’ diets.
Another mechanism of family influence on health behaviors that has been explored is family solidarity. An adapted version of Bengtson and Robert’s (1991) model of intergenerational solidarity guided the Grzywacz and Marks’ (1999) study. The researchers adapted Bengtson and Robert’s model in the sense that they extended it from intergenerational solidarity (between parents and their children) to family solidarity (for family relationships in general, not restricted to only the parent-child relationship). They examined family solidarity, gender and health behaviors (body mass [diet indicator], physical activity, smoking, alcohol consumption, check-ups and medication use) using data from the National Survey of Midlife Development in the United States. They found that some dimensions of family solidarity had positive effects on some health behaviors, and negative effects on others. In general, higher levels of family solidarity were associated with a greater likelihood of engaging in positive health behaviors, and men’s health behaviors were positively influenced by family solidarity more so than women's health behaviors. Grzywacz and Marks cautioned though that the results imply greater family solidarity does not always lead to better health behaviors. They concluded that the complexities of their results suggest that each health behavior may have unique predictors and correlates.

Researchers have investigated specific health behaviors of married couples, such as dietary practices, and factors affecting couples’ practices. Lupton (2000) conducted a qualitative study of food preferences and habits of rural Australian couples, with and without children living at home. The findings indicated that their approaches to food are rather conservative, emphasizing a traditional meat and vegetable main meal, though pasta and stir-fry meals had been widely adopted. Lupton suggested that region of residence, social class and education contributes to a conservative approach. Though they did not exhibit the “gourmand sensibility” that characterizes the approach of the metropolitan middle class, the participants privileged other aspects of food such as tradition, nostalgia, sociality, and family togetherness. Health and balance were also valued and influenced food choices. Similar to Kemmer et al. (1998) findings, cohabitation and marriage marked the point at which many people started to prepare and consume more home-cooked, “balanced” meals, as compared to when they were single. Parents saw themselves as responsible for their children eating healthy foods and having a healthy diet. According to Lupton, these findings illustrated how eating healthy meals were an important aspect of living as a couple or a family.
Paisley, Sheeshka and Daly (2001) specifically investigated vegetable and fruit consumption of Canadian couples, with and without children, and two overarching themes emerged from the interviews. The first theme was the emergence of a fruit and vegetable morality that the researchers called the “should syndrome,” as participants often spoke of what they should and should not do regarding fruits and vegetables. Three related categories supported this moral discourse: 1) the low status of vegetables in childhood homes, where meat and potatoes had a higher status; 2) food wars, concerning childhood struggles with parents over foods, especially vegetables, consistent with Lupton’s (1994) findings; and 3) vegetables: the nouveau dish, dealt with the new societal status of fruits and vegetables that is associated with good health, and perceived pressure to eat fruits and vegetables. Paisley et al. (2001, p. 203) noted:

In childhood homes, the “should syndrome” had been supported by the low status of fruits and vegetables and by food rules. In contemporary times, the “should syndrome” was driven by the new status of fruits and vegetables as part of the “ideal” diet … Eating fruits and vegetables was perceived to be a virtuous practice; if you ate them, other people might assume that you were virtuous too.

The second overarching theme was the creation of couple gastronomies. In their lives as a couple, the participants constructed shared gastronomies consisting of rules, norms, practices, and meanings concerning food. These were different from the gastronomies of childhood and when they were single. The researchers found these couple gastronomies had been constructed primarily through commensality (eating together), which expanded the number and types of foods eaten when they became part of a couple; choice, representing a new approach to parenting and food rules that differed from their parents, whereby children are offered food choices; and balance, a guiding principle for food choices.

Not much is known about the relationship between marital status and health behaviors among older adults. Schone and Weinick (1998) investigated such a relationship using data from the 1987 National Medicare Expenditure Survey, finding that marriage had a positive impact on health behaviors of older adults. In other words, married older adults were more likely to practice healthy behaviors (such as regular physical activity, eating breakfast, wearing seat belts and not
smoking). These effects tended to be larger for men than for women. Because age had an effect on health behaviors, they suggest that the propensity to engage in health behaviors changes over the life course, even for older adults. Higher rates of social contact also had a significant positive effect on health behaviors. The researchers concluded that the benefits of marriage for health, which has been seen in younger populations (e.g. Umberson, 1987, 1992), continue into later life.

Schafer and Keith (1982) aimed to use a social-psychological approach to study the diet quality of married older adults and single older women who lived alone. They actually found that the single women made food decisions independent of others and had a significantly better diet than the married couples (which was due in part to the lower diet quality scores of the married men). For the older married women, a significant, negative relationship was found between household role dissatisfaction and diet quality, where greater dissatisfaction was related to poorer diets. For the single women, there was a negative relationship between age and diet quality, where the older they were, the poorer their diet quality. The researchers speculated that such findings suggest marriage might diminish negative effects of age on diet quality of older adults, or that it may be due to the fact that the sample included single elderly women who were older than the married elderly women.

Horwath (1989) examined the interaction of living arrangements, marital status and dietary patterns among older Australians. Her analysis of self-completed questionnaires revealed that older men living with a spouse generally had better diets than older men who lived alone. Older women living alone, however, had fairly similar dietary patterns to the married women and nutrient intakes equal to or better than the women who lived with a spouse, similar to Schafer and Keith (1982). Horwath asserted that the findings indicate that the relationship between living arrangements, marital status and dietary patterns are contingent on gender.

In examining the differences among family statuses, Louk, Schafer, Schafer and Keith (1999) compared the dietary intake of husbands and wives at different family life stages (assumed to be typical stages). Questionnaires were completed by married couples in the following categories: 1) young families – married couples with at least one child under six years of age; 2) established families – married couples with no children under six, but with at least one child between six and eighteen; 3) empty-nest families – married couples with no children under eighteen, and none living at home; and 4) older families – married couples with no kids at home,
and the wife is 60 or older. They essentially found that in the later life stages, empty-nest and older families, there was more similarity in nutrient intake between the spouses. The researchers speculated that this could reflect that after years of eating apart because of work and children’s schedules, they are now eating together again. Unfortunately, there are no data on the couples’ past dietary patterns to support this. The pattern of nutrient intake similarity could eventually become true for the younger families, but it could also be that separate schedules was not a pattern earlier in life for the older families. Cross-sectional data are not so insightful in this area. Family status transitions, such as the ones represented in Louk, Schafer, Schafer and Keith’s (1999) research, do involve change and thus may represent “windows of vulnerability” for health behavior change, as hypothesized by Lau et al. (1990).

Marriage and parenthood represent two family statuses and transitions that have received attention in the literature, and have been addressed thus far. Other family statuses and transitions have received little to no attention in the literature, although they may be just as likely to influence health behavior as marriage and parenthood. Examples of such neglected statuses and transitions are lifelong singleness, divorce, remarriage, late marriages, empty nest, and families in which children have “returned to the nest.” Valentine (1999) observed that much of the academic literature on domestic food consumption has mainly examined households consisting of a nuclear family with children, and generally when the children are young, noting Kemmer et al. (1998) as an exception. Valentine (1999, p. 506) asserted:

> By taking a snapshot of consumption in this way, research has obscured the fluid composition of many modern households, thus overlooking the ways that households, gender identities, and food consumption practices are all (re)negotiated and (re)produced throughout the multiple stages which make up an individual’s lifecourse.

Retirement, widowhood and caregiving are also major life course transitions, typically occurring in later life and involving family, that may impact health behavior.

**Later Life Transitions: Retirement, Widowhood and Caregiving**

Transitions often associated with later life, e.g. retirement, widowhood and caregiving,
might impact the health behavior of individuals experiencing such transitions. Regarding dietary behavior, Hendricks, Calasanti and Turner (1988, p. 77) stated, “Loss of spouse and retirement are two roles … portending a change in eating habits. The alterations in living situations and contexts of eating that both these transitions imply can have an important influence on nutrition.”

Retirement is not a family life transition per se, though such a change in employment status affects family. Whether there is an effect on dietary and other health behavior is much more of an unknown, for studies of the effect of retirement on health behavior in general, and dietary behavior in particular, are quite rare. Lauque et al. (1995) investigated the effects of retirement on the dietary behavior of French men and women, assessing them six months prior to and one year after retirement. The researchers observed few changes overall, but did find that retirees take more time for meals, especially breakfast and lunch. They also ate more often at restaurants or friends’ homes, as well as had guests over to eat more often. Vitamin and mineral supplement use was not frequent, but did increase after retirement, with some subjects beginning supplement use after retirement. Nutrient distribution (e.g. percentage of fats, carbohydrates, proteins, etc.) did not vary between the two time periods, and food intake did not change after retirement, although the amount of fish consumed showed an increase. From their findings, the researchers concluded that retirement does not bring about major modifications in eating habits during the first year of retirement. They interpreted the increase in supplement use as a sign of concern about nutrition, health and aging. Although the researchers understood their findings as indication that there is no “significant” change in nutritional intake, the lifestyle changes and social changes related to eating could be significant to those who have instituted such changes in their lives, and the leisurely enjoyment of meals and friends could perhaps contribute to overall quality of life.

A very limited amount of research has addressed the life course transition of widowhood and possible effects on health behavior, with few attempts to investigate a relationship between widowhood and dietary behavior. Among his examples of other household types and life stages, Valentine (1999) presented the case of a British elder widower, Walter, as his first illustration of some of the processes of change that affect food consumption, focusing on home as a site of consumption. Walter’s wife died from cancer, but shortly before she died, she began teaching Walter how to cook. While they were married, they followed a traditional division of housework,
where his wife did all the cooking and care of the house, and Walter took care of the car and yard work. His wife’s illness and death forced a reconstruction of his gender identity; Walter did not just learn enough about cooking to get by, but worked on his culinary skills, watching cooking programs on the television, using family recipe books, and becoming something of an experimenter in the kitchen. Cooking also became a way to reinforce family ties with his daughter and mother-in-law, for whom he made special treats and meals. Reciprocal food sharing became a part of Walter’s sense of neighborhood and community, participating in food exchanges with other widows. When his male friends remarked that they could not do what he does, Walter contended that men and women should share cooking duties. Although Walter enjoyed cooking for others, he did not enjoy cooking for one, which made him feel sad and alone. When he cooked just for himself, it was cheaper and easier for him to use convenience and frozen foods. In an attempt to maintain some continuity, Walter continued to formally set the table for each meal. Valentine (1999, p. 508) concluded his presentation of Walter’s case with a deep concern of Walter’s: “Walter fears the day when he no longer has the motivation to make this effort, however emotionally painful it can be, because the ritual of preparing and consuming a meal gives temporal rhythm to his day and requires him to exercise some self-discipline in order to look after himself.”

Sidenvall, Nydahl and Fjellstrom (2000) interviewed single and cohabitating Swedish older women about the meaning of preparing, cooking and serving meals. The findings showed that the fundamental meaning of preparing and cooking meals was to do something for others, and was viewed as preparing a gift. As long as they were able, cohabitating women continued to cook with duty and joy as they had always done. For widows, however, and particularly those who had recently lost their spouse, the meaning of cooking and eating was lost; they felt it was of no use to cook for only one person. The researchers concluded that these women might be at nutritional risk, as meal skipping was common, as well as some psychological risk from a loss in self-esteem.

Rosenbloom and Whittington (1993) compared the eating practices of recently widowed elders to same-age adults whose spouses were still living. They found that widowhood triggered disorganization and changes in daily routines associated with food preparation and consumption. The widows in the study reported a loss of appetite, lack of enjoyment of meals, unintentional
weight loss, and less use of vitamin and mineral supplements; on the whole, they experienced a decline in nutritional quality. Greater levels of grief were associated with adverse dietary behaviors. All the participants had the means to purchase and prepare foods, which suggested to the researchers that social activities surrounding eating were stronger contributors to changes in dietary behavior and nutrient intake. Although these changes appear to be possibly linked with the bereavement process and may be temporary responses to a stressful event, there is some evidence that widowed persons are at nutritional risk due to altered food and eating behavior.

Shahar, Schultz, Shahar and Wing (2001) investigated the effects of widowhood on weight and dietary intake and behavior among recently widowed older adults, comparing them to married older adults, matched on age, sex and race. Weight loss was significantly higher among widowed elders. They enjoyed their eating less, ate more meals alone, and consumed more commercial meals (and therefore fewer homemade meals) and fewer snacks. They lacked interest in activities related to food and eating, such as cooking and grocery shopping. The researchers found that widowhood dramatically changed the social environment of the individuals and “triggered changes in daily routines associated with food preparation and eating” (Shahar et al., 2001, p. 195). These findings are consistent with Rosenbloom and Whittington (1993).

Howarth (1993) focused on the food consumption patterns of widowed English people over the age of 75. She too found that the domestic organization of dietary activities could be completely changed by widowhood. Howarth’s research suggested that older widowed people “attempt to maintain continuity of food consumption, both men and women strive to retain familiar practices” (Howarth, 1993, p. 77), similar to Walter’s setting of the table for meals. This striving for continuity, however, was more difficult for the men, and so most of the widowers were inclined to use convenience foods and technology that made cooking less threatening. Some men reported that their daughters cooked for them or that they were part of a reciprocal arrangement with neighbors who were widows.

Quandt, McDonald, Arcury, Bell and Vitolins (2000) explored the dietary behaviors of American older widows, conceptualizing the behaviors as nutritional self-management strategies. Data from in-depth interviews with widowed women, who had been widowed from less than one year to 39 years, revealed that there are varied responses to widowhood. Some of the responses had a positive impact on their nutritional strategies, such as following their own dietary needs.
But most responses resulted in a negative impact, such as meal skipping, and reduced home food production and dietary variety. Quandt, McDonald, Arcury, Bell and Vitolins (2000, p. 94) proposed, “Widowhood may provide a teachable moment for getting women to begin to take care of their own nutritional needs, rather than catering exclusively to their husbands.” But they also cautioned that the life course of the population studied needs to be taken into account when generalizing from the findings; for example, younger widows might face different problems. One could speculate that future cohorts of older widows might also be different. Kemmer et al. (1998) demonstrated that the newly married/cohabitating women in their study were less deferential to their husbands food preferences when preparing food than women in earlier studies, and suggested that newer cohorts of young women considered their own food preferences more so than in the past. This could result in somewhat different nutritional behavior for these women if and when they become widowed.

McDonald, Quandt, Arcury and Vitolins (2000) interviewed older widowers about their dietary behavior. Their research showed that widowers used a variety of means to create a reliable nutritional strategy after becoming widowed, such as self-care, informal support, formal programs or some combination of these. They identified key risk factors for not having an adequate strategy: low income, poor health and a lack of social integration. Many of the widowers cared for their ailing wives before widowhood, and the researchers speculated that they had reason therefore to become more self-sufficient, including in food-related tasks. Wells and Kendig (1997) suggested that caregiving, often a precursor to widowhood, might help prepare older people for widowhood.

Relatively little is known about the effects of caregiving on the health behavior of the caregivers; what is known seems to indicate a generally negative trend, although this may depend on the behavior and gender of the caregiver. Burton, Schulz, German, Hirsch and Mittlemark (1994) compared married adults caring for a spouse with married adults not caring for their spouse, and found that a large proportion of the caregiving individuals reported much less time for exercise, rest or their own health concerns. Similarly, Connell and Schulenberg (1990) found that spouse and adult children caregivers neglected their own self-care needs whenever the demands of caregiving increased. Sisk (2000) investigated the relation of caregiver burden and health behaviors. The results suggested that caregivers with lower subjective burden
scores practiced more health-promoting behaviors (e.g. eating nutritiously) than those perceiving higher subjective burden. Connell (1994) conducted a study that actually detailed specific health behaviors of caregivers. After beginning caregiving, about 32 percent of the caregivers in the study ate less nutritiously, 32 percent decreased exercise, and 43 percent increased the amount they smoked. The negative direction of the behaviors seemed to be attempts to reduce stress, however, as caregivers reported finding comfort in food and reduced tension and anxiety from smoking. Prohaska and Clark (1997) speculated that the reasons for caregivers’ low rates of positive health behaviors are most likely role overload and possibly some denial that they are even at risk.

**Social Support**

Social support is another mechanism through which social relationships might influence the health behaviors of individuals. Numerous studies have linked social support and health and dietary behaviors for specific conditions, such as cardiovascular disease (Bovbjerg et al., 1995; Ford, Ahluwalia & Galuska, 2000; Rogers, 1987) chronic renal failure (Hitchcock, Brantley, Jones & McKnight, 1992; Oka & Chaboyer, 1999), diabetes (Brown et al., 2000; Garay-Sevilla et al, 1995; Kaplan & Hartwell, 1987; Pham, Fortin & Thibadeau, 1996; Ruggerio, Spirito, Bond, Coustan & McGarvey, 1990; Wdowik, Kendall & Harris, 1997), hypertension (Cohen et al., 1991; Wilson & Ampey-Thornhill, 2001), obesity (Brownell, 1984; Hiyaki & Brownell, 1996; Wadden et al., 1990), and even phenylketonuria, generally referred to as PKU (Waisbren et al., 1997). Positive associations between social support and weight loss and weight management have also been established (Hart, Einav, Weingarten & Stein, 1990; Jeffrey et al., 1984; Parham, 1993; Wing & Jeffrey, 1999).

Kelsey, Earp and Kirkley (1997) reviewed literature from the early 1980s to mid-1990s in the area of social support and dietary change, in order to answer whether social support is beneficial for dietary change (which they defined as dietary differences made to improve compliance with recommendations for the control of heart disease, diabetes or weight reduction). They examined how social support affects ability to change diet, explored aspects of support most helpful for change, and groups for whom support is most useful. The authors stated that relationships have several support-related aspects, including the provision of: “models
for lifestyle change; controls and constraints on behavior (i.e., peers may support healthy or unhealthy eating habits); access to information; and a sense of meaning and purpose to life that can make healthy lifestyle changes seem more attainable” and “resources to directly assist individuals who are trying to make changes in their diets” (Kelsey et al., 1997, p. 71). They noted that support could come from family, friends, co-workers, professional sources (e.g. health care providers, therapists, social workers), community affiliations, religious activities, and organized self-help groups. Kelsey et al. remarked that there can be a negative dimension to relationships that should be considered when looking at the effects of social support on behavior change, as sabotaging, nagging, or family conflicts or demands around food can have a negative impact on dietary change, and they cited studies that have shown that negative interaction with others correlated with poor compliance to dietary regimens.

Kelsey et al.’s (1997) review found several studies that showed gender differences regarding the effect of social support on dietary change, and they suggested that social support might operate differently for men and women, based on research that indicated women’s social networks might support healthy eating and health behaviors, whereas in men’s social networks support for less healthy behaviors might be more the norm. Kelsey et al. cited a study on spousal support and involvement in weight loss programs, in which the men did better when treated without their wives, while women did better when they had their husbands involved. The men tended to be less involved in the group process when their wives were present, letting them handle the diet and exercise records. It was speculated that for the women, having their husbands involved with them in the program allowed them more freedom to choose appropriate foods to prepare at home.

Family members might also act as sources of support at critical times of crisis or of change, for example, when avoiding alcohol or caffeine during pregnancy, quitting smoking or adopting an exercise program (Aaronson, 1989; Cohen et al., 1988; Sallis et al., 1992). The family as a support network is an important factor in the initial development of health behaviors, as evidenced by several investigations (O’Reilly & Thomas, 1989; Potts, Hurwicz, Goldstein & Berkanovic, 1992; Rakowski et al., 1987; Zimmerman & Connor, 1989). Studies have shown the benefit of social support for children regarding the maintenance of health behavior (e.g. Wadden
et. al., 1990) as well as for older adults (Hawley & Klauber, 1988; Hanson, Mattison & Steen, 1987; Riffle, Yoho & Sams, 1989; Seigley, 1998).

Social support is generally thought to positively affect food intake and dietary quality among older adults, although this is not always a consistent finding in the literature. McIntosh, Shifflett and Picou (1989) found that an extensive friendship network was positively related to appetite and nutrient intake, and that friendship, marital status and companionship buffered the negative effects of financial stress and poor appetite on dietary intake. Conn and Armer (1995) found social support to be important in their study of older spouses. The researchers, putting forth that the spouse is an important family influence among married older adults, studied the extent of similarity in health behaviors reported by older married adults. Significant correlations between husband and wife were found for exercise, nutrition, interpersonal support, self-actualization and health responsibility. They concluded that, despite continued individual variation even among those in long-term marriages, older couples might provide an appropriate target for health behavior interventions.

Pierce, Sheehan and Ferris (2001) wanted to identify older women’s perceptions of support in response to a source of nutrition stress. Their definition of social support was help extended in response to an identified stressor, requiring the perception on the part of the provider and/or the recipient of support that a problem exists. The older women in their study, who resided in subsidized housing, reported low levels of support for dietary behavior and nutrition concerns. The researchers contemplated possible reasons for this finding, such as difficulty recognizing less tangible forms of assistance, and reluctance to accept emotional and informational support. The women were more likely to receive support if a physician prescribed a diet; this suggested to the researchers that physicians may mobilize social support and perhaps sanction the acceptance of offers of help. The women indicated that they received substantial support from friends, most of who lived in the same apartment building. The researchers felt that the women in this study were interested in improving their health through diet, but physical limitations, low income, and low levels of perceived support complicated their efforts.

Murphy, Prewitt, Boté, West and Iber (2001) found what they considered to be less conclusive evidence of the role of social support in their intervention trial to measure the relationship of locus of control and social support to dietary change. According to the researchers,
the dietary changes made by the intervention group members clearly illustrated the potential for dietary changes by older adults, and they did find significant correlations of social support with changes in intake of fiber and servings of fruits and vegetables. But based on their overall results, the researchers concluded that their study demonstrated how an intensive and skillful dietary intervention could succeed with some older adults, whether or not they bring strong internal locus of control or social support to the diet intervention program. The researchers hypothesized “the large amounts of instruction and personal attention provided in the diet intervention, over multiple years, may have negated the expected roles of internal locus of control and social support in behavior change” (Murphy et al., 2001). However, it seems likely that locus of control and social support did play a role in behavior change, but the dieticians implementing the intervention were the source of the self-efficacy and support. Additionally, part of the protocol included some group sessions, bimonthly in the second year and then quarterly in the third. This again could have been another source of support for the participants. Furthermore, the participants were almost exclusively men (recruited from a VA hospital), for whom social support might function differently, and they were not followed after the intervention ended. It would be insightful to know how the men fared, after their source of support in terms of the intervention, was removed.

Schoenberg (1998) found inconclusive evidence for a relationship between perceived social support and adherence to dietary regimens in a study of older African Americans with hypertension. However, Schoenberg offered reasons for the apparent lack of an association that included the identification of supportive others who did not fit standard definitions of supportive others (e.g. supernatural sources of support) and a gradual approach in diet modification, based on a philosophy of moderation and balance, whereby dietary changes entailed an incremental process that did not require much social support, as opposed to a radical change in diet that disrupts an individual’s way of life.

Schoenberg (1998) also did not find an association between living arrangements and perceived social support, despite that the majority of participants lived with their children and/or grandchildren. Living arrangements and social support are sometimes investigated, to determine whether living alone potentially affects dietary behavior, and how it may affect behavior. Such studies often presume a direct relationship between social support and living with others, and
therefore those who live alone may have less social support and smaller social networks. As Schoenberg’s results indicated, this may be an erroneous presumption to make. However, McIntosh and Shifflett (1984) examined the influence of social support systems on dietary intake of older adults, and concluded that living alone had a negative effect on dietary quality.

Torres, McIntosh and Kubena (1992) described their research on links between social networks and eating arrangements, in which they examined the social network and social background characteristics of older adults who are solitary eaters (those who usually both eat and live alone). Their results showed that the majority of the older adults in their study either lived and ate alone or lived and ate with others. Few had mixed living and eating arrangements, where they lived alone and ate with others or lived with others and ate alone (although there were some in the latter category, which the investigators believed warranted more research into their situations, speculating possible household conflict as the reason for such an eating arrangement). The greater the number of companions and percentage of family in the social network, the less likely the older adult was to both live and eat alone. As far as gender differences, women were more likely than men to live and eat alone, but they were also more likely than men to live alone but eat with others. In general, those less likely to live and eat alone were male, had higher income, and were older. Those who live alone but eat with others were female and of low income, but had a higher education than older adults who both live and eat with others.

**Environmental Factors**

As seen in the previous studies, environmental factors, such as living arrangements, have received some limited attention as related to dietary and health behavior. Other issues related to living arrangements and residence, and that I address in this section, include the context of age-segregated residential communities, such as nursing homes, assisted living facilities, independent living retirement communities and continuing care retirement communities.

**Living Arrangements**

The previously reviewed examples regarding living arrangements are those such as Torres et al. (1992) who related living arrangements and social networks to dietary behavior, or Horwath (1989) who examined living arrangements, marital status and dietary behavior. There has been
inconsistent evidence regarding the effects of living situations, particularly on dietary behavior. McIntosh and Shifflett (1984) found living alone had a negative effect on dietary quality for elders, as did Niewind, Krondl and Lau (1988) in terms of food variety, but Horwath (1989) found that the effects of living arrangements were contingent on gender, uncovering an adverse effect for men living alone, but not for women living alone. Similarly, Schlettwein and Barclay (1995) found that European women living alone did not differ from women living with others in dietary intake and nutritional status. Doyle (1994) explored the experience of living alone among Canadian older women, finding that almost two-thirds of them conceived of living alone as a choice, although they expressed a dislike of the necessity of cooking for one and eating alone.

Davis, Murphy and Neuhaus (1988) examined associations between living arrangements and various dietary behaviors, using data from the Nationwide Food Consumption Survey 1977–1978. They too found evidence that the eating behaviors of older adults living alone, especially men, were different from the behaviors of older adults living with a spouse. They suggested, as did McIntosh and Shifflett (1984) and Horwath (1989), that it is not just merely living with someone else that was influential, but living with a spouse had added significance and influence. In general, the researchers observed that “compared to those living with a spouse, those living alone ate more meals alone, ate a higher proportion of food away from home, consumed a higher percentage of total calories away from home, and skipped more meals, including breakfast” (Davis et al., 1988, p. S97). They also found that adults in the oldest age group, 75 years and older, “had the lowest proportion of persons eating away from home, the largest caloric consumption in the morning (and, correspondingly, the lowest evening consumption), the lowest proportion of breakfast skippers, the lowest proportion of calories from snacks, and the largest proportion of calories from ready-to-eat cereals” (Davis et al., 1988, p. S98). What is unknown, and generally not considered in such studies, is the number of years the person has lived alone, and adjustment to the living situation. The practices of a recently widowed woman living alone, for example, may be different from a woman who has been widowed and lived alone for 15 years, or from someone who has never been married and has always lived alone.

Age-Segregated Residential Communities

Research has fairly recently begun to examine dietary and health behavior of older
adults in particular residential settings, scrutinizing behaviors in the context of age-segregated communities. Over the last twenty years, a number of studies have addressed food and eating in the context of a nursing home. Research has examined dining experiences and interventions (Bonnel, 1995; Edwards, 1979; Hiatt, 1981; Stinnett & Adams, 1995), the attitudes and practices of the food services staff (Matthews, 1987), residents’ cultural influences, beliefs and attitudes towards food (Yen, 1995), residents’ reactions to food services (Alford, 1986), the effects of nursing home regulations on residents’ autonomy (which included dietary practices) (Cohen, Werner, Weinfield, Braun & Kraft, 1995), factors that influence residents with dementia (Amella, 1999; McDaniel, Hunt, Hackes and Pope, 2001; Soltesz & Dayton, 1995), and identity production, social interaction and organizational structure as reflected in dining experiences (Douglas-Steele, 1995). Kayser-Jones, an anthropologist, has conducted some studies on food and eating in nursing homes, investigating the social, cultural, psychological, environmental and clinical factors that influence residents’ eating, and making recommendations for improving the nutritional care of residents (Kayser-Jones, 1996, 2000; Kayser-Jones & Schell, 1997).

In the last decade, several books and articles in professional resources, aimed at those who work in long-term care, have appeared on the topic of food and eating in nursing homes (Alibrio, 1991; Foltz-Gray, 1998; Molis, 1993; Pagan, 2001; Wright, 1999). Zgola and Bordillon (2001) published a book as a guide for long-term care and food service administrators on how to restructure a facility’s dining program to better meet the needs of the residents, and render eating a more enjoyable experience. Brooks (1994) examined trends towards better quality food service for nursing home residents, noting that dignity issues being considered include the physical and social environment of the dining room, and the residents’ right to enjoy attractive meals that accommodate dietary restrictions. Foltz-Gray (1996) outlined strategies to increase food intake of long-term care residents, including the innovations of Chef Bill Richman, who has turned pureed food preparation into an art (e.g. rolling thickened pork chop puree in bread crumbs and shaping it in the form of a pork chop – formed foods increased residents’ consumption by 30–40%). Lutz (2001) hit the heart of the matter for many administrators, and outlined how nursing homes can provide a superior dining program for fewer dollars, citing the key issue to be taking a restaurant-style approach.
Assisted living facilities (ALFs) have established themselves as a senior housing alternative, and some academic and professional attention has been paid to the dining services and food-related issues of ALFs. Ball et al. (2000) assessed ALF residents’ views of quality of life in the facilities, and identified 14 significant domains of residents’ quality of life, one of which was food. A similar study in England found that good food and choices about food ranked as a characteristic of a good residence (Raynes, 1998). Mitchell (1999) presented the results of a study that investigated factors that contributed to quality of life in ALFs in California. Scores for flexibility of facilities were high, with choices of meal times and food as examples of such flexibility. The study found that it was primarily the social component of residents’ lives that made the greatest contribution to quality of life. Harper (2000), in discussing innovations of ALFs to improve dining satisfaction, presented the results of the 1999 National Assisted Living Satisfaction Study, which “revealed that food is the most important determinant of satisfaction among residents.” Dabbenigno (1998) asserted the importance of the dining experience to residents’ overall satisfaction with ALFs, and noted that residences should be aware of generational issues, and be prepared to meet the different food expectations of the next generation of residents.

Nickels (2000) described an innovation, a continuous-seating system, that is being used in some ALFs and retirement communities. In this system, residents can choose from a broad menu during set daily hours from morning to evening (such as 7:00 a.m. to 6:30 p.m.). This allows residents to adopt an eating schedule more in line with their personal habits and to plan day outings without risking a missed meal. There are advantages for staff, too, and the approach has not been any more costly than the traditional breakfast, lunch and dinner times approach. Others have also described innovations and approaches to dining services in retirement communities, such as Gilani (1995), emphasizing how improved food and dining services can enhance enjoyment of meals and overall quality of life.

Cluskey (2001a, 2001b) researched dining and food intake of residents in continuing care retirement communities (CCRCs). Cluskey (2001b) reported that residents in the community site ate fairly well, even the oldest old, who had similar or better intakes compared with other studies of older adults. The residents surveyed did not believe their intakes had changed as a result of residing in the community. Cluskey (2001a) also argued that CCRCs should offer the
option of having three meals a day provided by the CCRC, suggesting that doing so would result in improved food intakes among residents and ultimately contribute to the residents’ ability to remain independent. Asato (1992) surveyed residents of a retirement community, not on food intake, but on the use of kitchen appliances in their apartments. The residents surveyed averaged about four appliances per household, and the most frequently owned appliances were microwave ovens, coffeemakers, toasters and blenders.

A few ethnographies of communities in which elders reside have been conducted, though most are from the 1970s and 1980s. Gubrium’s (1997) ethnographic study of a nursing and residential home of the early 1970s considered the aspect of dining and eating at the facility. He observed that residents divided the day into three parts, according to mealtimes, and that a great deal of the residents’ discussions centered on dining and food, often involving judgments of the food. Jacobs (1975), in his description of a high-rise retirement complex, noted the importance of food and food related activities. Residents devoted a good portion of their leisure time to food-related activities, such as shopping, looking for bargains, clipping coupons, exchanging recipes, and discussing the day’s menu with neighbors. Food was frequently a topic of conversation, but it also was an incentive when social events were planned; the promise of food did more than anything else to draw residents to organized social activities of the complex.

Keith Ross (1977) described food-related activities in her study of the French retirement community Les Floralies, particularly the social organizational aspects of the dining room. At Les Floralies, the arena for public contact was the dining room. Because all members of the community were required to eat the noon meal there, it was the one place where each resident at least daily saw all the other residents. It is in the dining room that new residents met people, often moving to a table with established residents within a few days, although usually the new resident would move around a little to different tables during the first month before settling into a permanent spot. This also made the resident’s progress toward their attachment to a social network a public process. Keith Ross (1977, p.22) stated:

Being established at a table is the most important sign of incorporation into social life at the residence, and people change tables only under the influence of a forceful new attraction or of exploding hostility. Social ties to table partners are
often quite strong, and a place at the table also represents a person’s location in community information networks.

Bohannan (1981) reported on ethnographic research about the dietary patterns of elder permanent residents of low-cost downtown hotels in San Diego from 1974 to 1976. Food was a major need of hotel residents that was not met by the hotel; some residential hotels had dining facilities within or attached, but some did not, and residents had to go to restaurants to eat. Eating was tied to independence, in the sense that the residents would rather eat poorly than give up their independence. Social position also made a difference, as Bohannan (1981, p. 198) recounted:

The only startling discovery that we made is that people in the cheap residential hotels south of Broadway eat better than the people who live in middle-class hotels north of Broadway – and spend less money in the process. The restaurants north of Broadway cater to office workers at noon and to theatergoers in the evening. The result is that the only places to get inexpensive food in their area are hamburger houses, pancake houses and their equivalent. When we asked residents of the hotels north of Broadway why they did not use the restaurants south of Broadway, they said, “I have spent my entire life trying to get out of a place like that.”

The middle class hotel residents valued the social situation more highly than inexpensive, good food. They preferred to eat poorly and sometimes more expensively than to go back to the place that represented the social position that they continually worked to disassociate themselves from.

Moral Meanings

The final social aspect of dietary and health behavior considered is the moralistic meanings associated with food and eating. In the quote from Douglas (1984) at the beginning of this part of the chapter, she noted that the important questions about food habits are not only social, but also moral. Health behavior can be imbued with moral meaning, and dietary behavior in particular has been laden with moral undertones. Now, perhaps more than ever before, food and eating have an inherent morality associated with the objects of consumption and practices of

Manton (1999, p. 83) suggested that food and eating could be viewed as a morality play, asking, “Is eating the oldest sin?” Manton discussed issues of dieting and self-control, trust and gluttony, and changing moral meanings of food over the last century. Manton rationalized that the compulsive concern of Americans over the way their body is viewed and judged has lead to “aggravated” feelings and attitudes towards food, and because self-control is measured by the ability to control, manage and discipline the body, from this perspective every act of eating is a test of the will. Therefore, for most, eating is morally colored. According to Manton, a majority of women (90 percent) and about half of the American population considered themselves to be dieting at any one time in the late 1990s. The emphasis on dieting and the proliferation of group dieting centers and programs beginning in the 1950s has lead many American women to confessions of guilt and shame regarding weight and eating problems.

Manton (1999, p. 84) also discussed the view of eating as an issue of trust: “trust that one deserves to eat; trust also that the next meal will be there, so there is no need to be a glutton.” Manton noted that moral consideration of gluttony has been different from notions of obesity, because morally, one can be gluttonous without being fat. Manton wrote that this is so because fatness is not a sin in itself. However, today’s moral emphasis on individual responsibility, healthy eating and widespread knowledge of good and evil (foods), may have transformed fatness into a sin in the 21st century.

Manton (1999, p. 83) did address the idea that moral meanings of food and eating have changed over time, and wrote:

Food consumption consistently has had negative meaning throughout the twentieth century; however, the specific negative message given has changed over time. For an earlier-twentieth century American, food guilt may have meant illicitly eating meat on Fridays or failing to achieve membership in the “clean plate club.”

Manton purported that there is almost aspect of food that has not inspired a feeling of guilt at
some level. But she suggested that for many people, the first linking of food with guilt began in childhood with exhortations to think of the poor, starving children in some far-off foreign country, in order to urge children to finish eating what was on their plates.

Lupton (1996) has also commented on the moral nature of food and eating. Lupton (1996, p. 52) noted, “the exertion of dominance on the part of the parent, most commonly the mother, is partly exercised in relation to the eating habits of the child.” She proposed that eating practices in the family involve positive emotions and family bonding, but are also characterized by power struggles and feelings of frustration, unhappiness and hostility that accompany such struggles. Lupton recounted the story of a young man, whose parents would attempt to induce feelings of guilt in him as child, in order to get him to finish a particular meal that he did not like. Even as an adult, he cannot banish such feelings: “As a result of such appeals to his sense of morality, Simon says he still finds it difficult to leave food on the plate, even when his hunger is satisfied” (1996, p. 55).

Lupton (1996, p. 27) also addressed the concept of “good” and “bad” foods:

‘Good’ food is often described as nourishing and ‘good for you,’ but is also indicative of self-control and concern for one’s health, while ‘bad’ food is bad for one’s health and on a deeper level of meaning is a sign of moral weakness.

Alternatively then, eating “good” food can be a sign of moral strength, as indicated in Paisley et al.’s (2001) work. Lupton noted that foods can have aspects of both being good and bad, with meat as an example of a food having conflicting meanings in western societies. Healthy diets are often described in terms of a balanced diet, and eating foods in moderation (i.e., not too much “bad” food, and not too much “good” food). Lupton referred to focus group discussions about the conception of a healthy diet, in which a moral discourse emerged in some of the participants’ statements, using notions such as “you are what you eat,” and personal responsibility for one’s state of health. Some participants in Lupton’s research argued that though old-fashioned food might be considered unhealthy by contemporary standards, people did well and lived to a good old age on such food.

I have thus far attempted to demonstrate the variety and significance of social aspects of health behavior, focusing on dietary practices. Gender is clearly an element of important
influence, permeating contexts of social relationships, transitions, environment, and moral meaning, and contributing to health behavior differences between men and women through mechanisms such as role expectations, starting at very young ages and lasting to very old ages. Our social relationships are gendered too, and family relationships are quite important. There is much evidence to demonstrate that family fosters and influences the health behavior of the individual family members, though it may differ depending on the behavior, age, gender and family status. Some ways that family may influence an individual’s health behavior are through modeling, socialization, social control, family solidarity, and social support. Family life course transitions may also impact health behavior, as role and living situation changes bring about new circumstances under which practices are renegotiated. The living arrangements and environments are influential contexts, particularly in age-segregated communities where the elder lacks a certain amount of control over food and eating. Finally, moral connotations were highlighted, illustrating that dietary practices cannot be separated from moral discourse, as such behavior is deeply embedded in moral meaning for most people. The next part of this chapter reflects on theoretical considerations of health behavior, and understandings of how and why individuals behave in certain ways.

Background Part III: Conceptual and Theoretical Foundations

Gochman (1997) has asserted that basic research in health behavior, which establishes sound theoretical foundations, would improve the effectiveness of health promotion and health education efforts, implying that sound theoretical foundations are currently lacking. One contention is that this is partly the result of an almost exclusive focus on intrapersonal processes in theory development on health behavior; in other words, much conceptualization has focused on the role of psychological issues such as beliefs, attitudes, values, locus of control, and self-efficacy. The relevance of these processes is not in dispute, but the superficial treatment of social issues and temporal processes and the neglect of meaning in many frameworks of health behavior are challenged. Furthermore, older adults and issues of age have not been considered adequately in conceptualization; Hendricks et al. (1988, p. 61) contended that “a conceptual framework for a sociologically meaningful analysis of nutrition in later life does not exist.” The point is still valid almost fifteen years later, and although the focus of this research is not nutrition per se, the aim is
to bring to the forefront the social issues of dietary behavior, particularly for older adults. In this part then, I first review a brief state of theory in health behavior to provide background before discussing the frameworks used to guide this study.

This dissertation is based on the premise that many elements of health behavior, including eating habits and food preferences, are first learned at an early age, and then either maintained or somehow modified across the remaining life span. Life course concepts are, consequently, adopted as a means of guiding the employment of methods and of informing the analysis of interview data and interpretation of the findings. I thus examine the life course perspective and its use in health and health behavior research. A secondary theoretical perspective that I review is symbolic interactionism. Symbolic interactionism assigns importance to issues of social interaction and context, but also highlights aspects of the individual not addressed by psychological models, such as concepts of self and meaning. Commonalities between the life course perspective and symbolic interactionism pave the way for an integration of perspectives that will further illuminate certain aspects of analysis and discussion. Finally, a few theories used in health behavior research, which incorporate social determinants of behavior, are addressed, as they constitute a broader, less focused level of consideration in the analysis and interpretation of findings.

**Major Models and Theories of Health Behavior**

In order to illustrate how health behavior theory is lacking, it is necessary to briefly review the more well-used and popular current theories of health behavior. These theories of health behavior include the Health Belief Model, Health Locus of Control, the Transtheoretical Model (or Stages of Change Model), Protection Motivation Theory, Theory of Reasoned Action and Theory of Planned Behavior. Table 2.1 provides an overview of when each of these theories was introduced, the field it originated from, defining features/characteristics, and key components and constructs. These models have been studied and applied both separately

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2 This discussion and overview does not include theories and models that address interventions, health behavior at the level of groups, communities and organizations (e.g. diffusion of innovations, organizational theories, and communication theory/media studies framework), or use of health services.
(in pure and, more commonly, in modified forms) and in various combinations. The field of psychology has been and continues to be a strong contributor to health behavior theory, and as would be expected, there is a strong emphasis on the psychological processes of the individual as mediators of health behavior. A few other currently used theories include Social Cognitive Theory, Social Networks & Social Support, and Ecological models; these address some relevant social processes, and are reviewed later in the chapter because of potential insights they can offer.

The individual and his or her psychological processes (e.g. cognition, motivation, beliefs) cannot be discounted, for such intrapersonal factors certainly affect health behavior. But to focus on such factors is likely over-psychologizing the issue. Why, for example, do people persist in unhealthy behaviors (e.g. smoking) despite the knowledge of the harmful effects or persist in healthy behaviors (e.g. swimming every day before work) no matter how they feel? To better understand health behavior, particularly dietary behavior (which has long been considered to be embedded in social issues), social processes that affect health behavior need to be as well understood as psychological processes. The life course perspective is a theoretical framework that has infrequently been applied to health behavior, but has much potential to address social processes that are missing from the major theories.
<table>
<thead>
<tr>
<th>Theory/Model</th>
<th>Field</th>
<th>Defining Features</th>
<th>Key Components, Concepts, Constructs &amp; Principles</th>
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| Health Belief Model (Rosenstock, 1960) | Social Psychology, Public Health | Focus on beliefs and perceptions | • *Individual perceptions*: perceived susceptibility and perceived severity  
• *Modifying factors*: cues to action, perceived threat, and other variables  
• *Likelihood of action*: perceived benefits minus perceived barriers  
• *Self-efficacy* |
| Health Locus of Control Theory (Wallston, Wallston, Kaplan & Maides, 1976) | Psychology | Personal control beliefs | • *Internals*: people who believe that their health is under their own control  
• *Externals*: people who believe that external factors, such as luck, determine their health |
| Transtheoretical Model or Stages of Change Model (Prochaska, 1979) | Psychology | Temporal aspect and processes of change | • *Stages of change*: precontemplation, contemplation, preparation, action, maintenance  
• *Processes of change*: consciousness raising, dramatic relief, self re-evaluation, environmental re-evaluation, self liberation, helping relationships, counter conditioning, contingency management, stimulus control, social liberation  
• *Decisional balance*: Pros & cons  
• *Self-efficacy*: confidence & temptation |
| Protection Motivation Theory (Rogers, 1975) | Psychology | Fear appeals and persuasion, motivations | • *Sources of information*: environmental and intrapersonal  
• *Cognitive mediating processes*: threat appraisal, coping appraisal, maladaptive response, adaptive response  
• *Coping modes*: Adaptive coping, maladaptive coping |
• *Attitude*: behavioral belief, evaluation  
• *Subjective Norm*: normative belief, motivation to comply  
• *Perceived behavioral control*: control belief, perceived power (Theory of Planned behavior only) |
The Life Course Perspective

The research community has increasingly come to recognize that to study the individual is to also study that individual’s environment and social situations at multiple levels. People do not perform actions in a vacuum; far from being isolated events, behavior must be considered in various contexts and as influenced by multiple mediating factors. As Dannefer and Uhlenberg (1999, p.312) explained:

Without systematic analysis of life circumstances and subjective experiences that lie behind the observed behavior, an appealing and culturally familiar image of a volitional and more or less autonomous individual obscures the analytical problem of the constraints within which choices are made, and the constitutive role of social interaction and social structure in constructing ‘choice’ in the first place.

Dannefer and Uhlenberg (1999) made this statement in their review of the life course perspective and its value and use as a theoretical orientation. Bengtson, Burgess and Parrott (1997, p. S79) described the life course perspective as a framework “about processes at both macro- and micro-social levels of analysis for both populations and individuals over time,” although as Hatch (2000) pointed out, families have been used as the unit of analysis also. Elder, a pioneer in developing the life course perspective and still a prolific advocate of the framework, asserted that a life course perspective emphasizes “the social pathways of human lives, their sequence of events, transitions and social roles” (Elder, 1995, p. 103). His work has stressed the social forces that shape the life course and the resulting consequences for individual development.

Elder (1985) identified life trajectories, transitions and events as three key concepts in the life course perspective. A trajectory (also called a pathway or career) is the course of an individual’s experiences in a particular domain (e.g. family, work, education, residence) over time; it consists of a series of linked states of existence. The multiple trajectories of an individual’s life course are interdependent and reciprocally influence each other. Trajectories involve sequences of events and transitions, and a transition is a change in one’s state of existence, such as from married to widowed. As Elder is fond of saying, “Transitions are always embedded in trajectories that give them distinctive meaning and form” (Elder, 1985, p. 31; Elder, 1995, p. 105). An event is a discrete happening that usually initiates a transition (e.g. marriage is the
event, but the change in marital status from single to married is the transition). Transitions and events contribute to the uniqueness of the forms and meanings of individual trajectories.

Elder (1995; Giele and Elder, 1998) also identified four central constructs of the life course perspective: location in time and place, linked lives, human agency, and timing of lives. Location in time and place refers to historical context and sociocultural background, including both the social and physical environments. Linked lives signify the role of social relationships and social integration in human lives. Human agency refers to the role of the individual in meeting needs and goals and of self-regulation in development. The timing of lives involves several dimensions of time: historical time, social timing, the synchrony of individual timing and significant others’ timing, and life stage. Social timing “refers to the incidence, duration, and sequence of roles and to related age expectations and beliefs [of a society]” (Elder, 1995, p. 114). Synchrony in timing refers to the scheduling of multiple trajectories, and Elder (1995) provides the example of a young couple who schedules work and family events to minimize pressures of time, energy and finances, such as postponing having children until an age in the mid to late 30s. The life stage principle suggests that the effects of social change will vary in type and influence across the life course. In other words, the age and stage in life at which an individual experiences social change will determine how that change influences the individual, and will be different from the effect on another person at a different age and stage. Finally, life course analysis is also sensitive to the impact of early life experiences on later experiences.

Variation and interdependence are key features of the perspective (Elder, 1985; Elder, 1995). Although a birth cohort may be exposed to similar broader societal contexts, differences in place, timing, choices and social structural constraints will cause members of a cohort to have varying experiences. Interdependence is a feature of lives and trajectories. Changes in one person’s life influences the life of another (e.g. a parent who takes a new job in another state means a change in school and friends for a child), and changes in one trajectory often influence changes in another trajectory (e.g. becoming widowed might mean a move to a smaller residence).

*The Life Course Perspective and Health Behavior*

A number of studies have examined health issues using a life course perspective. For
example, work utilizing the Terman Study’s longitudinal research has demonstrated the importance of life course patterns of transitions and events in physical and emotional health, and to various aspects of family, work, health and behavior (Clipp, Elder, George & Pieper, 1998; Elder, Shanahan & Clipp, 1994; Clipp, Pavalko & Elder, 1992). Ferraro, Farmer and Wybraniec (1997) examined health trajectories of adults, looking at the long-term dynamic relationships between physical disability and personal assessments of health among black and white adults, while considering changing morbidity. Prout (1989) and Rose (1991) also addressed sickness, disease and disability with a life course theoretical framework. Moen, Dempster-McClain and Williams (1992) considered the relationship between women’s multiple roles and their health over the life course, and implications for successful aging. Several researchers have focused on health issues as related to socioeconomic status and inequality, incorporating a life course perspective (e.g. Lynch, Kaplan and Salonen, 1997; Rahkonen, Lahelma & Huuhka, 1997; Robert & House, 1994; Wadsworth, 1997).

But few studies have focused specifically on health behavior using a life course perspective. Some have used a life cycle approach, which, according to O’Rand and Krecker (1990, p. 258), when “most precisely defined, requires explicit treatment of stages (phases), maturation (development), and generation (reproduction).” The concept is relevant for examining notions of social order, identified common states and equilibrium processes, and therefore is limited in examining heterogeneity and change (O’Rand & Krecker, 1990). The concept as applied to the family assumes typical passage (for individuals or families) through successive critical and typical stages (e.g. for families, beginning with courtship and ending with widowhood). It also tends to implicitly assume a limited definition of “family,” generally referring to the nuclear family structure. Schafer and Keith (1981) studied influences on food decisions across the family life cycle; they considered environmental influences and personal concerns on decisions made about food at different stages of the family life cycle, focusing on the nuclear family. They found that changes and unique events at each life cycle stage have a bearing on the family’s food patterns and what particular influences are important to the family. The cost of food and personal concerns about weight and health were the most important considerations, but they found that family members (of the nuclear family) also have significant influence, which is constant over time.
Medeiros et al. (1993) also used a life cycle orientation to assess differences in dietary practices and nutrition beliefs through the adult life span. They found stage differences, which they referred to as age-related differences, even though their study was cross-sectional. They also found a potential cohort difference, although they did not refer to it as such. Noting that the over-60 adult group in their study seemed less secure in their nutrition information, the authors hypothesized that it may be a function of the recency with which research-based information has become available to that group, and that older adults might not have had the same opportunity to learn recent information as the younger age groups have had.

There are other possible explanations that Medeiros, Shipp and Taylor (1993) neglected to offer. First is that older adults have more experience with changing and sometimes conflicting nutritional information. While the youngest age group may have just learned the latest recommendations, older adults have likely been exposed to earlier recommendations as well. Older adults may be insecure in their knowledge either because they do not know the latest information (and are certain there is a latest recommendation out there) or are unsure as to the certainty of the latest information (knowing that it was different in the past and may change again in a few years). Another possible explanation is that older adults are more firmly ensconced in habit, and therefore are less likely to respond to new information without direct experience.

There are some researchers who promote a life span approach (occasionally referred to as life stage, e.g. Devine and Olson, 1991), which is a developmental stage approach that is grounded in individual psychology and refers to development from birth to death. Rakowski (1988), for example, noting the need to examine health behaviors over time, cited a life-span perspective. He investigated predictors of health practices within and across four age cohorts of adults (ages 20–30, 31–41, 42–53, 54–64) and found much variation. Only education and gender were the most consistent predictors of health practices. Devine and Olson (1991) used what they refer to as a life stage framework to examine influences on women’s motives for preventive dietary behavior, citing life span developmental psychology research in their background. They concluded that motives vary with life stage, due to altered perceptions of health status, body weight and social roles. They noted that their study did not include women who made different choices about marriage and family, and at least recognized that different choices are made by women. They further noted the possibility of a cohort effect, as women in younger cohorts may
have a different orientation to personal nutrition than the women in the older cohort, which may be related to the timing and influence of new public information about diet and health.

For their part, the concepts of life cycle and life span recognize the importance of considering temporal aspects of and influences on phenomena (such as transitions) and the need to view phenomena in the context of the entire span of life and an individual’s personal history. But all of these concepts lack the life course perspective’s appreciation for variation, multiple socio-cultural contexts, interaction among contexts, timing, and influence of cohort and period effects (such as social change and historical events).

Nowicki (1996), for example, examined the influence of the Great Depression in a case study of an older woman’s health behaviors. Nowicki found that while this woman realized the value and importance of healthy food, she also valued sweets as a symbol of pleasure and joy, which is a view she developed during the Great Depression due to the infrequency of consuming sweets during that period. Nowicki (1996, p. 247) therefore asserted, “By understanding the implications of Depression-era beliefs and values on elders, with its effect on health behavior throughout the life span, health care professionals can assist these clients to change behaviors toward a more healthy lifestyle.” Although not using an explicit life course approach, Nowicki demonstrated the influence on an individual and her actions from past experience and historical events, carried throughout the life course.

Backett and Davison (1995) conducted research on general health behavior and meanings associated with health behavior, citing a life course framework. They used inductive analysis, with data from two qualitative studies conducted in the United Kingdom, in order to examine the role of socio-cultural constructions of aging in personal assessments of daily health behavior. The authors found that respondents regularly referred to biographical, social, and cultural factors in their explanations of health and illness, and in their rationale behind associated beliefs and behaviors; respondents particularly emphasized structurally defined and culturally experienced life stages. For example, for the “young and single” respondents, youth was defined as a time when the body is in peak condition, and able to achieve an input/output balance. They believed that the body can handle abuse, such as drinking and smoking, although anticipated that in the future it would be necessary to cut down on or quit bad habits. These young people felt that a lot of unhealthy food could be consumed, because physical activity could easily burn it off.
The “young and married with no children” respondents indicated that changes in behavior were expected once one got married domestic life replaced carefree single life. This stage was seen as a transition to a more responsible concern with health, when awareness of physiological aging combined with changing social identities and expectations. “Married with children” respondents felt that they no longer took good health for granted. They had increased awareness of the need to be healthy, although their actions themselves did not change too much. “Having no time” was a common theme for these respondents, as they felt their time was taken up by many simultaneously-occurring factors such as moving, increased work responsibilities, managing finances and home, having and caring for children, and less spontaneous leisure time. There was an increased awareness of the need to be a healthy parent, but most expressed that their children’s health needs came first.

For the respondents in these studies, Backett and Davison (1995) noted that stereotypes of different facets of the life course and what is perceived to be considered as appropriate for their position in the life course were powerful sources of cultural meaning, which was the foundation of behavior. The precise content of what was appropriate varied with age, gender and class, but what is relevant is that the respondents made these types of differentiations. The researchers offered valuable insights with this study, however, their research is subject to some critique. Although a life course perspective seems implicated in this study, the authors give the reader the sense that they actually used a life span developmental approach, because of the definition and examination of very specific life stages. It therefore lacks in the complexity afforded by a true life course approach.

With regard to specific health behaviors, some limited research invoking a life course framework has been conducted. Concerning physical activity and exercise, O’Brien Cousins and colleagues examined the role of marriage for women’s participation in physical activity throughout their adult years, as well as compare the life experiences of sedentary and active older women (Janzen & O’Brien Cousins, 1995; O’Brien Cousins, 2000; O’Brien Cousins & Keating, 1995). Research on the effects of life course transitions is a type of life course research, although the researchers may or may not explicitly acknowledge life course concepts. For example, marriage, parenthood, widowhood and caregiving are family life course transitions that have been addressed in terms of their implications for health behavior, as reviewed earlier.
Kemmer et al. (1998) implicitly used a life course approach in their examination of the consequences of the transition from single to married/cohabitating for food and eating habits. Their interest in the transition from single to married/cohabitating stemmed from “a recognition that this transition tends to represent a transitional stage in eating habits, and a desire to understand more about how changes in eating habits and food choices are negotiated and experienced” (Kemmer et al., 1998, p. 49). They interviewed couples before and after their marriage/cohabitation, and found significant changes in dietary behavior and significant differences between their findings and those of previous studies in the subject, most of which had been conducted ten to fifteen years earlier. They attributed these differences to social change that has influenced individual attitudes and behavior. For example, the men and women in their study shared responsibility and control of food purchase and preparation more so than in previous studies, indicating changes in attitudes and patterns in gender relations and female labor force participation.

In a key piece examining specific health behavior using a life course perspective, Devine et al. (1998) used qualitative interviews to investigate influences on the fruit and vegetable choices of adults. Their analysis showed that past life course events and experiences were strong influences on present systems for fruit and vegetable choices. Key influences on fruit and vegetable dietary trajectories included food upbringing, roles, health, ethnic traditions, resources, location and the food system. Early life food experiences were a prominent factor in shaping fruit and vegetable trajectories, creating lasting “food roots” (Devine et al., 1998, p. 364). While having favorable early experiences with fruits and vegetables resulted in more positive trajectories of higher fruit and vegetable consumption, the opposite was also true, as negative or non-existent experiences resulted in lifelong dislike or non-incorporation of fruits and vegetables into personal food systems and practices. For example, growing up on a farm or having a garden earlier in life was prominent among positive experiences with fruits and vegetables.

Although rooted in experiences with long-lasting effects, food choice patterns can change over time and with exposure to new environments. Devine et al.’s (1998) results suggested that life course transitions are times when food choice systems may undergo change (and, according to the authors, offer opportunities for intervention). The study also provided support for the importance of role transitions and social status, especially familial. Role and family transitions,
such as childbearing, marriage, divorce, employment, empty nest and return nesters, affected fruit and vegetable trajectories. For example, new parents increased the serving and eating of vegetables for their children’s sake, and for newlyweds, it took some adjustment to mesh a personal food system with the system of a new spouse.

Edstrom and Devine (2001) conducted a 10 year follow-up to a 1988 study, in order to understand women’s perceptions of stability and change in their orientation to food and nutrition during a time of physical, social and psychological transitions. Using a life course perspective as a conceptual guide, the researchers analyzed qualitative interviews of 17 women. The researchers found that most of the women described consistent orientations to food and nutrition, with little to no perceived change during the ten-year period, despite changes in health, social environment and roles. Three of the women perceived noteworthy changes in their orientations, and attributed the changes to debilitating disease and transitions in family and work roles. Edstrom and Devine therefore concluded that the women’s perceptions of consistency in food and nutrition orientations are evidence of stable trajectories, which influence their responses to nutrition education and approaches to dietary changes.

Brombach (2001b) used a life course approach in the investigation of biographical factors that shape current eating behavior of older German women. After interviewing the women about their socialization to eating in childhood and then eating and drinking throughout their life course, Brombach identified four different “eating types.” She distinguished the four types, designated as conservative-splendid, conservative-scarce, liberal-splendid, and liberal-scarce, primarily on the basis of the degree of rigidity (conservative) versus flexibility (liberal) shown in eating behaviors, particularly in respect to time and place, and on the degree of acceptance of new foods (splendid) versus preference of known foods (scarce, as in new foods are scarcely integrated). The eating type changed only in certain cases, such as marriage to a partner of another eating type, illness or fear of health implications.

Quandt, Vitolins, Dewalt and Roos (1997) used a life course approach for understanding the meal patterns of rural older adults. The elder respondents in their study indicated that as they have grown older, they have experienced changes in their meal and food consumption patterns, e.g. smaller meals and more frequent cold meals. They also perceived processes that affected their current eating patterns, such as changes in work patterns, family life stage, health
and health awareness. The experiences of men and women seemed to be somewhat different; for example, cooking for others had meaning for many of these women. The authors posited that these older adults’ recollections of meals through their lifetimes reveal multiple meanings associated with food. In addition to the biological importance of eating, food also has social meanings that relate to the family, and to gender and family roles. Life course changes in these roles brought about changes in meal patterns (e.g. the loss of a spouse, followed by fewer cooked meals), and older adults recognized these changes and their influence on the social meanings of food and meals. The authors emphasized that attention should be given to the social and cultural dimensions of nutrition, encouraging health professionals to be aware of life events and transitions in their clients’ lives and of possible consequences related to eating behavior.

The evidence thus far supports the hypothesis that life course factors, particularly family life and role transitions, influence health behaviors such as dietary practices. Most research targets adults who have experienced marriage and children, but it is reasonable to think that family influences behavior for those who marry and remain childless or those who never marry. Family may have a different meaning for couples without children or the never-married, but they are no less involved in family life (e.g. Allen & Pickett, 1987).

The life course paradigm is a more youthful theoretical framework, as it did not really begin to be clearly articulated as a theoretical perspective until post-World War II, in the late 1950s and early 1960s. Other older theoretical traditions contributed to the development of the life course perspective; one of those perspectives is symbolic interactionism. Symbolic interactionist insights seem to mesh well with a life course perspective. Hatch (2000) noted that the life course perspective can benefit from integration with symbolic interactionism, and in fact that a symbolic interactionist perspective is implicit in many life course studies. After reviewing symbolic interactionism, I will address the potential of integrating a life course perspective with symbolic interactionism, and then symbolic interactionist approaches in studies of health and behavior.

Symbolic Interactionism

One of the oldest theoretical traditions to come out of the field of American sociology is symbolic interactionism. Early intellectual fathers include Cooley, Mead, Thomas (who with hi
colleague Znaniecki, also provided intellectual antecedents for the life course perspective), and Blumer (who coined the term symbolic interactionism in 1937). Although these early leaders would not have necessarily characterized themselves or their work as symbolic interactionist (Dingwall, 2001), they nevertheless laid the foundation for the orientation that is known today for a focus on how people create and communicate meaning through social interaction.

LaRossa and Reitzes (1993) identified seven assumptions that reflect three central themes of symbolic interactionism. The first theme involves the importance of meanings for human behavior, and the authors use Blumer’s (1969) three fundamental premises to organize the three assumptions under this theme. The first assumption is that people will “act toward things on the basis of the meanings that the things have for them” (Blumer, 1969, p. 2). The second assumption is that “the meaning of a thing for a person grows out of the ways in which other persons act towards the person with regard to the thing” (Blumer, 1969, p. 4); in other words, meaning comes from a process of interaction with others. The third assumption is that “the use of meanings by the actor occurs through a process of interpretation” (Blumer, 1969, p. 5). The meanings of things are dealt with and modified through the course of an active interpretive process; it is a formative process, not an automatic one. These three premises show the importance, source and process of meaning making.

The second theme, according to LaRossa and Reitzes (1993), concentrates on the development and importance of self-concept. Regarding development, they attribute the fourth assumption to an insight originated by Cooley, and his idea of the “looking glass self.” This assumption is that people “are not born with a sense of self but develop self-concepts through social interaction” (LaRossa & Reitzes, 1993, p. 144). And then, as the fifth assumption proposes, once self-concepts have been developed, they provide important motivation for behavior. As maintained by LaRossa and Reitzes, a central tenet that develops out of this assumption is the idea that self-values and self-beliefs, as well as self-feeling and positive self-assessments, affect behavior.

The third theme deals with assumptions about society. The sixth assumption recognizes that individual behavior is affected by societal norms and values, and proposes “individuals and small groups are influenced by larger cultural and societal processes” (LaRossa & Reitzes, 1993, p. 144). To follow then the seventh assumption emphasizes the dynamic nature of social structure,
challenging structural determinism; people work out the details of social structure through social interaction in everyday situations (LaRossa & Reitzes, 1993).

Key concepts of symbolic interactionism include: symbols, identities, roles, interactions, and contexts. Although separated out for defining, each concept is related and closely linked to each other. The first concept, symbols, is anything that socially has come to stand for something else (Vander Zanden, 1990). Human beings use symbols to mentally represent the world: people, objects, events and ideas. They can take many forms including verbal and written words, gestures and objects (e.g. clothing, flags, tattoos). As Vander Zanden (1990, p. 34) noted, symbols “allow us to not only name objects in our habitat, but also to designate one another: we give each person a name; we form age, occupational, and other categories for people; and we conceive of people as members of large social units, including groups, families, tribes, communities and nations.” Vander Zanden also asserted that symbols allow the regulation of present behavior based on the past and the anticipated future, and makes it possible for people to communicate with one another.

A second key concept is the identity. Identities refer to self-meanings in a role (LaRossa & Reitzes, 1993). Altheide (2000) stressed that identity is a social production as opposed to an individual property, as identity claims require the agreement of others. Salience of an identity is important, and refers to the probability that an identity will be invoked in a given situation; the greater the prominence of an identity, the more motivation for the individual to perform and excel in role-related behaviors (McCall & Simmons, 1978; Stryker, 1980). Further, Altheide (2000) noted that some work suggests that people distinguish between personal identity (how one thinks of oneself), social identity (how one is thought of by others) and situated identity (changes with each new situation).

A third key concept is the role. Roles are shared norms regarding social positions, and entail systems of meaning by which role occupants are able to maintain regularity in their social interactions and anticipate future behaviors (LaRossa & Reitzes, 1993). The content of a role includes knowledge, ability and motivation and directs the proper extent, direction and duration of feelings and emotions. LaRossa and Reitzes (1993) pointed out that often roles are best understood in relation to complementary and counterroles. For example, the role of mother emerges and becomes meaningful in relation to the role of daughter or son. Additionally,
individuals may construct different identities within a role. For example, within the role of spouse may be the identities of financial provider, friend, lover, and domestic partner. Roles can change over time and may be said to have careers.

The fourth key concept is interactions, for “it is through social interaction that individuals apply broad shared symbols and actively create the specific meanings of self, others and situations” (LaRossa & Reitzes, 1993, p.149). Vander Zanden (1990) stated that society is continually created and re-created as people interact with one another. One feature of social interaction is the presentation of self in everyday life (LaRossa & Reitzes, 1993). According to Goffman (1959), this presentation involves using verbal and nonverbal signs to convey and announce one’s role and identity, while at the same time, making inferences about others and the way they are responding to the presentation. Another feature of social interaction entails the actions, responses and subjective meanings of other people (LaRossa & Reitzes, 1993).

A third feature of social interaction involves the meanings that people give situations (LaRossa & Reitzes, 1993). Referred to by symbolic interactionists as “definition of the situation,” individuals’ definitions of situations are considered critical to social interaction. Situations may be defined in a number of ways, but the assumption is that in whatever way the situation is defined, that will influence how we act. Groups or societies work toward the establishment and maintenance of more or less shared definitions of situations. In this way we are able to fit our actions to those of other people. For example, there is a shared definition of the situation when people enter a table-service restaurant in American society. Unless there is sign indicating that customers should seat themselves, patron wait until someone approaches them about seating. Once seated, other employees take food orders and serve the food. It is expected at the end of the meal, extra money is left for the employees attending the table, based on a percentage of the bill. The definition of the situation in a fast food restaurant is different, and people act accordingly, such as seating themselves and not leaving a tip.

LaRossa and Reitzes (1993) observed that since rarely, if ever, complete agreement on definitions of situations is ever achieved, most people are satisfied with a working consensus; this provides situations with some regularity and predictability. When a group is striving for working consensus, they monitor whether things are “normal” or not. When things are not normal, the person who is guilty of violating some aspect of the group’s working consensus is expected
to account for their behavior. Continuing with the restaurant example, if a person walks into a table service restaurant and seats themselves at a table (and no sign has indicated that this is acceptable behavior), then that person may be questioned and corrected by employees, unless it is a child or a foreign individual (the action is justified because it is assumed that they do not yet know correct behavior), or a relative of the owner of the restaurant (the action is justified based on their unique social position). In fact, other patrons who witness such behavior might assume that the person who sat herself must know someone who works at the restaurant, one of the few acceptable ways to account for such behavior.

The fifth key concept of symbolic interactionism is contexts. These are the backdrops and circumstances in which identities are formed, roles are occupied and interactions occur. Symbolic interactionism is interested in the connections between the individual and culture or society, and in how behavior is shaped by culture and how culture is shaped by behavior (LaRossa & Reitzes, 1993). The perspective recognizes various levels of contexts, from the micro and immediate structural properties to the macro and larger, societal level aspects. LaRossa and Reitzes (1993) asserted that symbolic interactionism views the mapping of connections as an important aspect of its theoretical mission.

**Integrating the Life Course Perspective and Symbolic Interactionism**

As previously mentioned, the life course perspective and symbolic interactionism share early roots, particularly in the Chicago school of sociology in the earlier part of the 20th century. This renders incorporation of the two historically and theoretically consistent. Hatch (2000) pointed out that some contemporary life course researchers explicitly use symbolic interactionism in their work. She offered the examples of Allen and Chin-Sang (1990), who studied how older African American women defined work and leisure experiences over their lifetimes, and Elder (1985), who emphasized that definitions of situations must be understood in order to understand the impact of life events.

Although symbolic interactionism has been criticized for being ahistoric and neglectful of broader social structures and processes (Hatch, 2000; LaRossa & Reitzes, 1993), this seems to be more of a result of the focus of researchers, rather than a lack of applicability and capacity on the part of symbolic interactionism as a theoretical framework. Symbolic interactionists have
tended to be more interested in microprocesses than macrounits of organization (LaRossa & Reitzes, 1993). Theoretically linking symbolic interactionism with the life course perspective works toward correcting any theoretical deficiencies that may exist in such respects, even if nothing more is added than providing a more explicit orientation towards the broader processes and societal context.

Both perspectives take a dynamic, process point of reference, but a life course perspective also highlights a temporal element that is absent in symbolic interactionism. The life course element of location in time underscores the need to consider the intersection of age, cohort and period. The concept of trajectories compels those who utilize a life course perspective to view lives in terms of a whole, rather than in split segments, and assess stability and change over time. Such a holistic view is consistent with symbolic interactionism. Additionally, location in place is another aspect of cultural background considered in life course perspectives. An emphasis on spatial circumstances and environment fits within symbolic interactionism’s concept of contexts, but adds an emphasis on place that is not as well defined in symbolic interactionism.

Symbolic interactionism strengthens a life course perspective in terms of emphasis on meaning and social interaction. Individuals’ perceptions, i.e. how an individual experiences and gives meaning to an event (or transition, role, practice, or other phenomena), is important in understanding individuals’ responses and subsequent actions. A focus on subjective interpretations complements the biographical component in a life course perspective, in a sense adding a second “funnel” for the experiences of the other elements in the life course perspective, as the interpretive process mediates the impact and experience of events and transitions on an individual as much as the timing of those events and transitions. Meaning is not permanently established, though, as the perceptions and expectations can be reinforced but also challenged by social interaction. Alternatively, expectations for behavior shape social interaction. It is the interactive nature of social relations and the content of interaction that is key according to symbolic interactionism; this interactive context more fully expresses the social relations concept and mechanisms of influence of the life course perspective, and furthers an understanding of why people of different backgrounds have different experiences.

An integration of the two perspectives is not only doable, but also of theoretical value in the study of social influences on individual behavior. This study was originally developed
under the guidance of a life course perspective, along with a few other relevant theoretical considerations to be discussed. It became clear throughout the course of the investigation, however, that symbolic interactionism could be a useful framework for understanding the research and developing a model of influences on dietary behavior of older women, particularly as incorporated with a life course perspective.

Symbolic Interactionism and Health Behavior

Symbolic interactionism is no stranger to health research, however, similar to the life course perspective, symbolic interactionism is not a commonly invoked theoretical framework in the study of health behavior, and even less so in the study of behaviors that are primary, everyday types of behaviors and/or health preventive and promotive behaviors, such as dietary practices. It has been more common for symbolic interactionist perspectives to be applied to understand the various ways that culturally created meanings of health, sicknesses and illness have become part of our health experiences (Fife, 1994, 1995; Frank, 2000; Trippet, 1991; Vander Zanden, 1990) or to understand particular health-related experiences, such as menopause (Guillemin, 2000), caregiving (Clarke, 2001; O’Neill & Sorenson, 1991; Schumacher, 1995), cancer (Heishman, 2000), AIDS/HIV (Ezzy, 1998; Flowers, Smith, Sheeran & Beail, 1998; Sandstrom, 1998; Tewksbury & McGaughey, 1997), mental illness (Doubt, 1994; Smith, 1993; Walsh, 1995), chronic pain (Encandela, 1997) and dementia/Alzheimer’s disease (Golander & Raz, 1996; Vittoria, 1999).

In the area of health-related behavior, studies have focused more on illness behavior, such as symptom response, care seeking and medical-related behavior. Research on social contacts, social groups and medical advice has highlighted how social dynamics are involved in the interpretation of and reaction to symptoms of possible illness (Geersten, 1997). Studies have investigated medication taking and adherence (Burton & Hudson, 2001; Hoekelman, 2001), care seeking related to acute illness (Alonzo & Reynolds, 1994), and communication in health care settings (Frazier & Garvin, 1996; Sigman, 1985).

Little research has used symbolic interaction to understand health behavior, particularly those actions related to wellness and health prevention and promotion. Glik and Kronenfeld (1989) developed an alternative to the concept of the sick role – the concept of the well role, based
in part on symbolic interaction. Pezza (1989–1990) examined efforts to promote lifestyle changes and better health, particularly employer promotion of employee health and wellness, from a symbolic interactionist perspective, and ultimately advocated the use of the perspective in the development and investigation of such efforts.

Duncan, Travis and McAuley (1995) used symbolic interactionism as one of the theoretical frameworks that informed their study of older adult mall walkers and subsequent development of interventions to encourage physical activity among older adults. For the older adult mall walkers, such activity was not just exercise, but it was also a kind of work that replaced work roles that were lost through retirement. According to the researchers, “Roles, rituals and meanings are created during the experience of mall walking that establish a sense of community and belonging that are important elements in the lives of the older mall walker” (Duncan et al., 1995, p. 76). Consistent with a symbolic interactionist vein of analysis, one could also speculate that these people also had salient work identities, in which the replacement of lost work roles was relevant and meaningful to them.

It is not a stretch to see how symbolic interactionism could illuminate roles, rituals and meanings associated with food and eating experiences throughout life, and to a small extent, researchers have applied symbolic interactionism to such experiences. Some have approached the American fast food phenomena from a symbolic interactionist perspective (Law, 1984; Shelton, 1993), as well as eating out in general (Finkelstein, 1985). Others have studied such diverse dietary topics as written instructions for the preparation of food (Tomlinson, 1986), commitment to natural foods (Pestello, 1995), anorexia (Jack, 2000; Taub & McLorb, 2001), weight issues (Sobal & Maurer, 2000) and drinking patterns and sociability in an African American outdoor drinking place (Roebuck, 1986). Yet neither everyday dietary practices nor behaviors throughout life have been explored from this perspective.

**Broader Theoretical Considerations**

Some of the major theories/models do make some effort to go beyond the intrapersonal world of the individual, and prime examples are Social Cognitive Theory, Heaney and Isreal’s (1997) model of Social Networks and Social Support, and Ecological models. These theories incorporate social, cultural and other environmental factors that affect individuals more so than
the other major theories and models. Therefore, they provide theoretical considerations and insights that are in line with a focus on social and life course influences on dietary behavior.

Bandura (1986), a social psychologist, developed Social Cognitive Theory (SCT). The theory is defined by a focus on the interaction between the person, environment (all factors physically external to the person) and behavior. It is assumed that all three affect one another, referred to as reciprocal determinism. There are a number of other key principles and constructs of SCT that affect this interaction. One is the situation, which is the person’s perception of the environment. Other components are the expectations and expectancies of the person; expectations are anticipated outcomes, and expectancies are the values placed on a given outcome. Aspects of the individual that affect performance of the behavior are self-efficacy, self-control and emotional coping responses. Behavioral capability, observational learning and reinforcement (positive and negative) are concepts that involve what and how behaviors are learned and performed by the individual.

One problem with how Social Cognitive Theory has been used is that the whole theory is seldom applied, but rather single aspects of the theory are used in its name (Baranowski, Perry and Parcel, 1997). The single most-applied aspect of SCT is the self-efficacy component. Frequently, if researchers refer to using SCT as guiding their studies, it is the self-efficacy construct that has been adapted for their purposes. The self-efficacy construct has appeared in numerous articles on health behaviors (e.g. Conn, 1997; Duncan et al., 1995; Strecher, DeVellis, Becker & Rosenstock, 1986), and often has been augmented as a construct to other theories/models, such as such as protection motivation theory (Rogers & Prentice-Dunn, 1997) and the transtheoretical model (Prochaska, Redding and Evers, 1997). The apparent attractiveness of self-efficacy may partly have to do with the disciplines utilizing the construct; it is very appealing to psychologists and was developed by a social psychologist (Bandura, 1986). Its popularity also may reflect that an emphasis on changing individuals’ actions is easier than trying to change social and structural factors.

SCT considers environmental influences on behavior (Bandura, 1986). The concept of reciprocal determinism is a cornerstone construct of SCT, and as mentioned, posits that there is a dynamic interaction of the person, the environment and the behavior. One is not simply the result of the other, but all three are constantly interacting, such that not only does the person and the
environment influence the behavior, but behavior can influence the person and the environment. The environment has many aspects and includes both the social environment (e.g. family, friends, peers) and the physical environment (e.g. room size, ambient temperature, availability of certain foods). SCT tries to situate behavior in social as well as personal spheres of influence more so than the other current theories. SCT does heavily focus on intrapersonal processes though, and lacks some social specificity, particularly with regard to a temporal perspective, the importance of meaning and social structural factors in the environment.

The social environment takes a prominent place in the conceptual model of the relationship of social networks and social support to health, as presented by Heaney and Israel (1997). The terms “social network” and “social support” are concepts that describe aspects of social relationships, and though they are not theories per se, there is empirical evidence to show that the concepts play an important role in health and health behavior (Heaney & Israel, 1997; Potts et al., 1992; Trippet, 1991). Social networks are thought to have certain characteristics in various degrees, such as levels of reciprocity, intensity, complexity and density. Different types of social support are postulated: emotional, instrumental, informational and appraisal. In Heaney and Israel’s model, different pathways affect health (physical, mental and social) directly and indirectly through stressors, individual coping resources, organizational and community resources and health behaviors. Several of these paths entail reciprocal influence. For example, social networks and social support may influence health status, but health status may also influence the extent to which an individual is able to maintain and rally a social network and social support (Heaney & Israel, 1997).

Heaney and Israel’s (1997) model lacks in a couple of areas, perhaps due to the focus on the role of stress in this particular web of relations. It is interesting that no relationship is indicated in the model between stress and health behaviors, although it is known that stress affects health behaviors (Lerman & Glanz, 1997). A direct effect of social networks and social support on health behaviors is indicated, but it is unclear through what mechanisms this effect is manifested. It is also not clear whether certain types of social networks or social support, and whether the interaction between quality and quantity of the social networks and social support, affect the rest of the model. However, this model of social networks and social support clearly includes social context as a major component of influence on health and health behaviors, and
therefore makes an important contribution to health behavior theory. Additionally, social support is in a sense a type of social interaction, with social networks a type of context, and thus is consistent with a symbolic interactionist perspective.

In their review of ecological models of health behavior, Sallis and Owen (1997) noted that social cognitive theory shares some features with ecological models, such as an emphasis on relationships between behavior and personal and environmental factors. According to Sallis and Owen (1997, p. 404), ecological models propose that “behaviors are influenced by intrapersonal, social and cultural, and physical environment variables; posit that these variables are likely to interact; and describe multiple levels of social and cultural and physical environment variables.” A contribution of ecological models is the recognition that humans are also biological organisms, and that biology has a role to play as a variable that interacts with sociocultural and physical environments. Thus, for example, physical aging changes as they affect health behaviors, particularly dietary practices, of older adults are indeed relevant as they relate to other contexts. Unlike many other theories that include the environment as a factor, ecological models assume that environments directly influence behavior and there is no mediation through cognitive processes.

Sallis and Owen (1997) considered the identification of physical environment factors as a unique contribution of ecological models. However, Bandura (1986) also has indicated that physical environment influences behavior, though perhaps not as prominently or evidently as ecological models. What would be a unique contribution of ecological models is to develop behavior-specific ecological models, as Sallis and Owen suggest. They do not believe general ecological models of health behavior will be useful, because environmental (social, cultural and physical) influences are behavior specific.

These three theories/models (social cognitive theory, the model of social networks and social support, and ecological models) though recognizing the significance and importance of contexts beyond the individual and influences beyond the psychological, still do not reflect an appreciation for temporality and the influence of past experiences, transitions and other issues of time and timing. The transtheoretical model incorporates a limited temporal aspect in terms of stages of change that an individual progresses through, though movement back and forth across stages is accounted for and linearity is not assumed. Interestingly, integrated models (those
that draw from or combine more than one theory) often add a temporal dimension to the model. Most combination models used the transtheoretical model’s stages of change as the temporal perspective, but Maddux and DuCharme (1997) included a temporal dimension in the form of repetition and habit. Rakowski and Hickey (1980) integrated a temporal perspective with the health belief model to propose a working model of older adults’ health behaviors that included some process-oriented stages in its framework. The authors suggested that a model of older adult health behavior should have the capability to address long-term stability or change in health behavior. The recognition that behaviors involve time-related processes and develop (and change) over time is an important acknowledgment. It bears repeating that behaviors do not occur in a vacuum, particularly one that is devoid of environmental or temporal dimensions.

Summary

The three parts of this chapter illustrate the significance and need for research on the dietary behavior of older adults, particularly women, guided by theoretical frameworks that highlight social issues. This dissertation begins to fill gaps in knowledge about dietary practices of older adults, adding to what appears to be a somewhat sketchy base of literature on the food-and eating-related activities of elders, as reviewed in Part I of the chapter. This chapter further demonstrated in Part II the importance of social issues related to dietary and health behavior, such as the consideration of gender as it affects health and behavior through roles and societal expectations, the impact of social relationships, statuses (and concomitant roles) and life course transitions on the development and progression of health behavior, and environmental situations that impact behavior and the social milieu for behavior. This social focus also included reference to moral discourse on dietary behavior, based upon the proposition that moral orientations regarding health behavior are socially constructed and shaped.

Part III turned to theoretical considerations, illuminating deficiencies in commonly used theories of health behavior and strengths in theories not often applied to the study of health behavior, especially the life course perspective and symbolic interactionism. Deficiencies of popular theories include an extreme focus on psychological processes that neglects wider social factors, while strengths of the life course perspective and symbolic interactionism involve temporal, social, structural and interpretive processes, though the frameworks do not preclude
the function and operation of intrapersonal factors. The utilization of a life course perspective is a fundamental theoretical orientation of my research, as it guided the questions asked and the methods that were employed in the dissertation. It is in the next chapter that I review the methodology of my research, detailing exactly how I conducted the study.
Chapter Three
Research Methodology

The overall design for this study utilized a qualitative research framework, based mainly on in-depth narrative interviews with a small sample of older women. The interviews served as the basis for exploring life experiences as related to individual development of dietary behaviors and the construction of meaningful themes.

The Research Site and Participants

In Chapter Four, I more fully describe the research setting and the participants in my study, thus providing a context for the findings and discussion. In this section, I begin by describing my entry into the research site, sampling and recruitment procedures, and potential limitations and advantages associated with the procedures used.

Entry into the Community

I recruited participants from and conducted my research at a local retirement community, for which I use the pseudonym Colonial Square (all persons of Colonial Square will also be referred to by pseudonyms). I had previously conducted fieldwork and established contacts with residents, management and staff at Colonial Square. This relationship with the community facilitated my current investigation.

Mr. Doyle, the associate executive director, was the first person I had met with at Colonial Square, in early 2000. Mr. Doyle at that time was the day-to-day administrative head of Colonial Square, because the executive director, Mr. Mast, had a few other communities under his supervision and therefore was unable to be at Colonial Square full-time. I had presented my plans for a small research project to Mr. Doyle and asked for approval to enter the community. I had been to Colonial Square once before, about a year prior, on a class field trip. The professor for that course had called Mr. Doyle on my behalf, as a way of introduction. After meeting with Mr. Doyle, who appeared enthusiastic about the project, my main contact became Alice, the activities director. That project was completed in a period of three months.
The following year, in 2001, I met with Alice again, to discuss my return to the community in order to conduct my dissertation research. Elizabeth, the assistant activities director, was also present at this meeting because Alice would be leaving the position within a month and Elizabeth would be assuming the director position. Both seemed earnest in their support of the research and interested in the topic. At this time, the executive director, Mr. Mast, was at the community full-time and the one in charge of everyday operations. I met with him briefly at a later time; Elizabeth had conveyed my plans, and I met him when I procured his signature on a document for IRB purposes. This document stated that I had administrative approval to conduct my research at Colonial Square. The meeting consisted of a handshake and a few words of good luck, after Elizabeth presented him with the document to sign. He seemed perfectly content to allow Elizabeth to continue in her role as my staff liaison.

I periodically met with Elizabeth and the new assistant director, Courtney, for information, introductions to other staff members and their impressions regarding food, eating and activities at Colonial Square. Elizabeth’s job description changed during the time I conducted my research, from September 2001 to March 2002. In early 2002, she began to spend most of her time overseeing activities at the other on-campus facilities, Oak Ridge Manor (the personal care facility) and the Meadows (the Alzheimer’s care facility), while Courtney became the main person responsible for organizing activities for the residents of Colonial Square.

**Recruitment and Sampling**

For recruitment purposes, I prepared letters to potential participants that briefly described the study and its purpose, invited the participation of eligible women (at least age 65), and gave my name and contact information, as well as that of my faculty advisor, for further questions. Each letter included a postcard with places for the participant to write her name, address and phone number. The letter instructed interested women to fill in the appropriate information on the card and return it to the receptionist in the lobby of the complex, who kept all responses in a manila envelope that I provided. The potential participants were given a one-week period for returning the cards.

At the end of September 2001, I met Elizabeth at Colonial Square. She stood with me as I put letters into the residents’ in-house mailboxes, indicating which apartments had women in the
household, and therefore whether or not a letter (or letters) should be placed in the box. A total of 145 letters were sent out. After all potential participants had letters in their boxes, the manila envelope was given to the receptionist, Jill. I explained that residents would be giving her cards regarding their interest in my research, and asked her to keep them in the manila envelope that I gave her.

Two days later, a woman who had received my letter called me, and expressed her wish to participate. I again briefly described what I was doing and why, reviewed what her involvement would be and the amount of time that I anticipated participation would require. I also emphasized that the interviews would be tape-recorded. I then asked if she was still interested in participating. She was still interested, and so I collected her information and set up an appointment with her.

I collected the returned cards from Jill the day after the deadline; twenty cards had been returned. I then contacted these people by telephone. If they were not home, and I was able to, I left a message about who I was and that I would be calling back at a later time. Once I was able to reach a potential participant, I went through the same procedures as described above; I gave a somewhat more detailed description of the research and explained of the nature of participation in the research. I also screened to be sure that the elder would have the available time to become involved and that tape-recording would be acceptable. After responding to any concerns or questions, I asked the elder if she would be willing to participate in the study. If she agreed, then I set up an appointment with her, to review the informed consent form and begin the interview process. A woman who had not returned a card called me two days after the deadline had passed, asking if she could still join my study. I went through the same procedure and set up a meeting. My total number of responses at that point was 22.

Of the 22 who responded, two women did not work out from the start, and were not used in the study. One woman replied that she had only returned the card as a courtesy, and was not interested in participating in the research. After finally reaching the second woman, I concluded that due to very recent illnesses and operations, participation in the research would be too much of hardship for her; I also suspected some possible cognitive impairment. During the data collection period, two other women were eventually dropped from the study. The interview process had begun with each, but due to illnesses, family issues, travels, other demands on their
time, and several missed appointments, I determined that it was not convenient for them to be participating, and presented to them the opportunity to opt out of their commitments. Each took the opportunity.

Therefore, the total number of participants for this study is 18. All the participants were living independently, although two of them did receive some assistance from others for personal physical care. None of the women reported or exhibited any cognitive impairment. The sample consisted entirely of older women for the reasons discussed earlier. Minorities were not excluded from the research, but were not particularly sought out during the recruitment process. As mentioned, I provide more of an overview of the sample in the next chapter.

Because of the in-depth nature of the interviews and the likelihood of at least a few hours of interviewing with each participant, the sample size was kept to a small number. My intention was that sampling would be purposive, and the participants would, at a minimum, vary by age and would live in varied current familial situations, operationalized as different current marital statuses. The goals of purposive, or purposeful, sampling include capturing heterogeneity and examining cases critical for any theories that a study begins with (Maxwell, 1996). The reasoning behind my use of purposive sampling stems from my use a life course perspective and interest in whether and how life course transitions, especially familial, affect an individual’s dietary behaviors. Upon meeting each of the women who responded to my invitation, and gathering basic information, it appeared that I had enough variation in age and marital status (and marital histories) among participants to warrant a hold on further recruiting.

Limitations and Advantages of Recruitment, Sample and Setting

Older adults who volunteer to be involved in research are more likely to be better educated (Ganguli, Lytle, Reynolds & Dodge, 1998); this sample as a whole is better educated than the general older adult population. Also, the older women in this study reside in a rather upscale retirement community, and tend to have a higher socio-economic status (SES). Both education and SES have been associated with health behaviors, with higher levels of education and SES often correlating with better health practices (Resnick, 2000). However, this neither invalidates responses nor renders participants’ responses as less useful. Rather, much can be learned about how they came to have such healthy behaviors, beyond that they have more
education and higher SES, and what factors may be related to those who have less than stellar practices. Additionally, the educational and SES characteristics of the women do vary to some degree, and not all of the participants have had lifelong higher SES – financial security was not a constant throughout their lives. Some participants have or had a spouse who was better educated, and was a source of influence for the participant regarding dietary behaviors and/or volunteering. Another caveat is that the sample is only women, and the experiences of older men will not be explored; thus findings might not apply to older men.

Finally, recruiting residents of a retirement community may standardize some aspects of the study and the participants to a certain extent (e.g. place, white race, and, as mentioned, often SES). However, there is still much heterogeneity in the life histories and life experiences of the women interviewed. The retirement community does provide food security; it also perhaps provides more opportunities for better nutrition. But mere availability does not always translate into residents having better dietary practices or more nutritious diets. This site offers the opportunity to explore in-depth particular aspects of environmental and structural factors as related to dietary practices, and to more closely examine an aspect of daily life, food and eating, in such communities. Not enough research has explored everyday life in contemporary retirement communities.

Data Collection

Interviewing

I used in-depth narrative interviewing as the main method of collecting data, because of the capacity of this method for collecting histories and eliciting aspects of context, meaning and process in the responses of the participants. I conducted the interviews in the participant’s home in Colonial Square, which was the preference of all the participants. At the first appointment, before beginning the interviews, I obtained informed consent both verbally and in writing, as indicated by the participant’s oral agreement and their signature on the IRB approved consent form (see Appendix A). The participant retained a signed copy of the consent form. The informed consent process involved discussion of the participants’ rights and responsibilities, including how anonymity and confidentiality would be ensured. This was reviewed as needed throughout the time the participant was actively involved in the research process.
The entire interview process was essentially comprised of two parts. At the first meeting, after obtaining informed consent, I began a general life history interview with the participant, using a life history interview guide that I developed for this study (see Appendix B). Leininger’s life health care history contributed to the development of the life history interview guide. Leininger (1985, p. 124) states the general purpose of the life health care history as “to document and identify longitudinal pattern(s) of an individual’s perceived, known, and experienced health, care, and illness lifeways within particular cultural and environmental contexts.” My purpose was to develop an overview of various “lifeways” in the domains of family, education, career, and residence/geographic mobility. Rybarczyk and Bellg (1997) also contributed to the development of the life history interview guide, as I borrowed ideas for topics from their suggestions for questions for life experience interviews. The life history interviews also garnered some information on religious affiliations and leisure activities (e.g. volunteering, hobbies, travels, vacations).

The life history interviews involved discussion of the details of the participant’s past and present/recent life experiences and meaningful reflections on their experiences and histories. Some participants began talking about their present situation and life circumstances, while other began with their birth and childhoods. For many, a loose chronological structure seemed to be most comfortable and most logical to them. There was, however, even for those moving in a chronological progression though their past, some back and forth movement between past and present; this was expected, as narrative processes are often open and free flowing. Reflections on experiences and the meaning of those experiences occurred throughout the interview. If needed, I used questions and prompts specifically designed to probe certain topics, elicit elaboration or clarification, to follow-up, or to return the focus to the interview’s purpose and move the interview along (e.g. if a tangent was followed, such as telling another person’s story). This general overview of a participant’s life would take one to two interview sessions, resulting in total of one to just over two hours of interviewing on the participant’s life history.

In the next session scheduled after reviewing a participant’s general life history, I began a “food” history interview with the participant, in which I elicited details about their food and eating experiences over their lifetimes. I also used an interview guide for these interviews that was created for this purpose. Devine et al. (1998) shared their interview guide with me, which
was of much assistance and contributed to the development of my food history interview guide (see Appendix B). Prior to the initial food history interview session, I made phone calls to participants, in order to confirm our appointment and to ask the participant to have ready one or two of their favorite recipes. I explained that discussion of the recipes was a way to get us started talking about food and eating. The recipes were good icebreakers for this part of the interview process, and in addition to getting a participant in the mode for further talking about food and eating experiences, they also drew out interesting information, for example, on the participant’s view of cooking. The recipes can also be considered a visual cue for recall, and the process of looking for and choosing the recipes to share likely encouraged the participant to ponder the topic somewhat and begin the recall process before our actual meeting.

I therefore began the food history interview by asking the participant what recipes they had chosen and to tell me about the recipes: where did they get them, how long have they had them, when did they use them and how often, and so forth. Some of the participants had written down the recipes that they chose for me. Others pulled out a cookbook or cards from their collection, and I copied the recipes into my handwritten notes. See Appendix E for a compilation of recipes collected from the participants. From there, the food history interviews progressed in a variety of ways. Again, the interview was fairly free flowing, with back and forth movement between the past and present, and reflections on experiences occurring throughout the interviews. If needed, I asked questions and used probes in order to cover topical areas that had not come up, to get clarification or elaboration, or to bring the focus of conversation back to food and eating (if the narrative had gone astray). These interviews were conducted over the course of one to two sessions, and ranged from a total of 1½ to 3 hours.

Throughout the entire interviewing process, participants were allowed to use certain techniques, specifically visual cues, to assist in recall of past experiences and events. For example, a few participants referred to photographs and framed pictures in their apartment. I also took copious handwritten notes during each interview session, and made notes on the sessions afterwards, recording my thoughts and impressions, and noting anything that happened before, during and after the interview session while at Colonial Square.
Tape Recording and Transcription

Each interview session was tape-recorded with the expressed permission of the participant. I secured all tapes of the interviews in my office, and only my faculty advisor and I have access to the tapes. I transcribed the tape-recorded interviews, using a transcription machine and word processing computer software. The tapes and transcriptions were labeled with an assigned interview number, as well as the numeric identifier assigned to each participant. These numeric identifiers correspond to a unique pseudonym used for each participant. I maintain and have access to the identification list, which is secured in a cabinet in my office; the only other person with access to the list is my faculty advisor. The transcribed interviews use pseudonyms for all individual names and places in order to protect the identities of the participants. All interview transcripts are secured in my office, and only my advisor and I have access to transcripts.

Participant Observation

There are a few other methods I used in this research that involve participant observation. They included taking meals in the Dining Room, attending a food committee meeting, informal conversations, and picture taking. There are not many ways to just “hang out” at a retirement community. However, in the course of interviewing and any participant observation, I took available opportunities to spend additional time at Colonial Square and with various people at Colonial Square, both those who were and who were not participants in this research.

Taking meals in the Dining Room was always preceded by an invitation from residents and staff (the director of dining services and the activities director). I went to five lunches and two dinners with residents, and one dinner with the activities staff. These meals were on various days of the week, at various times and with various numbers of people. Sometimes the participant and I would dine by ourselves, and at other times we were joined by other residents, including husbands and those who were not in the study. These were generally regular meals, but one dinner was a special once-a-month event called “Friday Night Out” (explained in greater detail in Chapter Four). Usually my meal was charged as a guest meal to the account of the inviting participant, and any efforts to reimburse them for the meal were turned down. For two of the dinners and one lunch, my meal was charged to the administration’s account. I also had
one lunch with a participant in her home. As soon as possible after a meal, I recorded notes on the experience, including meal choices and items, staff and service, atmosphere, my dining companions, and topics of conversation.

I also had the opportunity to attend one of the food services committee meetings. This is a standing committee of the Residents’ Association, which is composed of eight residents and two staff members (the director of dining services and the chef). The president of the Resident’s Association also tries to attend when he can. At this monthly meeting, residents reported on Dining Room related issues they noticed and that other residents had brought to their attention. Then the dining services director distributed a compilation of comments written on dining room comments cards for the previous month, and the committee addressed each and every comment. There were 47 comments, which referred to food and service, and listed the name(s) of the resident(s) who wrote comments. The meeting took about an hour and a half, with another 20 minutes of conversation among a few of the committee members after the meeting was adjourned. I took notes both during the meeting and then again as soon as possible after the meeting, to record impressions thoughts, conversation, and such.

Informal conversations occurred in structured and unstructured ways. Although I did not set up a formal interview session with the director of dining services and the activities staff, I did make a point of getting together with them informally to talk about their jobs at Colonial Square and their views, as related to the residents and food and eating. These conversations were about 20 minutes to 40 minutes long (not including the dinner with activities staff). I also had informal conversations with other staff, such as the receptionist and the resident services coordinator, who provided me with a copy of the resident handbook. I had informal conversations with other residents, either in the dining room, or before or after interview sessions. A couple of informal conversations with residents occurred as I was out taking pictures one day. I took photographs of areas inside and outside of Colonial Square. Again, I took notes on these informal conversations as soon as possible after they occurred.

Limitations and Advantages of the Data Collection Methods

One caveat regards recall in retrospective interviews. The scope of information requested can place a large recall burden on the participant. The use of question probes and visual aids
were intended to aid recall. Visual aids would also confirm comments of participants. Regarding the authenticity of recall, the participants are “viewed as experienced people who give authentic insight on their constructed world,” (O’Brien Cousins, 2000) and as such it is their interpretations of the past that are important, for it is these perceptions that affect their current actions.

Participant observation methods in some ways provided corroboration for comments that participants made; for example, items mentioned as entrée alternatives at dinner were confirmed when I had dinner in the Dining Room. Participant observation also made it possible to collect different kinds of data, gathering information from sources other than the participants and interviews (Bernard, 1995). For example, attending a food services committee meeting provided information and insight on how residents’ suggestions and complaints are addressed by Colonial Square management and also by other residents. Participant observation thus additionally imparted more of a context of the community itself and for participant remarks and responses, which as Bernard (1995, p. 141) stated, “gives you an intuitive understanding of what’s going on in a culture and allows you to speak with confidence about the meaning of the data.”

Data Processing and Analysis

The bulk of the data used for analysis consists of interview transcripts, field notes and recipes. However, there are a few other items collected that were referred to for analysis and in the preparation of this written report. These items include: copies of weekly and daily menus, a blank sample of a dining room comment card, a copy of one month’s worth of resident comments from comments cards (from the food committee meeting), a copy of the resident handbook, marketing brochures and printed materials, leasing materials, physical layout sketches, and photographs that I took of Colonial Square.

Data Processing and Management

There were three ways in which I processed the data to organize and prepare it for analysis: 1) use of descriptive statistics; 2) development of life course timelines; and 3) content coding. I entered information on several characteristics of each participant related to age, family, education, career, health, religion and residence/place into an Excel spreadsheet. I then applied basic descriptive statistical techniques to produce frequencies, averages, medians and modes for
several of the characteristics. This provided a descriptive overview of the sample, and is a good part of the basis for the contextual description. The spreadsheet also provided a snapshot of each participant, useful for contextualizing comments made by a particular participant.

A different type of snapshot was the life course timeline. Based on notes and transcripts, I developed a general outline for each participant of major life events and transitions, following the general trajectories for family life, education, career, and residence. These timelines began with the birth of the participant, and included but were not limited to: graduation from high school and institutions of higher education, marriage(s), divorces, death of husband(s), birth of children, death of parents, health events, major residential moves (including to Colonial Square), the beginning and end of jobs, and retirement. These life course timelines illustrated the variety of life experiences of the participants, and again were useful for contextualizing comments made in the interviews.

Finally, coding of the data is a process that prepares the data for analysis, but is also a sort of analysis itself. The process of open coding involved a close reading of notes and transcripts, and marking key words and phrases in each line. I did not use pre-established words and phrases in coding. Next, I used focused coding. Focused coding involved line-by-line analysis of the areas of text already identified by open coding as having relevance to the study. The goal of open and focused coding is to generate an exhaustive list of themes in a codebook that will guide analysis, interpretation and writing. Thematic codebooks contain lists of themes and sub-themes, as well as references to the sources in which they were identified. It is this development of themes that is precursor to analysis, but the decision to categorize pieces of text requires analytical decision-making and thus is a type of pre-analysis.

Data Analysis

Data analysis in this study was iterative, in that I built on ideas throughout the study. Analysis of the content of the interviews actually began early in the research process. It involved reviewing notes, and transcriptions, in order to: 1) include and follow-up on potentially important themes and concepts in later interviews with a participant, 2) design participant specific questions, and 3) identify productive leads for analysis. This is similar to the grounded theory process of qualitative data analysis (Glaser & Strauss, 1967).
Throughout analysis, and also beginning fairly early in the research process, I wrote memos, which are notes that I write to myself about the data, and are primarily conceptual in content (Miles & Huberman, 1994). They are records of ideas about and reflections on the research, and range from a brief comment in the margins of a transcript to an analytic essay (Maxwell, 1996). These memos assisted me in making sense of the research, guiding my interpretation and writing.

After data collection was completed, I returned to the data, using thematic analysis to extract meaningful themes, patterns and topics. Luborsky (1994) provides suggested definitions of themes, patterns and topics to serve as a guideline for qualitative researchers, but also notes that a theme cannot be formulated apart from the specific contexts and topics of discussion from which it emerges. Luborsky (1994, p. 195) suggests that themes are “the manifest generalized statements by informants about beliefs, attitudes, values, or sentiments,” whereas patterns “describe findings from the researcher’s frame of reference.” He suggests also that a topic is the summary of the content of replies by many people to a question.

With these guidelines in mind, the generation of meaning from analysis involved clustering techniques and making contrasts and comparisons (Miles & Huberman, 1994). I identified recurring themes, and begin to categorize (i.e. cluster) pieces of text that related to various themes. The clustering process grouped phenomena according to common meanings (themes), and then conceptualizes “objects” (e.g. events, acts, individuals, processes, settings/locales, sites or cases as a whole) that have similar identified patterns or characteristics. Making comparisons and contrasts, on the other hand, highlighted points at which there were concrete and conceptual differences in the data. Identifying differences in data (data that cannot be clustered and grouped, or is a single instance of a theme) sharpened my understanding and helped me to make sense of what was going on. In both clustering and contrasting, I used the snapshots of participants as developed from the life course timelines, in order to see the contexts of commonalities and differences. Additionally, I made comparisons with relevant literature findings, in order to get a sense of how my data related to previous research and further identify relevant factors in the narratives that I collected.

Later phases of analysis progressed from the exploration of the data as described above to a theoretical treatment of the data. The codebook, theoretically oriented memos, and my findings
provided the basis for the development of a theoretical model. This model is therefore “grounded” in the data. The theoretical foundations of the research, specifically a life course perspective and symbolic interactionism, also guided development of a model.

Finally, participants were given the opportunity to have copies of the interview materials in audio and printed forms. I offered a copy of the tape recording of interview sessions to each participant, which all but one declined. I also extended an offer of a copy of the interview transcripts to each participant, and none have as yet to take the offer. I will make available copies of any written reports, including the dissertation itself and other publications such as journal articles, to the participants.

Validity

Perhaps the most serious validity threats to my research emerged from self-report bias/social desirability, recall deficiencies and pigeonholing data with my framework (i.e. compartmentalizing the data without consideration of alternative explanations). There were several ways that I dealt with these threats. These included: member checks, rich data, visual cues, participant observation, searching for discrepant evidence and negative cases, feedback, and comparisons (Bernard, 1995; Maxwell, 1996; Miles and Huberman, 1994).

Member checks, rich data, and visual cues were methods used during data collection. Member checks occurred during the interview sessions, in which I clarified issues, asked for elaboration and confirmation of ideas and points from previous conversations. This worked toward preventing the interpretation of comments based on preconceived ideas; it also somewhat empowered the participants as research partners. I attempted to reduce self-report bias by establishing positive, empowering relationships with the participants, and by reassuring them of the value of their stories for my research specifically and for gerontology in general. For rich data, I collected details about events, transitions and life experiences, as well as about dietary experiences and practices, in order to provide a full and revealing picture of influences on and contexts of dietary behavior. The visual cues assisted in recall, and in some cases, corroborated information (e.g. a picture of the family farm).

Searching for discrepant evidence and negative cases, feedback, and comparisons were all methods used during data analysis. Searching for discrepant evidence and negative cases
during analysis was a measure to reduce pigeonholing data and give a more complete picture of influences on dietary behavior. Feedback from my advisor and committee developed my ideas and interpretations, and pointed out weaknesses, flaws and assumptions that I did not recognize; this again reduced boxing in effects, and suggested new ways to reflect on the research and alternatives to consider. Comparisons with the literature assisted in identifying relevant factors and discrepant data, supporting and challenging my interpretations, and again reminding me to think in alternative ways.

 Participant observation extended validity both in data collection and in data analysis. In data collection, participant observation methods provided some degree of corroboration of what participants said, particularly with regard to the community and the Dining Room. In data analysis, participant observation gave a measure of understanding and confidence when making sense of and generating meaning from findings, due to the increased conceptual knowledge of the context.
Chapter Four

The Setting and Participant Characteristics

This chapter describes the physical and social environment of Colonial Square and socio-demographic characteristics of the participants in this research. The setting of the retirement community is important to know and understand; it is within this multi-layered environment that the participants live and act. In turn, it is important to gain familiarity with the women who shared their stories for this research. Similar in many ways, each woman expresses a unique life history. Their current residential setting, their characteristics, and their particular life courses have influenced and shaped their dietary behaviors and relationships to food. Together, the setting and life characteristics make up significant contexts in which to situate their stories of food and eating.

The description of the setting is divided into four sections. The first section discusses a brief historical background of the place and the physical locale, locating Colonial Square in time and space relative to the larger community of Lexington, Kentucky. The second section describes the structure itself and physical layout of the complex. The third section delves into the activities, amenities and services offered to residents, detailing the dining services particularly, and includes ways in which residents provide input into operations. The fourth section addresses the social environment, including general characteristics of the resident population, social interaction and community participation. A section on participant characteristics and life overviews completes the chapter.

The Setting: Historical and Physical Location

Kentucky was involved in the 1980s retirement community boom, including the opening of several retirement communities in the Lexington metropolitan area. Colonial Square was one of three retirement communities in town when it opened in the mid-1980s. However, despite the optimism of this new residential opportunity, the community (or at least the building) had quite an inauspicious beginning, according to the facility’s archives. Just before construction on the apartment complex was to be completed, and a grand opening would herald the new community’s readiness with pomp and circumstance, a fire broke out. The fire leveled much of the building and construction essentially had to start from the beginning. A week later, fire investigators concluded their investigation and revealed the cause of the fire: sparks from a
welder’s torch. The opening of a “premier” retirement community in Lexington would have to be postponed. But construction crews moved quickly (and likely with more caution) and Colonial Square was ready once again for its grand opening. Less than a year after the fire, the complex opened without a hitch, and the first group of apartments was ready for occupancy. Within a month, the first two residents, a married couple, moved into an apartment. In the next five months, fifteen apartments were occupied.

Throughout the 1980s, the building continued to fill with new residents. Two years after its opening, a private company, the Retirement Housing Company (RHC),\(^1\) bought the community, and took over management operations. Founded in 1978, RHC is a publicly traded company on the New York Stock Exchange (since 1997) that not only operates Colonial Square, but also owns or provides services for more than 50 communities in 16 states. The communities comprise a range of care levels and services, including independent living, personal care/assisted living, skilled nursing and Alzheimer’s care, and any one community may have a combination of levels of care. The company’s focus is on large upscale congregate and continuing care retirement communities, both for-profit and not-for-profit.

By the late 1990s, occupancy rates at Colonial Square were running consistently in the upper 90\(^{th}\) percentiles. Starting on a waiting list became the norm for anyone wishing to secure an apartment ($250 to get on the list), and a future’s list had even been developed. The future’s list was a step below the waiting list, designed for those interested, but not quite ready to make a definite commitment (it does require a $100 deposit, of course transferable, if one decides to go to the wait list). There have been changes in the community over the years, including the development of a Wellness Center, and within the last two years, the addition of a wellness “store” within the center (this will be explained further later on).

There has been expansion on the property of Colonial Square during the past three years. It is now a campus that includes a personal care facility, Oak Ridge Manor, and a care facility for those in the early stages of Alzheimer’s disease, the Meadows.\(^2\) The early 2000’s, however, have seen a bit of a marketing struggle for Colonial Square. In addition to some residents of Colonial Square making their way over to Oak Ridge Manor and the Meadows, there is increased competition. Colonial Square is now one of about six retirement communities in the Lexington

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\(^1\) A pseudonym, for purposes of confidentiality.

\(^2\) Oak Ridge Manor and the Meadows are also pseudonyms, for purposes of confidentiality.
area. The latest community, brand new and built from the ground up, is almost identical to Colonial Square in its service and amenity offerings. It opened one to two years ago, and is only 10 to 15 minutes away. Occupancy rates at Colonial Square have fallen somewhat, although not precipitously.

Colonial Square is situated on 20 acres of land in the Lexington, Kentucky metropolitan area. The location, long used for farming and agriculture, became rapidly engulfed by urban expansion since the 1970s, resulting in the transformation to residential and commercial land use along the area’s main transportation corridor. The complex is on the north-northeastern corner of an intersection on this major road. It is not quite five minutes from shopping, banking, restaurants and some entertainment (movie theaters), and is about 15 minutes from downtown, government offices, and cultural centers. Colonial Square is also on a local bus route.

Colonial Square is surrounded to the north and northeast by a middle class neighborhood, consisting of mixed housing, such as apartments, townhouses and single-family dwellings. To the west and south are commercial developments, comprised of building clusters that house offices and facilities for health care, business and industry. To the east are some woods, and then an industrial area. On the property and about 100 yards away from the main structure is Oak Ridge Manor, the three-story personal care facility, and adjacent to Oak Ridge is the Meadows, a one-story Alzheimer’s care facility.

**The Setting: Physical Structure**

Colonial Square’s main physical structure is a mid-rise apartment complex, consisting of three above-ground levels and a basement. Colonial Square contains 178 private apartments, several public spaces and common areas, and offices and staff work areas.

**Entering the Building**

The building is laid out in a U-shape, with the parking lot creating an asphalt “U” around the building. Along the outer edges of the parking lot are carports, for residents only. Certain spaces nearer to the front of the building are designated for visitors, although it is sometimes necessary for visitors to park in resident parking spaces. Generally, this is not a problem, although visitors are supposed to enter the building through the main doors in the front, as other
entries to the building are locked (residents carry keys to the building). Occasionally if visitors are expected, a resident will meet them at the doorway closest to the apartment and let them in, particularly if the apartment is in the back of the building. Visitors are also supposed to sign-in at the front desk, although this is not strictly enforced. After 9:00 p.m., the front doors are locked, and a phone at the front may be used to call security to allow entry.

Entering the building through the main entrance leads into a small lobby area. The receptionist sits to the right, behind a long white counter. This position is usually occupied by Jill, who works daytimes for about 30 hours a week; in the evenings a security officer sits behind the counter, answering the phones and overseeing the comings and goings of the building. At other times, a nurse, nursing assistant or someone from activities will staff the desk when Jill is not there. Directly ahead is an elevator, the access to which used to require going around a cherry, round pedestal table with a sign proclaiming who the manager was that day and a large flower arrangement – one could hardly see the elevator behind the flowers. But the table has been removed, and although the reason is unknown, it is likely that it was recognized that the table blocked traffic flow. At Christmas time, a poinsettia “tree” was set up in the lobby. There is a board on an easel to the left of the doors that states the manager on duty and activities for the day. Most illumination in the lobby during the day comes from a large window behind the receptionist’s desk. At night there is soft lighting from lamps and an overhead light.

The First Floor

There are two corridors off the lobby, one to the right and one to the left. These lead to resident apartments, but also to administrative offices and service facilities. Most public spaces are on the first floor. To the left, the first public space is the computer lab and library. The computer lab is a small room with about six computers set up for resident use. Connected to the lab through a wide, open doorway is the library, another small room that contains books, magazines and newspapers. There is a table and a few chairs for residents who choose to peruse materials in the library. There is also a separate entrance to the library off the corridor. Along this corridor there are also public restrooms (with a water fountain and a place to hang coats just outside of them), the Wellness Center and the beauty salon. The smell of hair care and treatment products is strong and pungent as one passes the salon, particularly if the door is opened.
On the left corridor, before one gets to the apartments, is the loading dock and an entrance to the kitchen, which further leads to the office of the director of dining services. The kitchen has a commercial appearance, such as one would see in a restaurant or hotel, with abundant stainless steel counters and appliances. The director's office is a very small room at the back of the kitchen, brightly lit by overhead fluorescent lights, and with a window that looks out into the kitchen. The office was formerly located across the hall from the kitchen, but the director has recently moved into this space to allow greater involvement with and accessibility.
to the kitchen staff. Much further down the left corridor, after passing about five or six resident apartments, double doors lead outside to a covered concrete porch area.

Moving from the main entrance along the right corridor brings one to the main administrative offices, where the executive director, resident services coordinator, staff development manager, and marketing director all have offices. The mailboxes are located here, and bulletin boards for community news and communications are in the mailbox station. A sign above the mailboxes indicates whether the mail has been delivered yet that day or not. Post-it notes stuck on the outside of some mailboxes indicate that a package is waiting, which can be picked up at any time from a bookshelf in the main administrative office area. Next are the in-house boxes. These are rows upon rows of dark brown cubbyholes used for delivery of flyers, newsletters, memos and other information from the management. Personal communications between residents can also be delivered this way.

Across the hall from the in-house mailboxes is the entrance to the Living Room and Dining Room. A sign at the entrance of the Living Room proclaims the featured soups and entrees for the next meal to be served. Residents go through the Living Room to get into the Dining Room, passing along the way the hostess station to have one’s card scanned for meals. There are actually two parts to the Living Room: a large room, which is the main area, and then a smaller room known as the “fireplace room” (due to the presence of a gas log fireplace). The fireplace room is an area connecting the main Living Room and the Dining Room, and is the current location of the hostess station, a small, rectangular table of dark cherry wood with brass drawer pulls. In here, there are a few loveseats and a few wing chairs of the same type as in the main Living Room. Someone’s personal photo album, covered in lavender lace, sits on a coffee table. The Living Room areas are elegantly appointed, with dark woods and upholstery fabrics in light pastel and neutral colors. Furnishings are arranged in groupings. Beyond the hostess station, one moves through a small room, with two dining tables (each seats four) and a sideboard, and into the main dining area, which holds about 20 tables and the buffet.

The Dining Room has a pleasant feel. It is a well-lit area, with ornate wrought iron chandeliers (painted a cream color) and small lanterns hanging from the ceiling. The walls are painted beige or are covered in pinkish-gray brick, with gold-accented decorations (mirrors and prints), and brown carpeting with a dark blue grid pattern. The chairs all have armrests and wheels, to make them easier to get in and out of, and are upholstered in coral, green and beige
stripes. Tables will seat various numbers of residents; there are two-tops, four-tops and six-tops (tables that seat two, four and six, respectively). A white tablecloth covers each table, which is set with cloth napkins, silver utensils (a salad fork, a dinner fork, a knife, a soup spoon and a tea spoon), water goblets, cups and saucers, and bread plates. Each table also has a salt and pepper set, a small white container with packets of sugar and artificial sweeteners, comment cards, and small pencils. Tables that seat six will have two sets of the condiments, cards and pencils. At dinner, a menu is placed at each setting. Residents in wheelchairs can be accommodated in the Dining Room, but limited space between most tables generally makes navigation difficult.

Figure 4.2: The Dining Room and Living Room Area of Colonial Square

Note: Figure is not to scale.
The wall separating the main dining area from the hallway and lobby is lined with multi-paned windows at chair rail height; there are no window treatments here. The buffet at the end of the room, where there is a doorway to the kitchen, is used only at lunch and the continental breakfast, as table service only is available for the evening meal. At dinner, the buffet holds water pitchers and coffee carafes for the servers. To the side of this area is another “room,” sometimes referred to as the “garden room.” Although part of the main dining area, several gray brick, faux columns against short walls create wide doorways, and essentially separate the garden room, giving it the feel of being a different room. There are large windows all along the outer wall of the garden room, hung with white sheer draperies.

One can also get to a private dining room from the Living Room, through a doorway on the side of Living Room opposite of the doorway to the fireplace room and Dining Room. The private dining room also has a separate entrance down the hall. Across the hall from the private dining room, before the resident apartments, is a multipurpose day room. Interspersed among the apartments of both wings are laundry rooms (there are free washers and dryers on each floor for the residents’ use), trash disposal rooms, housekeeping closets, stairwells (a total of six) and elevators (a total of four; only the central elevator services the basement).

Two years ago, management contracted for the remodeling of the hallways and common areas on each floor. The carpet had gotten old, worn and in need of replacement, and the look of the interiors was outdated. The residents of each hallway voted on final color schemes and patterns, which resulted in each hallway being a little different from the others. The preferences of the residents’ were apparently for light, soft colors, in various shades of blue, beige, mauve and green prevailing.

There are 51 apartment homes on the first floor. They range in size from about 480 to 1064 square feet, and vary in layouts and location, from a studio to a two-bedroom/two-bath plan, on the first, second or third floor, and with or without a balcony or courtyard view. Residents are able to make minor cosmetic changes to their apartments, such as in decor and painting/wallpapering, but any major changes need the approval of management. All apartments are carpeted, and have fully equipped kitchens (all electric appliances), individual climate control, drapes and washer dryer hook-ups. The apartments have some features to assist elders and those with disabilities, such as wheelchair-accessible sinks and grab bars in the showers. In general, however, maneuvering room for someone in a wheelchair is limited through existing
doorways, hallways and many of the kitchens. Apartments also come equipped with emergency pull cords (generally in the bedroom), and an electronic check-in system in the bathroom.

*The Second Floor*

The second floor consists of mostly apartments; there are 61 apartments on this level. Just as on the first floor, there are laundry rooms, trash disposal rooms, housekeeping closets, stairwells and elevators intermittently stationed on each wing. There is also a public restroom, and a conference room that is used for both staff and resident meetings.

Figure 4.3: Second Floor of Colonial Square

![Second Floor Plan]

Note: Figure is not to scale.
Facing the central elevator, on the right side, are about half a dozen square tables, with four high-back chairs around each. On the left side of the elevator are chairs and a television. Directly in front of the central elevator is a coffee table, which is surrounded by a loveseat and a couple of chairs. On the coffee table are magazines, mostly related to travel. Behind this grouping are double doors that lead out to a second floor balcony that is just above the main entrance. On the opposite side, behind the elevator, is a large balcony overlooking the back of the property. Just as on the first floor, there are also other elevators located at various intervals on each wing. These are helpful of course, but it is still a very long walk to the Dining Room, mailboxes, etc. on the first floor from the back of the building, regardless of floor or elevator location. In fact, occasionally one sees a “mobie” or two parked in an alcove or lounge area (“mobie” is the nickname used for electric chair carts).

Anyone interested in the history of Colonial Square can go down the right corridor to the first small side alcove after the first block of apartments. Here one can peruse the Residents’ Archives, designated as such by a handwritten paper sign. A dark brown three-shelf bookcase and a filing cabinet contain historical records that sketch the history of Colonial Square, up to about three years ago. The archives include photo albums, videos, association meeting minutes, newsletters, resident rosters, “alumni” lists, entries made by the archivist on events and happenings, the history of Memory Hill and other miscellaneous items.

The Third Floor

The third floor, with 66 apartments, is basically the same as the second floor. One difference is in how the open (lounge) spaces on this level are used. To the left of the central elevator a lounge area is set up for serious TV viewing; there are several rows of chairs facing a large television, which is set on a stand high enough so that nobody’s head will be in anyone else’s way. The other open space, to the right of the elevator, is set up as a gaming area with billiards and about three or four poker tables. The jewel tone colors and dark wood is reminiscent of a pool hall. A long, pub-like lamp hangs over the billiard table, casting a yellowish light. A mural of a horse racing event covers the entire right wall; it has an impressionistic flair to it. Another difference of the third floor is the guest apartment for overnight visitors.
The Basement

Finally, there is the basement, a fairly stark and sterile area with bright fluorescent lights and off-white concrete walls. The basement is mostly staff territory dominated by offices, such as those for activities, housekeeping, maintenance, and the home health agency. The employee break room is also located in the basement. There are three areas for residents in the basement: a workshop for residents inclined to woodworking; a shuffleboard court; and limited storage space for residents’ use. Apparently neither the workshop or shuffleboard court is used much.

The Grounds

The grounds of Colonial Square are a point of pride for both residents and staff. The landscaping is professional and meticulously maintained, with many trees and plenty of flowers in the spring and summer. Residents are allowed to do some landscaping and outdoor decorating just outside their apartments. There are many birdfeeders, window boxes and even some metal sculptures of animals and insects. Attached to the back of the building is a large, uncovered concrete and brick terrace. Behind the building, beyond the terrace, is a very large courtyard area, in which paved walking paths (lit at night) meander throughout to the eastern area of the property. Outdoor recreational facilities include shuffleboard courts, a putting green, and a swimming pool (closed from September to May) and tennis courts.

There is an herb garden among the walking paths, which has suffered from some neglect since the passing of the resident who began it. The raised garden boxes and garden plots in the northeastern area of the property are popular with residents. Also to the eastern side of the property is Memory Hill. Memory Hill is not really much of a hill, but it is a grassy area, with a small bridge walk and trees, that was developed from funds donated in memory of deceased residents. There is a plaque in the ground designating the area as such.

The Setting: Activities, Amenities and Services

Residents need to have some level of financial security to live at Colonial Square. In fact, each potential resident is subjected to a financial screening before moving in to assure the American Retirement Corporation that the resident will be able to meet the monthly financial obligation for years to come. Monthly fees range from $1550.00 for a basic studio, to $3140.00 for
two people living in a two-bedroom/two-bath apartment on the first floor that opens out to the courtyard (there is a $400.00 double occupancy fee). These monthly fees do include a number of services and amenities, such as dining services, weekly housekeeping, maintenance, washers and dryers, all utilities (except phone and cable), wellness services, activities (some events have an extra cost), transportation, and safety and security systems. Many residents feel that all the services and amenities justify the monthly cost. The services that are often a consideration in decisions to move to Colonial Square, and which seem to be quite appreciated, are the dining services.

*Dining Services*

The director of dining services has the following staff under his supervision: the chef, cooks, hostesses, servers and bus people. The majority of the food and dining services staff tends to be young, as most all of the hosts, servers and bus people are high school and college students. The food and dining services at Colonial Square also include preparation of the meals for Oak Ridge Manor and the Meadows, sending the food across the parking lot via a mobile hot/cold unit (it looks like an oversize golf cart with a big refrigerator on it). They also cater any activities or special events as requested by other staff.

There is a free continental breakfast available in the Dining Room on weekday mornings from 8:30 a.m. to 9:30 a.m. This breakfast includes baked goods (e.g. muffins, breads, pastries, dry cereals, hot oatmeal, fresh fruit, coffee, tea, milk and juice. On Saturdays, complimentary coffee and donuts are served from 9:00 a.m. to 11:00 a.m. on the second floor in the elevator lobby area. This is referred to as the “Coffee Klatch.”

One meal a day is included in the monthly fee, and residents may choose to take either lunch or dinner. Which meal a resident chooses can change from day to day. Lunch is served from 11:30 a.m. to 1:00 p.m. on weekdays; a lunchtime meal is not served on Saturdays. Lunch meals are buffet-style, and include breads, soup, salads, two or three entrees, three or four sides, relish/garnish items, and desserts. A server brings beverages to the table. Friday lunches are “brunches,” in that they include such breakfast foods as scrambled eggs, sausage, bacon, hash browns, and biscuits and gravy.

Dinner is served from 3:30 p.m. to 7:00 p.m. Monday through Saturday. Sunday “dinner” is served from 11:00 a.m. to 1:30 p.m., and there is no evening meal. Weekly abbreviated menus
are sent out to residents that list featured salads, entrees and sides for dinner each night (see samples in Appendix C). Dinner meals are provided by table service. There is a menu for the evening meal (Figure 4.4) and options for the various courses at each place setting on the tables.

Figure 4.4: Sample Dinner Menu

<table>
<thead>
<tr>
<th>SOUP DU JOUR</th>
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<table>
<thead>
<tr>
<th>SALADS</th>
</tr>
</thead>
<tbody>
<tr>
<td>House Garden Salad*</td>
</tr>
<tr>
<td>Spinach Salad</td>
</tr>
<tr>
<td>Sugar Free Jell-O*</td>
</tr>
</tbody>
</table>

* Salad is served with your choice of 1000 Island, Low Fat Ranch, Blue Cheese, Low Fat Italian, Honey Mustard, French or Oil & Vinegar

<table>
<thead>
<tr>
<th>ENTREES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grilled Chicken</td>
</tr>
</tbody>
</table>

* Breast of chicken grilled

<table>
<thead>
<tr>
<th>Hot Browns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fried Oysters</td>
</tr>
</tbody>
</table>

* Turkey, ham and bacon served on toast and topped with a cream sauce

<table>
<thead>
<tr>
<th>ACCOMPANIMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onion Rings</td>
</tr>
<tr>
<td>Mixed Vegetables</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Broccoli</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cauliflower</td>
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</table>

<table>
<thead>
<tr>
<th>ALTERNATIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresh Seasonal Fruit Plate*</td>
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</table>

* Served with your choice of cottage cheese, tuna or chicken salad

<table>
<thead>
<tr>
<th>DESSERTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grilled Chicken Breast</td>
</tr>
</tbody>
</table>

* Ice cream flavors include Vanilla, Chocolate, Low Fat Frozen Yogurt along with a Featured Flavor. For Sugar Free selections and Daily Features......Please Ask Your Server.

* DENOTES NO ADDED SUGAR OR SALT
A young man or woman takes the resident’s order and brings the food and beverages to the tables. Twice a week, on Thursdays and Saturdays, wine is served; red and white wine carafes are on the table and diners may help themselves. Dinners include breads, soup, salads, three choices of entrees (one is usually chosen), four choices of sides (two are usually chosen, although three is acceptable), and desserts. There is a daily feature salad, in addition to a house salad and jello. There are alternative entrees that are always available, if none of the main entrees are appealing. One can choose from: a fresh fruit plate with choice of cottage cheese, chicken salad or tuna salad; a grilled chicken breast; or a grilled ham steak. Interestingly, the grilled chicken breast is listed on the menu as an alternative even on the evenings that grilled chicken breast is a main entrée item. There is a featured dessert each day (e.g. a bread pudding, apple pie or chocolate cake), and there are standard desserts that are always available: ice cream, sherbet, and frozen yogurt. Some low-sodium and sugar-free items are available. Menus will designate if an item has no added sugar or salt. There is no dietician on staff, although occasionally, a consulting dietician comes through.

A resident may have as much as they like of any item at all meals. However, there are no doggie bags; leftover food may not be taken back to the resident’s apartment, because the policy is that no food is allowed to leave the Dining Room. The only exception is that one serving of a dessert may be taken home, as long as the resident provides a container, and the resident has not already eaten a dessert. Another corporate regulation for the Dining Room is a “no tipping” policy, which applies to all employees, not just the dining staff.

As far as accounting for meals, each resident is assigned a bar code. The code is kept at the hostess stand. The resident also has the code imprinted on a Colonial Square charge card (often hung on a key ring). As the resident enters the dining room, the code is scanned, electronically recording the meal for the resident. Periodically a report is available at the hostess stand giving the number of meals already served during the month for each resident. At the end of the month, the totals are sent to the business office for billing purposes. Meals not taken by the end of the month are lost; they cannot be saved and used later, although residents do receive a small refund for meals not taken. Meals not taken also cannot be used for guests or any other residents; the only exception is when the other resident is a “second” person in the same apartment. A resident can pre-order extra meals if it has been put into his/her lease. A resident
can also have a lunch only meal package. The bar code scanning is a recent development, and was instituted only within the last year. Previously, residents were each issued a month’s worth of meal tickets, which were redeemed when taking a meal. Also, each resident was issued five extra lunch tickets per month. They used their allotments as they saw fit, and many used the extra tickets for guests.

The Resident Council (and not the corporate administration) has suggested a Dining Room dress code for residents and guests. It is suggested that for lunch, women wear dresses, pant suits, walking shorts, skirts and blouses, and that men wear a casual suit, slacks or walking shorts (no jacket is required). For dinner, Sunday and special events, women should wear dresses or pant suits and men should wear dress shirts, slacks, a tie and a jacket. The jacket is required and is defined as a sport coat or suit coat. On Saturdays, the dress code for dinner is more relaxed and follows the same guidelines as weekday lunch. No one will be barred from going into the Dining Room if they do not follow the code, but others may frown upon them if they are not dressed according to the guidelines and the mental and physical wellness of that resident may be questioned.

Guests are welcome to dine at Colonial Square, if accompanied by a resident or staff member. Residents are charged a guest meal rate for their visitors; dinner and lunch for an adult costs $11.00 and $6.00, respectively, and for children ages 5–11, the prices are $5.50 and $3.00. Children under the age of five may eat free. Residents can reserve tables for guests, as a few tables are set aside each evening for reservations, either made for 4:15 to 4:45 p.m. or 6:15 to 6:45 p.m. Residents, of course, do not need reservations, and are seated and served on a first come, first-served basis during the designated dining hours. If there must be a wait for a table, then the host or hostess will start a wait list. Although there is not a set rule, the resident handbook asks that residents and guests limit their time in the Dining Room to no more than one hour and thirty minutes.

Room service is available for an extra fee. The delivery charge for a meal tray is $3.25, and each additional tray to the same apartment is $1.75. Regular meal deliveries count as though they were meals consumed in the Dining Room, and are billed as such (the resident’s bar code is scanned before the meal is delivered). Up to five complimentary deliveries can be made to residents returning from a hospital admission or from outpatient surgery, based on the approval of the wellness nurse. Such meals count as meals consumed and are billed to the resident, but
there is no delivery charge. Take-out meals can also be prepared for pick-up. Again, take-out meals are counted as meals consumed, and there is an extra fee of $1.75 per take-out meal.

Two miscellaneous food and dining services are offered for residents’ personal functions. A catering service is available, and residents can request catering for any private celebrations or special occasions that they are hosting on the premises. The cost will depend on the items selected and quantity prepared. Residents can also reserve the private dining room for personal use, e.g. a dinner with family. Staff may use the private dining room for official business, e.g. a marketing luncheon.

Other Services and Amenities

There are a number of other services and amenities provided for residents. These include wellness services, safety systems, maintenance, housekeeping, transportation, social activities programs and other recreational activities and facilities.

The Wellness Center provides residents with health information and health education programs, basic drugstore-type items at a small cost (such as toiletries, pain relievers and digestive aids) and health services administered by the wellness nurse, such as blood pressure checks (very popular with residents, particularly after breakfast on open clinic days), and shots/injections. Podiatrists, dentists and massage therapists have hours in the clinic and residents can schedule appointments for their services. Residents can also contract for private duty services through the on-site home health agency.

The emergency response system is under the aegis of wellness services. Emergency pull cords are located in a convenient place in resident apartments, often in a bedroom area. There is a staff person available 24 hours a day to respond to emergencies. A “call first” response was established due to the frequency of false alarms. Therefore, the front desk staff person calls the apartment at the sounding of the alarm, before a staff member goes to the apartment. Another system in place to monitor residents’ status involves a type of check-in procedure. A button in the main bathroom begins flashing around 5:00 a.m., and residents must push the button by 11:00 a.m. (which makes it stop flashing), to let a computer know that they are okay. In the evening, security and/or a nurse will get a printout from the computer and check on any residents who did not push their button; they are aware of residents who may be on vacation or an extended leave.
Routine maintenance and housekeeping services are included in the monthly rental fee, although extra services can be acquired, with the charges appearing on the monthly bill. Routine services offered by maintenance include work on appliances and permanent fixtures, preventive maintenance on air conditioning and heating units, and painting of apartments as needed. Housekeeping is provided on a weekly basis and includes cleaning bathrooms and the kitchen (including floors, countertops and outside of appliances), vacuuming, dusting and bed linen changes. There are also annual services that include window washing, carpet cleaning, cabinet cleaning and thorough cleaning of the refrigerator.

The Activities Department of Colonial Square oversees transportation, social programs and use of recreational facilities. Colonial Square has a bus, van, and car for transportation purposes. On Wednesdays and Saturdays, twice a day, the bus makes a shopping circuit, called “the Loop.” The morning circuit is different from the afternoon circuit. There are several stops on these routes, including discount stores, drugstores, a mall and grocery stores. The resident is dropped off at one of these places, and the bus will return later at a designated time to pick them up. Many residents do their grocery shopping this way. Residents can schedule transportation for personal reasons, such as shopping or medical appointments, although medical appointments take priority. On Sunday mornings, church service runs are made to particular churches. Colonial Square transportation is also provided to select fine arts, cultural and entertainment programs and events in Lexington; these trips are set up by the Activities Department.

In addition to such trips, the Activities Department organizes a number of social programs and activities, as well as coordinates the use of indoor and outdoor facilities for leisure and recreational pursuits. Social programs may be holiday parties, games (Bridge and Bingo are popular), special entertainment, educational speakers, and movie showings. The Activities Department also sponsors a Social Hour each Wednesday from 4:00 p.m. to 5:00 p.m. in the multipurpose day room. It is essentially a cocktail hour, where residents can have a glass of wine and some hors d’oeuvres before dinner. An activities staff member generally plays the role of “bartender.” Hard liquor is not served, but residents can bring their own if they want.

Another activity called the Dinner Club involves a monthly outing to a local restaurant. Sometimes, longer trips are planned to go to a special restaurant out of town. During warmer times of the year, cookouts are held, and a luau has become an annual tradition at Colonial Square. Events and activities are often planned and advertised with the qualifier, “refreshments
will be provided,” or sometimes more specifically, “hot dogs and popcorn will be $1.00.” Activities staff have noted that at certain events, if a small fee is not charged, too many people will come for the free food. They have also noted that an event or activity is much more popular if food is available, even if there is a nominal cost.

Additional activities provided include exercise classes and vespers services. The Activities Department coordinates use of certain areas inside, such as the common areas on the second and third floors, the conference room, and multipurpose day room, and areas outside, such as the garden areas and raised box gardens.

Special Activities and Events

There are also special activities and events that occur, sometimes organized by the Activities Department and sometimes in conjunction with other departments. For example, banking services are a special activity. About once a week, a representative from a bank will be in the Living Room on Friday mornings. Residents can actually conduct business with the bank at those times. Different weeks will have a different bank representative.

A special event put on by Dining services, and supported by Activities, is held once a month, on a Friday night. “Friday Night Out” involves a special meal served that evening in the Dining Room (e.g. prime rib, stuffed flounder). In the Living Room, wine and hors d’oeuvres (cheeses, fruits and crackers) are served, and live musical entertainment plays, to enjoy before and/or after the meal. A special event completely organized by the residents is the annual fall bazaar. Residents donate items to be sold at the bazaar, from secondhand things, such as furniture and cookware, to handcrafted items, such as wreaths and homemade baked goods, including cakes, muffins, pies and cookies. Money raised by the sale is donated to the Employee Appreciation Fund. This is a fund built up all year by donations and sales such as the fall bazaar, and then divided among hourly employees, based on the number of hours they have worked. Because there is a no tipping policy, residents can show their appreciation to the employees through this fund.

Resident Involvement in Community Operations

Although residents do not own any part of Colonial Square, there are mechanisms in place for resident involvement in how the community is operated. Management and staff seem
to try to keep lines of communication open with the residents. Residents, of course, may talk
directly with employees. There is also a suggestion box, through which residents can bring up
issues. A major avenue of involvement for residents is through the Residents Association, to
which all residents automatically belong upon moving in. It is governed by a Resident Council,
for which the officers and at-large Council members are elected by the entire membership. There
are various standing and special committees (e.g. food services committee, activities committee),
which have chairs who are appointed by the Council. The relevant managers and directors
attend committee meetings; for example, the director of dining services attends the food services
committee meeting and the executive director attends Council and Association meetings. In
this way, residents play an active role in the running of the community, by airing complaints,
reinforcing positive aspects, making suggestions and working through issues.

Management recognizes that dining experiences are an important part of the lives of
residents, and that providing a means of communication about their experiences is a valuable
tool for both sides. In addition to verbal communication, residents may also submit their views of
their dining experiences in writing via the comment cards mentioned earlier (Figure 4.5).

Figure 4.5: Dining Room Comment Card
Residents are welcome to comment on their meals and the service, extolling the good and lamenting the bad. Residents are required to sign their names to the card, however, because otherwise management will not consider their comments. Each month, the director of dining services compiles and types up all comments for the previous month. He then brings these to the food services committee, which meets the first Wednesday of the month, and distributes a copy to each committee member. Each comment is reviewed and addressed by the director, the chef (who also attends) and the committee members. Committee members may shed more light on a comment, reinforce a comment, or they may refute a comment, dismissing it (e.g. “She thinks everything is too salty!”).

The Setting: The Social Milieu

Resident Characteristics

There are about 200 to 205 residents of Colonial Square. The residents are overwhelmingly white, and most are well educated and fairly affluent. Many had professional careers, but some come from trade and agricultural backgrounds, and many women were full-time homemakers. The women outnumber the men here, although in the past year or two, a slight surge in the number of men, particularly unmarried men, has been noted. As similar as they are in certain demographic characteristics, residents do come from all over the United States (e.g. Massachusetts, Michigan, Texas) and bring regional differences with them. Despite these geographically diverse origins, many of the residents are from Kentucky. The state to contribute the second largest number of residents is Florida; usually they had moved to Florida from somewhere else first, and had planned to retire there.

Social Organization and Community Participation

Many residents speak well of the general community of adults that have gathered themselves at Colonial Square. The friendliness of the people who live there is often mentioned as a strength of the community, and some residents mentioned it as a positive point that helped sell them on the idea of Colonial Square. A few remarked that there are certain residents they will avoid, often people who are perceived as negative and complaining. Although the openness and acceptance of others is also brought up as an asset of the community, the residents are not
without at least a loose social organization. There are definitely groups of residents, some of which are apparently quite tight and cliquish. There are also some residents who are perceived by others to be the “elites” of Colonial Square. These resident “elites” are active people, involved in leadership roles and governance at Colonial Square, and often participate in organizations and volunteer roles in Lexington. They maintain a high level of social engagement, but usually had been as socially active before moving to Colonial Square. They are in a way, the good “popular” kids of high school or college, those who were always involved in student government and social activities, the ones who organized fundraisers and volunteered for charities.

Residents, of course, can be as involved, or not involved, as they like in the Colonial Square community activities. Some residents involve themselves through the Residents Association, serving as an officer or on a committee. Others take tasks upon themselves. For example, the resident archives are mostly the work of one resident who was a professional archivist before his retirement; when he died though, the driving force behind the archives faded. It has not been kept well up-to-date since then. The herb garden in the middle of walking paths in the back of the property was planted by a botanically-minded resident, who has also since passed away. It fell into some neglect for a while, but has now been taken under wing by another resident, who will attempt to revitalize it when spring weather returns. Some are only involved in community activities, some only in activities outside the community, and others are involved in activities both within and outside the community.

Places of Social Interaction and Activity

Different public areas of Colonial Square are used and inhabited in different ways and at different times. This often seems to depend on what is happening or about to happen, and the centrality of the place, physically and socially. For example, in the lobby, there tends to be a moderate amount of traffic, because it is necessary to go through the lobby to get to a variety of other places, such as the mailboxes, administrative offices, and the day room, for those who live on the left side of the building. There are also a number of functions that the front desk serves for residents, including paperwork to make routine maintenance requests and schedule transportation. Traffic becomes particularly heavy around meal times and just before the bus is ready to leave for a recreational trip or a shopping circuit. Often there are one or two people who sit in one of the few wing chairs, either waiting for someone or just to pass the time. Frequently,
after they have had dinner, a small group of women (five or six) will occupy the lobby, chatting about various topics, including the dinner.

The Living Room is generally an area where much waiting occurs, such as for lunch or dinner. It is also a meeting place, where residents will arrange to join up with each other or guests before going into the Dining Room. The fireplace alcove is mainly used for waiting before meals. Sometimes, there is a card or two sitting out on a table, in view of those passing through; these are either sympathy or get well cards for sick or grieving residents, which anyone can sign. Sometimes special events and activities will occur in the Living Room, such as speakers and banking services, which liven up the place. Friday Night Out, for example is very popular, with many residents and guests going to dinner that evening. A wait list becomes necessary because the Dining Room cannot accommodate everyone at the same time. On these nights, it is lively and crowded in the Living Room. Otherwise, unless it is before a meal, on a bank day, on Friday Night Out, or a special activity is planned to be in the Living Room, it is a rather quiet place.

In the Dining Room, dinner is the most crowded mealtime, with roughly two rounds of diners; there is a wave around 4:30/5:00 p.m. and another wave around 5:30/6:00 p.m. There are some who do eat as early as 3:30 p.m., when the Dining Room opens for dinner. Lunch is not as well attended, for it seems most people chose to use their one meal a day at dinner. The “free” continental breakfast attracts about 30 regulars. Sometimes staff will get lunch from the Dining Room, but do not often eat there. Occasionally, there will be an administrative lunch meeting in the Dining Room. During the months of October and April, it is almost a ghost town at lunch on Fridays, as those are the days of the horse races.

Down the hall, the Multipurpose Day Room is frequently an active place, as a number of planned activities, such as crafts, exercise classes, dances, television events (local sports are important) and parties, enliven the area. Meetings and luncheons will also be held there, such as resident committee meetings or staff luncheons.

The conference room on the second floor is also used for meetings, both staff and resident, and for social activities, such as Bible study on Tuesday afternoons. In the second and third floor lounge/common areas, the tables are used for serious and not-so-serious card playing, mainly bridge, and mainly in afternoons and evenings. Otherwise, during the day it can be fairly quiet in the common areas and throughout the floors, though occasionally one hears the sound of a television from an apartment. A few people will pass through going from their apartment to
the first floor and vice versa. On the second floor, there is one woman who regularly leaves her apartment door wide open. She does not make much noise, although sometimes music will be softly playing. She often can be seen sitting in her living room, doing some sort of handiwork, such as cross-stitching. In the evenings, it may become a little livelier on these upper floors, with games and other social activities, such as movies and television viewing, taking place in the lounge areas.

Outside, the terrace is used during nice weather in the warmer months for informal gatherings and planned events, such as cookouts. Walking paths may be used during all times of the year, whenever the weather is accommodating. Quite a few residents walk about at various times during the day and evening hours. The outside shuffleboard courts, and the putting green and swimming pool (closed from September to May) are all well used in good weather, but the tennis courts are not often used, and look neglected.

The gardening areas are popular among residents. In years past, a lottery would be held annually to assign gardening spaces; however, demand for the beds has been down in recent years and a lottery has not been necessary. It is speculated by the Activities staff that there are fewer gardening residents who are interested or, more importantly, who are able. It seems the avid gardeners of the past are not as physically capable of keeping up a garden plot or box, and so have given them up.
Participant Characteristics and Life Overviews

The previous description of the setting presents a general portrait of the physical and social aspects of the community as whole at Colonial Square. It is in this setting that the participants of this study live and act out the daily routines of life. It is the place where a good number of their current dietary behaviors are performed and dietary preferences are enacted. While Colonial Square itself encompasses central physical and social contexts for the participants’ dietary behavior, the residents themselves have a number of personal and social characteristics that also provide context for their food- and eating-related practices. This section offers an overview of particular characteristics of the participants and their lives, to further contextualize and situate the stories they told.

Table 4.1: Residential and Mobility Characteristics of Participants

<table>
<thead>
<tr>
<th>Spatial Characteristic</th>
<th>Lexington</th>
<th>Kentucky</th>
<th>South</th>
<th>Midwest</th>
<th>Southwest</th>
<th>Northeast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place moved from a</td>
<td>11</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Place of birth</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Note. Each column value represents the number of participants for the category.

a The place where the participant was residing before moving to Colonial Square

The eighteen participants in this study were, of course, all residents of Colonial Square. Most participants (11 women or 61%) were already living in Lexington when they moved to Colonial Square (Table 4.1). Two others moved from elsewhere in the state; one from an urban area and the other from a rural area. Four women came from other states of the South Census region, and one came from the Southwest region (she also had retired there). It is striking that all but two of the women were born outside of Lexington, and over half (10 women) were born in states other than Kentucky, mainly the Northeast, Midwest and South. One woman who moved to Colonial Square from the Southwest was originally from the Midwest, where she was born and lived during young adulthood and middle age. Those who moved to Colonial Square from Florida (3 women, in the category of those who moved from the South) were originally from
the Midwest, Northeast and Kentucky. As seen in Table 4.2, the participants’ length of time in residence at Colonial Square ranged from 1 year to 18 years (she moved in when Colonial Square opened), with an average of 5 years. Thus, newcomers, long-time residents, and those in between are all represented in the participant mix.

Table 4.2: Select Socio-demographic Characteristics of the Participants

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Average</th>
<th>Median</th>
<th>Mode</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time in residence (in years) a</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Age (in years)</td>
<td>85</td>
<td>86</td>
<td>86</td>
<td>72</td>
<td>94</td>
</tr>
<tr>
<td>Married (in years)</td>
<td>54</td>
<td>56.5</td>
<td>NA</td>
<td>33</td>
<td>63</td>
</tr>
<tr>
<td>Widowed (in years)</td>
<td>15.2</td>
<td>15.5</td>
<td>3</td>
<td>3</td>
<td>38</td>
</tr>
<tr>
<td># of children</td>
<td>2.3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

a Amount of time the participant has been a resident of Colonial Square

Participants ranged in age from 72 to 94 years, with most them (12 women or 67%) in their eighties (Table 4.2). The majority of participants, 10 out of 18 women (56%) were widowed and one had twice experienced widowhood. On average the widowed women lived without husbands for just over 15 years, and with a range of 3 to 38 years. One third of the participants were married and at the time of the study lived with their husbands. Even though one participant was in her second marriage, all of the couples had been together from 33 to 63 years. One participant had been divorced for 21 years (a second marriage and a widow from a first marriage), and another participant was single and had never been married. All but two of the participants had children. Of those with children, all but one had grandchildren, and several had great-grandchildren. Complex family histories became manifest with the presence of step-children and step-grandchildren. Most participants had at least one child residing in Lexington or within an hour of Lexington.

On the whole, the participants were well educated. All of the women were at least high school graduates. Most of them, 14 out of 18 women, pursued education beyond high school, whether it was professional business school and/or college. Four women had some college (2–3 years) or an associate’s degree. Eight women had bachelor’s degrees and two women had
a master’s degree. A few of the college graduates had non-typical collegiate experiences, as a
couple of the women worked on their bachelor degrees over the course of quite a few years (one
woman went summers and weekends for 20 plus years) and another woman attended college
in her forties. For some, their education was a platform for their future career(s), but for others
it was not. The two women with their master’s and some of the women with their bachelor’s
worked in the field of their degree, but several of the participants never used their advanced
education, or at least did so only very briefly. This was often due to marrying soon after their
schooling, if not upon graduation, and becoming full-time wives and mothers.

All of the participants were retired and none were employed at the time of the study. The
women who worked in the past had traditional female employment in office/clerical positions
and in education (teachers, librarians and the state department of education). Three of the women
worked for their husbands, managing the office and bookkeeping for their husband’s business
(two of these businesses were out of their home, and these women were at the same time raising
their family and caring for ill parents). Another woman, who had initially retired from an
office position, took over her husband’s work when he became too ill to do it himself. Six of the
participants were full-time homemakers, yet only four women were homemakers from the start.
The others worked at least a few years before getting married. A few of these homemakers also
took on some paid work later in life. And then there was the army wife, who although technically
a homemaker, could be said to have had a “career” as an army wife, as she worked hard to fulfill
all the duties expected of a military wife, particularly one of the 1950s and 1960s.

The husbands of the participants, who had been or were married, worked in a variety of
fields. They were city and state government employees, engineers, store and business owners,
contractors, stockbrokers, farmers, army officers, professors, human resources employees, office
workers and truck drivers. The savings and retirement income from these various occupations
no doubt contributed to the state of financial well-being that most of these women enjoyed, in
addition, of course, to any retirement income they themselves brought in, as several had pensions
from their own careers.

Although fairly financially secure now, most of the women did not come from well-to-
do families. Many remembered difficult times during the Depression, although more so for the
women whose families did not farm. Most of the mothers of these women did not work and were
full-time homemakers (a few did part time work here and there, such as sewing or substitute teaching). Only three participants had mothers who worked full-time. About a third of the participants’ fathers were in agriculture, about a third were employed in blue-collar jobs, and a third were in white-collar professions (sales, government employees, business owners). Most of the participants’ parents had stable marital histories; only one of the women had parents who divorced. Three of the women had a parent die when they were young, either as a teen or young adult.

Some of the women came from large families, with four of the women having 6 to 8 siblings. Another eight women had medium-sized families, with 2 to 4 siblings. Four participants had only one sibling. Two participants were only children, although one had uncles who were only a few years older – she grew up with them, and they were like brothers to her. Most of the women were at one extreme of the birth order spectrum. In other words, half of them were the oldest, and another four were the youngest. Two, of course, had no siblings and the other three women were somewhere in the middle.

For many of the women, religion was an important part of family life growing up, and continued to be an important aspect of their lives today, although in different ways than when they were younger. For the women who were the same religious denomination as their family growing up, this was almost a point of pride for them, for example, that they were a fourth generation Methodist. However, some of the participants claimed religious denominations different from the ones they grew up in, usually due to adopting their husband’s religious tradition upon marriage. All but one of the women, who were or had been married, were coupled with men of Protestant backgrounds, and so those who switched still remained within the Protestant tradition. One participant married a Jewish man, however, he and his family did not follow Jewish dietary regulations (they ate pork and pork products); he simply did not attend church with her.

At the time of the study, the participants claimed various religious denominations, although all were Protestant. Just over a third of them were Methodist (7 out of 18 women), and not quite a third were Presbyterian (5 out of 18 women). Three considered themselves a part of the Disciples of Christ tradition, and two women attended an Episcopalian church. One participant went to a Christian church. A few of them were attending the same church
in Lexington as they had before moving to Colonial Square. Church and service attendance sometimes depended on transportation (for those who no longer drove) and desire. Some women had various ways of getting to church: Colonial Square transportation, a church bus (that goes to Colonial Square to pick up parishioners) or friends and neighbors. This to some extent also influenced what particular church they went to. A few women no longer attended church services, due to either the physical difficulty of attending or a personal choice. However, these women participated in informal and private religious practices, such as watching religious programming, reading religious materials, Bible study, devotions, and private prayer. A few attended the Sunday vespers and mid-week Bible study that was held at Colonial Square.

Another aspect of family mentioned by some participants involved their ethnic heritage. For those who were aware of their ancestry, especially those not many generations removed from family members who migrated to the United States (one woman’s father was an immigrant), a European legacy was predominant. Those women who were of German, English, and Scottish stock particularly made their genealogy known. I think a few participants would have been tempted to claim Southern as their ethnic heritage, having a family line that has been firmly established in the American South. Many did not claim an ethnic tradition, and it did not seem to be a relevant aspect of their lives to them, in the past or present.

Finally, the participants rated their health as fair to good. A few had conditions in which their diet played a role in its management, such as diabetes, diverticulosis, high blood pressure and high cholesterol. The two women who had diabetes were both insulin dependent. Several participants had osteoporosis, and were taking calcium supplements and/or medication to treat it. Some have had falls and/or broken hips and had gone through, or were going through, physical therapy. One woman was permanently in a wheelchair. Some women underwent surgeries and/or treatment for serious illnesses, including two women who had hip replacements, two women who had a colostomy, two women who were afflicted with cancer, and one woman who was having difficulties with congestive heart failure. Several participants had other chronic conditions, such as arthritis and hearing loss (a few had hearing aids). Health declines were the reason most of the women who did not drive, no longer did (12 out of the 18 participants). Yet most counted themselves as fortunate health-wise and felt they were doing pretty well either for their age or as compared to others.
These eighteen women were very similar in some respects and very different in others. They brought to this study a minimum of seven decades of life experience, and the stories to show it. An overview of each participant’s life course, including various life course trajectories (family, education, career, place) can be found in Appendix D.
Chapter Five
Past and Present Influences on Dietary Practices of Older Women

This chapter explores past and present influences on the dietary practices of the women of this study. Some of these influences originated earlier in the women’s lives, even childhood, but continued to be felt in the present. Other influences related specifically to the retirement community environment in which the participants resided and spent much of their time. The various influences are sorted into four categories, constituting different levels of influence, from individual characteristics to wider contexts of corporate policy and even contemporary world events.

The first section addresses influences categorized as person factors; they represent psychological and biological processes of the individual that affected, or at least were perceived as affecting, dietary behavior. The next section concentrates on interpersonal relationships as a factor, illustrating the importance of social relationships such as family and the effect of interactions with other residents and employees of Colonial Square on particular dietary practices. The third section considers social roles and statuses as a category of influence, specifically how the women’s past and/or present statuses as parent and spouse were an influence on their dietary experiences. The fourth section reviews contexts of the participants’ dietary practices, focusing on contexts of meal patterns and food preparation, community policy contexts, and political economic forces. All of these factors shape participants’ dietary practices, interacting to create both common patterns and unique experiences.

Person Factors

Several women referred to personal characteristics and experiences as affecting their dietary patterns. Two of the participants believed that simply their own preferences and tastes (what they liked and disliked eating) influenced them, and did not necessarily view their preferences as having ever been influenced by others. Mrs. Michaels took a very psychological approach towards interpreting how and why she eats, as she related that she was somewhat affected by her moods, attitudes and overall the way she felt. She admitted to sometimes eating when she was bored or lonely.
Physical aging, especially as related to energy, strength and ambulation, affected the women in terms of shopping for food, getting to meals and social stigma. Shopping could be a difficult chore, even for the women who were still able to do so on their own. For example, Mrs. Michaels broke her hip, and a friend and her son had been picking up items from the store for her. Before that, she used Colonial Square transportation to get to the store, riding on the Loop (the shopping circuit that the Colonial Square bus runs on Wednesdays and Saturdays). But that did not solve all of her shopping problems:

And the grocery store was so big. I feel like I’d lean on that old thing [grocery cart] and try to get around. It took forever. And then another thing – they’ve got the milk and the bread in the far back of the store, so that you’ll go through all these other parts, and buy something else. Sometimes just all you need is milk. And you have to go way back there in the back of the store to get it. Their psychology and my energy doesn’t go together!

She simply did not have the strength and energy required to shop in a large supermarket. She further found that all the vegetables and fruit she liked to buy were heavy and hard to carry after they were bagged. There was only so much that could be bought at one time if the older woman did not have her own car or assistance with grocery shopping, such as someone to carry the purchased items.

Another issue for some of the women, particularly the oldest participants, was the distance of the Dining Room from a number of the apartments. Because of the physical layout of the building, residents living at the end of the longer wing had quite a walk to the Dining Room and other common areas of Colonial Square. For Mrs. Stokes, this walk could be physically demanding, and she often had to stop momentarily on her way to the Dining Room. Mrs. Monroe did not live as far from the Dining Room as Mrs. Stokes, but used a self-propelled wheelchair, which made the journey to and from the Dining Room a tiring one, particularly because there was a downward slope away from her apartment that she had to maneuver up on her way back.

Mrs. Randall brought up another mobility-related issue, which was the “appearance” of assistive devices and mobies in the Dining Room:
Also, there was a problem about the mobies and walkers and walking aids and things like that. They [other residents] were saying that it doesn’t look elegant. With those things sitting around the tables. So through the years, they have resolved: park it here in the living room and get inside. Now there’s some people who can’t quite do that. There have been comments through the years, “It’s beginning to look like a nursing home.” Well, those people, unfortunately, don’t realize that some of those people when they came in here were walking around like everybody else. And this is the aging process in this facility. Well, a lot of that disappeared when Oak Ridge Manor opened. Because, there were about fifteen or twenty who moved there from here. So, there was a period when we didn’t have as many of those mobies and things.

Residents age in place at Colonial Square, and a number of them needed devices to help them get around, or to help them as they rehabilitated after a surgery. Mrs. Randall had both her hips replaced, and therefore was understanding about assistive devices for personal as well as intellectual reasons:

But I have always thought – of course, I’ve been very sympathetic. Because you know, there was a time when I was on a walker. And I had been here a long time. And I would have hated for them to say you can’t come in the dining room on that walker, when I, you know, when eventually I was going to be off the walker. These people should not be that critical, because who knows what they’re going to be doing next week.

Another resident raised this issue in a conversation, but she was not as tolerant of assistive devices as Mrs. Randall. She seemed to assume that people who needed such devices perhaps should not be residing in an independent living community, and implied that people did not want to see those sorts of things. It appeared that there was some social stigma for residents who exhibited frailty and required physical assistance with ambulation. Mrs. Richardson had recently fallen, and utilized a metal shopping cart to support her when she walked around outside of her apartment; she said it helped her better than a walker and she felt more stable holding onto it. She
realized that she was upsetting other residents by her actions, and was apparently the recipient of looks and comments from other residents about the odd nature of using a shopping cart as a walker. The “appearance” of an older woman using a shopping cart was probably perceived by some residents as worse than if she used an actual walker. The reactions of other residents did not deter Mrs. Richardson, however, from continuing to use the shopping cart as an assistive device.

Other age-related health issues to some extent affected dietary practices. A few participants found that there were certain foods they had to avoid as they became older, because of digestive repercussions from consuming such foods (e.g. gas, diarrhea, indigestion). For example, Mrs. Donovan had discovered that it was better for her if she avoided foods that were spicy or acidic. Elevated cholesterol and blood pressure caused five participants to adjust their diets and/or go on medication. Over a third of the women reported bone health issues, which resulted in regularly taking calcium supplements. Supplementation practices are discussed further in Chapter Six. Some of the medications taken by participants required that they take them with a meal, take them with milk, or avoid certain foods. Mrs. Adams was on an anticoagulant medication, making it necessary for her to monitor her vitamin K intake, because she had to limit the amount of vitamin K she consumed while on this medicine.

Social Interaction and Relations

Interaction and relationships with family members, other residents and the employees of Colonial Square appeared to play a role in the food- and eating-related practices of the participants, from what they liked to eat, to who they ate with, to how they expressed their views on the food served in the Dining Room. Family members, for the most part, had been an important influence in the past for the participants, and were recognized as a continuing influence on current behavior. Specifically regarding food acquisition practices, a number of women depended on their interpersonal relationships, both with family members and with other residents, for assistance with food shopping. Social relationships and interaction with other residents of Colonial Square were very important in terms of food and eating; because the main meal was taken in the Dining Room, eating was a very social event for the residents, and the participants made social arrangements for dining according to their social inclinations. Social activities of Colonial Square often involved food and eating, and this section briefly describes
the participants’ involvement in such activities. Finally, I review relations with Colonial Square employees, particularly Dining Room management and staff, including how participants expressed their opinions to employees regarding the Dining Room.

*Family Relationships: Bringing the Past to the Present*

By far, the most commonly cited important influence in the older female residents’ lifetimes on their dietary practices was “upbringing.” Participants felt that how they were raised as children, regarding food and eating, had a profound influence throughout their lives. The participants frequently identified parents, particularly a mother, as an important influence on how they ate. They referred to certain foods they learned to eat and like that were served by their mother in childhood, or well-balanced meals that were served by parents and subsequently adopted by the participant herself. Mrs. Stokes remarked that she still loved macaroni and cheese, a dish often prepared by her mother. Three participants mentioned a grandmother as influential, and as someone involved in how they were raised, at least in some aspects. Mrs. Provost, for example, stated her grandmother, who lived with her family when she was young, was the biggest influence, because according to Mrs. Provost, “she started me off right, on good Southern food.”

Upbringing was not always perceived so positively, nor did it always have positive effects. Mrs. Monroe, for example, purposely avoided repeating her childhood dietary experiences when she had her own family. Mrs. Monroe felt that she grew up in a crazy, unpredictable household, where there were always a lot of people visiting, and things going on; she never knew who nor how many would be at her home. Because of this, her mother often prepared large meals that Mrs. Monroe felt were unappetizing, due mainly to their appearance and presentation. She also recalled her brothers coming in for dinner with greasy hands from working on cars, and she objected to the dirtiness of her brothers. She had always wanted nice things, and resented not having them as she grew up. She developed an aesthetic taste for “pretty” dishes as food presentation became important to her, and for neatness – her own children had to be clean and dressed for dinner. She desired structure and organization, and found ways to incorporate these characteristics into dietary practices throughout her life. Mrs. Monroe’s preference for order and structure could be seen in her past participation and current admiration for the Weight Watchers
program, and in present practices such as consistently making grocery lists (even more useful since others began shopping for her) and having her breakfast dishes and breakfast foods set out the night before.

Families of origin were certainly influential, but families of procreation also exerted an influence, although that influence was generally felt much less now that the women were no longer cooking for their families. A number of women cited family members’ preferences, such as husbands’ and children’s likes and dislikes, as having an impact on their dietary practices.

In a few cases, participants referred to a family member’s health as affecting their behavior. Mrs. Wilson’s husband’s open heart surgery greatly changed their diet almost 25 years ago, as they both altered their food habits to follow what would be considered a heart healthy regimen. When she was in her early 20s, Mrs. Monroe’s mother was diagnosed with diabetes. That diagnosis provided a great lesson, according to Mrs. Monroe, and it was a reason that she had always tried to eat fairly nutritiously. For example, she baked foods rather than fried them and enjoyed a wide variety of vegetables. Incidentally, Mrs. Monroe did not have diabetes.

Shopping for Food

The women in this study generally shopped once every week or two, to keep their basics stocked, such as milk, bread, juice and fruit. At least four of the women had someone else shop for them, because it was too difficult physically for them to do so. For example, Mrs. Provost’s fictive daughter did her shopping, while Mrs. Ford’s sister, who lived with her, shopped for them both. For the women who were able to shop for themselves, where they went for groceries depended to some extent on their transportation, and where their transportation could, or would, take them. Most of the women (12 of the 18 participants) no longer drove, and so they either had someone take them, or used Colonial Square transportation. Mrs. Stokes’ daughter took her grocery shopping (and did her shopping at the same time). Mrs. Richardson mainly just used the Loop, and Mrs. Jergens also rode the Loop, but if a friend or neighbor offered to take her, she went with them. The women who went on the Loop generally took rides from individuals to the store if offered. Some enjoyed the company. Mrs. Vossler could shop on her own, but she often accompanied her daughter, who shopped at a health food co-op, when she went shopping:
Every Friday afternoon, I go with my daughter, just to be with her. She goes to the co-op, and maybe I’ll pick up their oatmeal in bulk or mixed nuts or something to have in the house … I go to Kroger’s. I just go to the co-op with her. I buy very little because it’s very expensive. I don’t see the need for that.

For Mrs. Vossler, spending time with her daughter was the point of the shopping trip at the co-op. The majority of the women went to, or used, Kroger as the preferred place for purchasing groceries; Kroger was also the closest supermarket. The store mentioned second most often was Meijer.\(^1\) Shopping could be something of a social and/or leisure activity, as suggested by the comments of Mrs. Vossler, who liked to shop with her daughter, and by the example of Mrs. Jergens, who just plain liked to shop. Mrs. Jergens loved grocery shopping, which she explained, was why her kitchen cabinets and refrigerator were so full.

\textit{Interactions with Other Residents: Social Arrangements for Dining}

Many participants stated how much they enjoyed the social aspect of eating in the Dining Room, particularly the widowed and single women. For Mrs. Brown, meal times provided good opportunities to catch up with others: “That’s a good time – one of the visiting times.” Mrs. Provost, who generally went to the Dining Room for dinner, remarked: “After the day is over, it’s nice to be with other people.” Similar to other widows, Mrs. Michaels found that after her husband died, eating alone was a big and difficult change. It meant a lot to her to have people to eat with now, and she asserted: “I enjoy the Dining Room. And I think it’s a good way to keep from being lonesome, and it’s a good place to meet different people.”

The Dining Room was the main place where residents visited with one another, and as Mrs. Michaels pointed out, it was a place to make new friends. Mrs. Richardson occasionally attempted to make the acquaintance of new residents in the Dining Room:

\(^1\) Kroger is a large supermarket chain in the region, and Meijer is a regional superstore, a combination supermarket and discount store.
Sometimes, I tried to go in, with new people coming in, and ask them if they mind, you know, may I sit with them. But some people do not want, you know, they want to be so-called alone. But they’re usually very receptive to you sitting with them. But this is how you really get to know people. And help them to feel at home.

Colonial Square had varied patterns of social arrangements at meal times. Over half of the women had another resident or a group of residents with whom they regularly ate. At least two of the women met regular, but different residents or groups for meals, depending on the meal or day of the week. For example, Mrs. Faust and her husband had a regular group they ate with at breakfast, but they dined with different people each evening. Mrs. Donovan had a group she normally dined with during the week, but she ate with a different group on the weekends. Five of the women, like Mrs. Michaels, stated their preference for meeting different people, preferring to “mingle” or “circulate” among the residents rather than be a part of any particular group or clique.

How much pre-planning went into social arrangements for dining also varied. Most of the women generally did not plan ahead to meet someone, either because they met their regular dining companions basically around the same times, or because they just went down and sat with whomever they may have found. Others often called or had someone call and extend an invitation to join them at a meal. Two participants had a certain table (or tables) where they preferred to sit when they had a meal in the Dining Room, but the rest sat wherever they found a place or someone with whom they wished to dine. Periodically, the furniture was rearranged in the Dining Room, forcing people to break their habits at least temporarily until they settled into new habits.

*Interactions with Other Residents: Activities of Colonial Square*

Two-thirds of the women reported going on trips planned and organized by the Activities Department of Colonial Square; sometimes the destination was a place to eat, or the trip included dining (according the Activities staff, trips further away than a 45-minute drive generally included a meal on the itinerary – often lunch). Trips that included a meal were popular with the resident population. Mrs. Nichols and her husband had taken advantage of such opportunities:
“And we had gone out to dinner, oh, maybe 3 or 4, 5 times since we’ve been here, when they take a group to someplace we think we might like to try.” There were also parties organized by the Activities Department that the women sometimes attended, such as ice cream socials or holiday parties.

For a few women, the weekly Social Hour (coordinated by the Activities Department) was a way of “going out,” without actually going out. At this happy hour, residents provided their own alcohol; according to Mrs. Monroe, there was an unwritten rule that residents could have no more than two drinks. Residents also enjoyed hors d’oeuvres and finger foods, as well as conversation and social interaction, before heading to dinner. Mrs. Monroe, who never missed a Social Hour if she could help it, asserted that she tried to mingle with different people at the Social Hour. Mrs. Monroe actually often observed the tradition of having a cocktail hour in her apartment before heading to the Dining Room for dinner. Alcohol was also available in the Dining Room, as wine was served a couple of times a week, and several women would have a glass with dinner.

The Activities Department additionally oversaw the community’s raised garden beds and garden plots that were for resident use. At least five of the women did some gardening, if not in a garden bed, then on their own porch or balcony. Two of the women’s husbands’ did some gardening in the raised beds. Gardening participants commonly grew tomatoes and green peppers, although two women also grew herbs. Those who gardened had past experience gardening before moving to Colonial Square; this was not a new hobby taken up in later years. The gardening participants (or those with gardening husbands) often shared the bounty of their agricultural efforts with family and other residents, which seemed to be a common practice among gardening residents in general. They sometimes discussed their gardens with others, sharing tips and experiences.

*Communication with the Dining Room Employees*

Residents, of course, could communicate with staff directly. About a third of the women reported speaking to Dining Room management and staff in the halls or in the Dining Room. A few participants had suggested specific items to be served, or even not be served. For example, Ms. Carr found the serving of chili in the summertime to be an offense, and let the Dining
Room staff know this. Two of the women reported supplying recipes to the kitchen, such as Mrs. Donovan’s pie recipes.

The residents could also communicate through the comment cards on the Dining Room tables, letting their thoughts and suggestions be known. Patterns of filling out the comment cards ranged from Mrs. Jergens, who said she had never filled one out (although her granddaughter does when she visits) to Mrs. Monroe, who said that she had filled out the cards quite often (“a hundred times”). The majority of the women reported filling them out either sometimes or occasionally. Although the written comments at times expressed a complaint, they were more often complimentary. Several women mentioned that they felt it was important to let the staff know when they were doing a good job; some would only fill out the card if they had something positive to write, presumably operating on the maxim of “if you can’t say something nice, don’t say anything at all.”

It was unclear whether the requirement that comment cards be signed by the residents affected if and how the participants filled out the cards. At least two women actually believed that the comment cards receive no consideration at all by the staff and management, even when signed. At least that is what they heard, for the rumor mill at Colonial Square did not spare food services. One participant heard that Colonial Square tried to save money through “pinching pennies” in the Dining Room. Another participant heard that being tight with the money in the Dining Room was one way for the corporation to make more money for the stockholders.

Social Roles and Statuses

More than a few participants referred to their roles and statuses as a parent and/or a spouse when discussing dietary practices and influences on their behavior. For some, being a parent meant teaching their children to eat healthy, and modeling how to eat well. Mrs. Ford, with a college major in home economics, studied nutrition with great interest and tried to use principles of nutrition in selecting and preparing food for herself and her children. Mrs. Nichols also referred to raising children as influencing her: “I guess it just was the way I was raised. And then trying to carry that over to our children. I mean if you want your children to eat right, you have to eat right too. So you’re forced into that.” She felt at that point, the way she ate was largely habit.
For the women in the study who were still married, they continued in their role as the one mainly responsible for domestic food-related tasks. None of the husbands of the married women cooked, beyond simple food preparation, such as getting cereal. Their wives often helped them along, buying or preparing foods to have around for them. Mrs. Randall’s husband got his own breakfast and lunch, but he would prepare something that could be heated up, dished out, or easily put together, like a sandwich. Mrs. Nichols and Mrs. Wilson both acknowledged that the fact that meals were provided at Colonial Square was a factor in their decision to move, because they felt some security knowing that if anything would happen to them, their husbands’ would still be fed. Mrs. Nichols related this after her interview on food and eating had been conducted, as recorded in written notes:

She feels that the dining room is a good thing for her husband. She says that he is helpless in the kitchen – he lets things boil over, and does not know what to do. She has to fix something for him if she is not going to be there during a mealtime. For example, if she will be gone during their regular lunchtime, she has to make him a sandwich ahead of time, so that it is ready for him when he wants lunch. Generally, he is not involved in food preparation. She told a story as an example. One time she and her daughter-in-law were out shopping, while her son and husband stayed at the apartment. They were out shopping later than they thought they would be, and came home past normal lunchtime. Her son had gone into the kitchen and fixed himself something to eat. But her husband sat in his recliner, and waited until she came home, so that she could fix something for him.

For many men of this generation, such as Mr. Nichols, traditional gender roles dictated that it was almost completely a woman’s job to prepare food. However, the other husbands seemed able to manage better in the kitchen by themselves than Mr. Nichols. Mr. Wilson was the most able, having taken a cooking class with his wife and assisted her often in the preparation of food for parties and entertaining. The rest were more along the lines of Mr. Randall’s familiarity and ability in the kitchen, and perhaps did some limited cooking in the past.

The husbands of the married women were generally not involved in food shopping either, although there were exceptions. After Mrs. Florsheim’s husband retired in the late 1970s, he
began to take on more of the responsibility for shopping. She made the list and determined what
should be bought. She thought that he needed to get out and do something after he retired, and
particularly since moving to Colonial Square, perceiving that he had not transitioned or “settled
in” as well to their new environment as she had. Mrs. Faust reported that her husband would go
shopping “once in a great moon,” but it would be only to pick up some small item, not a regular
shopping trip. However, Mrs. Faust stated that she had to tell and/or show him exactly what to
get, which was no guarantee that he would buy what she wanted him to buy. Regarding shopping,
therefore, Mrs. Faust willingly retained that role: “And if I ask him to get coffee or anything, I
have to show him the bottle, show him what it is and how many ounces and … he’ll do it once in
a while. But no, he’s not – That’s my job. But at this point I want it – I want it to be my job.” Mrs.
Faust seemed to have thought that she was better suited to perform shopping tasks and would not
want her husband to have such duties anyway, even if he would be willing to take over shopping
activities.

Contexts

This section highlights contexts of the participants’ dietary practices. Before specifically
discussing the environmental contexts of meals, this section presents an overview of basic meal
patterns. This description itself provides a “context” for the following discussion of meals taken
in the Dining Room, and in their apartments. The food issue particularly focused on is meal
taking, but food preparation and eating out are also considered. This section proceeds to consider
community policy contexts (particularly dining hours, the dress code, and bringing food home),
and ends addressing general political economic forces perceived as influencing dietary behavior.

Meals: Overall Patterns

The women generally structured the day’s activities around meals and mealtimes,
although a few participants structured their mealtimes around their activities during the day. All
of the participants ate at least once a day in the Dining Room; for the most part, participants had
just one main meal, either lunch or dinner, in the Dining Room. (Breakfast was no extra cost,
and although a number of residents took breakfast, was not a main meal for any of them). All of
the women consumed at least one meal, or some food, in their apartments.
The women decided on either lunch or dinner as their main meal, and then generally always went to either lunch or dinner in the Dining Room. Mrs. Richardson, though, said she decided what meal she had in the Dining Room according to what was served, and might have both lunch and dinner in the Dining Room on the same day if she found the food at each meal especially appealing. In three cases, participants decided which meal to normally have each day based on their preferred personal schedule. Mrs. Donovan preferred to have her main meal at noontime, and so she had lunch in the Dining Room each day, and a light meal or snack at night. Nearly all of the participants had their main meal at dinner. About half of the dinner-taking participants intermittently had lunch in the Dining Room on Fridays, because of the special brunch menu – a few specifically mentioned that they liked the Eggs Benedict.

Two of the women had just two meals a day, but the rest had three meals a day, even if two of the meals were light, such as coffee and toast for breakfast. A few participants remarked that they were not as hungry as they used to be, although that did not necessarily mean they ate less. A third of the women mentioned that they were attempting to control their weight and knew people, including themselves, who had gained weight since moving to Colonial Square. Meals served in the Dining Room could consist of four courses if a resident chose, often a temptation difficult to resist. The women conscious of weight gain mentioned cutting back on desserts, eating fruit for dessert, or not eating the bread, as there was always a bread basket of rolls with dinner. A number of women said other residents warned them when they first came to Colonial Square that they would gain weight, because everybody gained weight when they first came. Only Mrs. Wilson said she had lost weight, but attributed the weight loss to stress and affairs surrounding her husband’s illness at the time that they moved.

_Eating in the Dining Room_

The general view of the Dining Room, and the meals served there, was overall positive. Each woman had a particular critique of the Dining Room, but for the most part felt that any deficiencies were relatively minor, and could be overlooked. Quite a few were happy enough to not have to cook and felt unjustified in seriously complaining. Prior to her move to Colonial Square, Mrs. Vossler underwent an operation, and during her recovery at home, she was unable to cook food, and had to no one to assist her. She essentially relied on canned items. She took
simple pleasure in the knowledge that she could always go down to the Dining Room to get something to eat. Three women recognized that when they first moved to Colonial Square, it was such a novelty to not have to cook or worry about fixing dinner, and all the food seemed wonderful, but after being there a while, the novelty wore off, and the food had become more institutional to them. Others mentioned that they recognized that it must be an impossible undertaking for the Dining Room staff to completely satisfy all the preferences of 200 plus residents, and felt that considering their task (and staff turnover), the staff did a good job.

Many participants mentioned that they thought the Dining Room had a wide variety in their food offerings, although a few thought that lately the menus had been somewhat repetitious. A majority stated that the Dining Room served too much yellow squash and zucchini, and not enough potatoes. All but one of the participants were satisfied with the overall nutritional quality of the foods available. Comments regarding the desire for more fruits surfaced, and a few women thought they could serve more green and leafy vegetables. Several appreciated attempts to offer more sugar-free, salt-free and fat-free options. Nutritional assessments of Dining Room offerings are further discussed in Chapter Six.

It seemed the latest news about the Dining Room always got around, as all but one or two of the women informed me that the Dining Room now served oatmeal at the continental breakfast, and how well that had gone over with the residents, whether they personally went to breakfast or not. Almost all also reported that there was a new Chinese cook, although their reactions to the Chinese dishes have been mixed. They seemed to appreciate that the kitchen tried something new, whether they liked it or not. Other fairly recent additions to the menus included more contemporary entrees, such as pasta dishes and sandwich wraps (sliced meats and vegetables wrapped in a tortilla). These too have had a mixed reception by the women, as many of them preferred the standard “well-balanced” meal of a meat entrée, with sides of potatoes and vegetables, which was the type of meal that most of them had always known. As Mrs. Adams clearly and simply stated: “As far as I’m concerned, my concept of eating is basically meat and potatoes.” This concept of a meal also explained the dismay voiced by some women that more potato dishes were not on the menu. Other critiques included too many heavy and high calorie foods, too generous portions, seasoning issues (too many spices/salt or too bland), and women originally from outside of the South reported “they cook different than I’m used to.”
Most of the participants seemed to perceive the current head chef as performing well, and trying very hard. They complimented her efforts, for example, her institution of a carving station once a week, and omelet station once a month. Mrs. Provost appreciated the chef’s introduction of frog legs and blackened catfish as menu items. The participants generally praised the service provided by the young men and women who waited on the residents. These young people did appear to make an effort to know the residents and pay attention to regular patterns of the residents. For example, Mrs. Randall remarked that she and her husband did not like to linger at dinner, and noted that the servers knew to keep the food coming for her and her husband, bringing iced teas in hand when they came to take their order, and serving their soup and salad at the same time.

The women also seemed to have found the food services director to be generally amiable enough, noting that he was fairly new, but approving of his performance overall thus far. He instituted the monthly “Friday Night Out” event, which was very popular and well received among the participants and other residents. “Friday Night Out” was very busy for the Dining Room, for it seemed that not only did most all residents make an effort to go that night, but also many residents brought guests. However, residents also paid attention to actions of the management and staff that did not directly affect them. Mrs. Monroe strongly disapproved of the director’s promotion of one staff member, as she believed that another one deserved it more.

About two-thirds of the women commented that they have had guests eat with them in the Dining Room from time to time. They were pleased with the décor and had enough confidence in the service and food quality to invite non-residents to join them for meals. About a quarter of the participants claimed to think that it was nicer to bring guests to the Dining Room than to go out to eat. Entertaining at Colonial Square is addressed further in Chapter Six, and eating out will be attended to later on in this chapter.

One participant revealed a distinctive perceived difference between cooking main meals at home and eating them in the Dining Room. Referring to her previous residence as “home,” Mrs. Faust remarked:

To me, the biggest change, I guess, is that your every meal is different. And when I cooked at home, often we had say, one dish one meal and maybe warm it up the
next. You don’t have warmed-over food here. And I think warmed-over food is good.

Warmed-over food, or leftovers, was something that some people just disliked, some people lived with, and some people, such as Mrs. Faust, enjoyed very much. Of course, there were no leftovers from meals in the Dining Room, and, with the little cooking needed for other meals, leftovers were not common at home either.

**Meals and Food at Home**

Meals and food eaten in the private residential apartments (or “home”) were generally simple and light, and prepared in small amounts, with an emphasis on quick and easy. Two of the women sometimes prepared big batches of something at a time, such as soups or vegetables, and stored or froze portions of it. Soup, sometimes homemade, but mostly canned, appeared quite often to be the base for a lunch or dinner. Cheese and crackers, a salad or a sandwich might accompany the soup. Three women kept frozen dinners for quick meals. Mrs. Donovan always had quite a few of the Kids’ Kitchen foods, little microwave-able plastic bowls of spaghetti and sauce, or chicken and vegetables, for example. Meant for children, these bowls come in small portions, which are the right size for a light meal or snack. The women all regularly kept bread, milk and juice at home, and most of them stocked coffee and tea as well. Peanut butter typically made the list of “foods on hand.” The women who ate breakfast at home stocked foods such as oatmeal, cereal and fruit for their breakfasts, and sometimes eggs. A couple of the participants kept very little food in their apartments, such as Mrs. Richardson (although her freezer is full of ice cream), but all except one of the rest stored a moderate amount of food items. Mrs. Jergens, however, stocked her cupboards and refrigerator full, and readily admitted that she did not really need it all.

About half of the women also stashed snacks at home. Of the women who reported snacking, they commonly stated that it was a bedtime snack. Snacking was not necessarily a regular occurrence, as only a few described snacking as an everyday happening. Over a third of the women, however, insisted that they almost never snacked, and that they never really had. Two of the women who snacked detailed more of a grazing pattern, where snacking was in place of
a meal, instead of filler between meals. Mrs. Donovan, who generally ate light in the evenings, described her evening intake as more snacking than a meal. Mrs. Vossler stated that she became hungry every couple of hours, and so she had to snack, sometimes on fruit, but she often had what she called “short” or “half” meals, four of them, throughout the day.

Health considerations to some extent influenced snacking and types of snack foods consumed. Mrs. Randall’s gastrointestinal system dictated her snacking; she said she had a snack at night because she had a little acid reflux if she became “empty,” and so would have a handful of dry Cheerios or something like that before bed. The type of snacks varied from healthful options such as fruit or Cheerios, to sweets such as cookies and candy, to the more unusual, albeit nutritious, choices of spinach or a piece of toast with cream cheese and green pepper. A few recounted how much they liked nuts. Several consciously tried to limit or watch their snacking. Mrs. Stokes, who was diabetic, monitored her carbohydrate intake to be sure she could afford to have a cookie and some milk before bed (she perhaps had water instead if she thought she needed to be careful). Ms. Carr was also diabetic, and claimed to have exactly six Ritz crackers before bed. Ms. Carr and a couple of other women purposely did not keep candy around to avoid snacking on sweets. Mrs. Michaels said she knew she would snack for comfort or something to do, and so she tried to have fruit around instead of food such as candy or potato chips.

Food and Eating at Home: Environmental Aspects

Where in the apartment the women consumed their food depended on several factors. One factor was where they felt comfortable eating. For example, at least two of the women preferred to eat in front of the television. Another factor was attitudes about where it was proper to eat. Mrs. Provost, for example, seemed to believe it was more civilized to eat at a table than in front of the television. A third factor was where they actually could eat, because of space issues and/or furniture use and placement. Two women had small tables in their kitchens, which took up significant amounts of space, but was where they generally ate. Others decided not to take up space in the kitchen with a table, and ate at a dining room table or in the living area. Three of the women, who had both tables in their kitchens and dining room areas, had one or the other or both covered with clutter, and so were relegated to eating at only one of the tables or in the living area.
Finally, two women did not have dining room tables at all; Mrs. Florsheim did not have a table in her dining area, eating mainly in the kitchen, and Mrs. Nichols gave away her dining room set to family.

The kitchens at Colonial Square, as previously described, had the basic modern conveniences most people depend upon, such as a full-size refrigerator, a full-size oven with stovetop, and a dishwasher. The women generally brought additional appliances with them. As a result of the desire for quick and easy meals, the microwave was a popular appliance in the kitchen, and one that all the women had. Mrs. Stokes cooked just about everything in the microwave. Coffeemakers and toasters were also common appliances found in the women’s kitchens. Over half of the women rarely used their ovens, if they turned them on at all. Mrs. Brown, for example, had only used the stovetop in her kitchen to heat soups. Only three of the participants, those women who continued to do a fair amount of cooking and/or baking, regularly used their ovens.

At least three of the participants used their ovens to store things, mainly pots and pans. For Mrs. Adams, who used oven space for storage, this caused her to be less likely to use the oven, because she did not want to bother with emptying and reloading it. The kitchens lacked storage space if a resident had a number of kitchen-related items to store. One participant related that she knew of people who used their dishwasher to store things. Mrs. Randall and Mrs. Wilson both had large cupboards that they had put in or brought, because both still did some cooking, and needed extra space to hold cookware and bakeware. Mrs. Wilson stated that the kitchen facilities in the apartments of Colonial Square were a major reason she and her husband chose Colonial Square over other retirement communities in town. Mrs. Wilson’s cabinet also had a pullout shelf, for additional counter space. Mrs. Adams noted:

And there’s not that much counter space for cooking. It’s a funny kitchen. It’s got this wonderful equipment, and this big oven – you could roast two turkeys. And it’s got a full-size refrigerator and a full-size dishwasher. And twin sinks. But there’s just not that much counter space to – the way I was used to working.

However, Mrs. Adams added: “But I don’t need to do that much cooking, so it doesn’t matter
much.” Ultimately for Mrs. Adams and most of the other women, counter space was not much of an issue.

Although Mrs. Randall and Mrs. Wilson still had cookware and bakeware, they gave away larger items, such as big stockpots. A number of the women gave away most of their cookware and bakeware, retaining only what they needed, such as a couple of pots and pans, and a skillet or two. This divesture of cooking items may have occurred just before the move, in anticipation of the limited time that would be spent in the kitchen; but for several, it came after they moved. At least a third of the women expressed that they felt they had brought more than they needed to their home at Colonial Square, despite their efforts (and children’s efforts) to pare down their belongings. Mrs. Florsheim recalled preparations for her and her husband’s move to Colonial Square:

I remember when we were packing up and the two daughters were there with us, and I had this old pot that I depended upon. And I remember Kate or Veronica, one saying to me, “Mother, you’re not going use that.” And I thought, well, why aren’t I going to use it? I’ve used it all my life. I sure am going to use it. I think I brought it, but I don’t think I’ve used it.

Mrs. Florsheim later donated an electric skillet to a sale; she liked the skillet, but she just did not use it. Mrs. Jergens had practically all the cooking items she had before her move, but she planned to begin “weeding out” things as soon as she was physically able (at the time her left arm was in a sling). If the participants had finer dishes and utensils, such as china and silver, they gave most of it to children. Mrs. Wilson, who gave away most of her silver, was planning to pare down even more as well:

Gave away silver. Kept very little of it. I kept the tea service, not to use, but just because I’m used to seeing it sitting on the table over there. But we really got rid of a lot of things. As a matter of fact, when I get around to it, I’m going to get rid of more stuff, because, you know, we’re not going to use it.

She kept the tea service for the sake of its familiar and sentimental qualities, not for utilitarian reasons. But most other things, unless they were used, would likely be given away. Mrs.
Richardson had also given china and silver to her daughter, and would be passing on her Spode china pieces. It seemed to comfort the women who were able to pass on items, such as cookbooks, china, silver, family cookware (e.g. a mother’s pot) or even dining room furniture, to adult children, as these were family heirlooms in a sense, and symbolized the passing on of family history. Mrs. Nichols had her mother-in-law’s cookbooks, and it pleased her that one of her daughters wanted to have them. It was important to be able to keep these objects in the family.

Almost half of the women mentioned that when asked to supply their favorite recipes, they had to “dig” them up. If they had cookbooks, they were not usually handy, as they might have been when they were cooking regularly. Mrs. Brown gave away all of her cookbooks, and several other women gave most of their cookbooks to family, particularly daughters. A few women still had recipe boxes, although Mrs. Ford kept hers in her bedroom, as it was no longer used for recipes, but as a source of memories and nostalgia. Four of the women recited recipes from memory. Cookbooks and recipes were no longer consulted, at least not on a regular basis. If they brought a dish to a function, family dinner or holiday celebration, it was often a dish that they knew how to prepare without looking it up in a cookbook or on a recipe card, such as salads (vegetable, fruit or Jello) or baked goods.

**Eating Out**

Eating out was, of course, an option for residents; in independent living facilities, residents come and go as they please, and are not restricted to eating only in their apartments or the Dining Room. However, participants in this study generally did not eat out very much. Quite a few of the women never really ate out much at restaurants before moving to Colonial Square, but others did not go as much as they previously had. Mrs. Richardson, for example, ate out most of the time before moving to Colonial Square, but after moving, she only went out occasionally. This pattern of infrequent dining out largely had to do with the fact that they paid for one meal a day at Colonial Square, and so they felt they might as well eat there. Mrs. Vossler affirmed that because meals were provided and paid for at Colonial Square, she just did not go out to eat. Mrs. Ford bluntly articulated this: “As long as it’s going to be there and we’re paying for it, we might as well use it. That’s the way I look at it.” Mrs. Florsheim and her husband very seldom went out.
to eat, and finances were first in mind when they did: “And when we do, we are actually horrified at the size of the servings and the size of the bill. To me, it’s just unconscionable to eat a $50 meal. It’s absolutely out of my line.” The women reported eating out with friends occasionally when they did go out, but more often mentioned eating out with family. A few regularly went out to eat after church on Sundays.

If they chose where to eat, stated preferences for restaurants tended to be places where American, regional (Kentuckian/Southern), country-style or “home-cooked” food was served. The women mentioned chain restaurants (such as Bob Evans, O’Charley’s, Steak-N-Shake and Cracker Barrel), steakhouses, cafeteria-style restaurants (such as Morrison’s and Picadilly’s), and places where they could eat ribs or catfish. Those who liked cafeteria-style restaurants said that they liked to see the food they chose, and know just what it was that they were getting to eat. They also found such restaurants to be more economical. Some also mentioned country clubs or more upscale independent restaurants, generally of a regional reputation, such as Emmett’s, Merrick Inn or Boone Tavern. These restaurants were for special occasions. Only three women mentioned ethnic restaurants; Mrs. Randall and Mrs. Nichols reported enjoying Chinese, and Mrs. Ford, a Northeasterner, reported that she liked to have Italian sometimes. Take-out or delivery from restaurants was rare. Occasionally, Mrs. Ford and her sister craved something they had not had in a long time, such as pizza (the Dining Room’s version was not to their liking), and ordered the delivery of a pizza from Papa John’s.

Almost all expressed little to no interest in fast food, with two women blaming fast food for ruining American diets and health, and contributing to the decline of the family dinner. If the participants had fast food, often it was because a family member had taken them. Family members’ choices of places to dine were not always the preference of the participant. Mrs. Adams, for example, related that sometimes she took her daughter’s family out to eat. Two granddaughters in their mid-twenties still lived at home, and would chose someplace they liked, such as the Applebee’s chain, which served “American” food. Mrs. Adams’ problem with those types of restaurants was not the food they served, however: “Where do college kids like to go? Oh – noise, noise, noise. I guess that’s one reason I don’t enjoy going out more. It’s the places the kids like tend to be noisy.” Mrs. Adams wore a hearing aid, and found conversation in noisy restaurants to be rather difficult.
Mrs. Adams took her family out to eat when her daughter had to work on Sunday afternoons; generally, she was invited to have Sunday dinner at her daughter’s house. Women who had adult children or other family in the area reported sometimes eating at family homes, particularly for holidays. However, several had family members eat with them at Colonial Square. They more often reported bringing them to the Dining Room to eat, as opposed to in their apartments, although meals were sometimes prepared for, or by, family members in the apartment. Mrs. Nichols related that that her daughter-in-law would frequently prepare a special meal for her and her husband when her son and daughter-in-law visited; in fact, she had a shelf of spices and sauces in her kitchen that she claimed only her daughter-in-law ever used.

Colonial Square Policies: Food and Dining

Colonial Square had a number of community policies, some handed down from the corporate office, and others devised at the community level. Particular policies that affected the residents’ dietary practices were the Dining Room hours for mealtimes, the dress code for the Dining Room, and the policy regarding taking food from the Dining Room.

Meal hours could be problematic. At least three of the participants were not on any type of schedule, as far as when they ate meals, before moving to Colonial Square, and found it trying to adjust to regular meal times. Mrs. Wilson, who generally went to the Dining Room for dinner, related that she and her husband ate whenever they felt like it before living at Colonial Square:

Mrs. W: And we have to struggle to be hungry here. You know, with our meals, we’ve never really been on a schedule. We’d be having dinner, depending on how the day went, at nine o’clock at night.

LC: But here you have to plan ahead.

Mrs. W: Oh, you absolutely have to. And you have to be hungry enough to eat. Which means, you can’t have a very late lunch. Or if you do, you better not eat much. And we’re still struggling a little bit to manage that. Because we’d been so not on a schedule. You know, we’d just get to working outside and all the sudden, it’s late. And so, we just went haphazard, just eating when it was convenient. So now, we really have to struggle to be hungry enough to enjoy our dinner. And I
know you’re supposed to eat regularly, but it’s still a problem for us. I find that we’re – I’ll say, “Oh my soul William! Here it is 1:30, 2:00 – we can’t have but just a bite.”

In another example, Mrs. Monroe did not go down for the continental breakfast because she found getting up early enough to be difficult, and because she ate a late breakfast, she almost never went down for lunch.

The perceived needs of the staff, particularly the servers, to some extent influenced when a few participants went to dinner:

And here, you have to have dinner early. Uh, 6:15 is as late as you should go. You really should go earlier, because the servers are college students, and the sooner they can serve everybody, the sooner they can go home. So we don’t like to go late. (Mrs. Wilson)

I go about 5:30 now. And that’s too early. I don’t like it. But I go. The little school girls – our waiters and waitresses, the schoolchildren, and they want to get through and get away, you know, so we go earlier and earlier so that they can get through and get away these short days. (Mrs. Provost)

There was the feeling among those who preferred to eat later that they should not go to the Dining Room too late, because of the young people who worked there. Although no one said that any of the servers had explicitly expressed wanting to go home as early as they could, it seemed that residents felt a bit rushed through their meals when they went later, even though they should have been able to receive service until 7:00 p.m.

The dress code for the Dining Room was a community policy devised and established by the residents many years ago. Nearly all of the participants stated that they were satisfied with the dress code in its current form. Almost a third of the women remarked that lately many residents had not been following the dress code, especially for dinner, as closely as it could or should be followed, and they observed people becoming more “lax” in how they dressed. However, they were inconsistent in whether they thought it was the men or women who were not as nicely attired for the evening meal. A small number of women thought that it was quite important
to have a dress code, and that it was good for people to make an effort to look nice for meals, especially dinner. Mrs. Michaels, however, did not attach as much importance to the dress code:

    Well, I think it’s more lenient than it used to be. They used to dress up quite a bit, and a lot of people do now, because that to them is the highlight of the day, and of course it’s the social time. I don’t feel that it’s that necessary. I sometimes put on some earrings and beads and wear what I got on. You know. Maybe a fancy sweater or something.

She explained why she thought that she and others had become more “lenient” about dressing up for meals:

    I think it’s harder for older people to get dressed. You get dressed once for the daytime, that’s about as much as you’re going to – you know, it’s hard to get dressed. When you have arthritis and all these ailments that we all get. I know by the time I get dressed, I’m tired.

Another factor that may have affected how closely the dress code was followed was the activities of the residents themselves. Mrs. Randall recounted the evolution of the dress code, from its institution to the current policy, which was apparently more casual on the weekends in the present incarnation than in the past. She asserted that this was due to people going to or coming from sporting events on weekends. She sometimes left right after dinner for bridge club; others had evening activities also that did not require dressing quite so nicely.

    A community policy issue brought up by several women was taking food from the Dining Room. The policy was that no food could be taken from the Dining Room, with the exception of desserts in a container provided by the resident. A few residents, such as Mrs. Faust, found fault with this system:

    If they bring you too much food and you can’t eat it, you can’t bring it up to your room. People fussed about that enough, and now you can bring dessert up. And if you order grapes for dessert, they bring you grapes for dessert and you can bring that up, but if they bring you a pile of grapes on a fruit plate, you can’t bring that
up. But you can bring ice cream up. That makes no sense to me. There are a few people who abuse that. You know, I understand that. When they decided to ease up a little bit on it – it was pretty funny. But you have to take your own container, but you don’t know what dessert’s going to be until you go down to supper. And so you never quite know whether you want to bring something down or not. But most of the time, I order a half of meal. Particularly the entrée, because generally the servings are really generous. More than people need. And if you have ham or something that’s very – such that could be used for lunch, I don’t see any reason why you couldn’t bring that back. It’s going to be thrown out. It doesn’t make any sense to me.

Mrs. Faust’s thrifty side found the policy to be rather nonsensical, for reasons of both logic and waste. She later revealed how she occasionally used this policy to her advantage, finding something of a technical loophole:

Sometimes I ask for a banana – if they have bananas available, they’ll bring me a banana for dessert. That’s when I’m too full to eat a dessert, and I bring it up and save it for breakfast. Because that’s a dessert I don’t have to bring a container to put it in.

Some residents found other ways to get around the policy, but without using loopholes like Mrs. Faust; they deliberately violated the policy by smuggling food out of the Dining Room. Mrs. Adams, for example, reported that she knew of people, mainly women, who sometimes “sneaked” food from the Dining Room. Mrs. Monroe admitted once to “squirreling away” a half of a baked potato in a little plastic bag, because she loved to fry it up for breakfast.

Politics and the Economy at Large

Two women mentioned larger political and economic forces as a perceived influence on dietary practices. Mrs. Faust was one participant who took a rather political economic approach, as she explained that availability and cost of food had influenced her as much as her family’s preferences. Recently, current political events played a role in dietary practices as reported by
another participant. Mrs. Stokes’ concern about the global issues of terrorism and biological warfare became personal matters for her:

**Mrs. Stokes**: Are you concerned about this anthrax thing?

**LC**: Not really. [Gives more explanation why she is not].

**Mrs. Stokes**: Well, I’m worried about it getting in the food. Because a lot of our food comes from out of country. A lot of the countries in South America. So I wash everything real good, grapes and all that. That is a terrible disease.

Although Mrs. Stokes was the only participant to bring up such events and relate it to food, several of the women did bring up the same issues and the events of September 11, 2001. They shared their anger, sadness and patriotism, and compared the fall of the Twin Towers to another event that they remembered all too well – the bombing of Pearl Harbor.

**The Interaction of the Various Influences**

This chapter demonstrated multiple factors that influenced dietary practices of older women, and that the women themselves perceived multiple factors at work, recognizing various levels of influence from the personal to the international. Intrapersonal factors surfaced, in terms of psychological processes and physical aging changes. Social processes emerged as important factors, as the social relational components of food and eating were key aspects of and almost inseparable from dietary practices, from food shopping to interacting with Dining Room staff. Social aspects of dietary practices as related to family statuses and roles illustrated the continuing influence of various social roles, whether past experience became over time a natural part of a current repertoire of behavior, or current experience reproduced what had always been the case (e.g. wives who prepared food for their husbands, as they always had).

The contexts of behaviors were quite important for understanding certain food- and eating-related practices. Contexts included physical spaces and environments at Colonial Square, but also policy controls on behavior. The ethnographic approach of this research no doubt greatly stimulated the identification and detailing of the contexts of practices, but it did not appear to be at all difficult for the women to discuss and recognize contextual factors.
Taken together, these various factors represented a life course perspective on dietary behavior, where earlier life course experiences affected later experiences and behaviors, personal factors interacted with social factors, and location in time and place influenced behavior both directly and indirectly (through affecting the factors of influence themselves, such as the content of certain social roles and statuses). Life course experiences and events, such as the health problems of a loved one or a national crisis, played an important role in how the participants related to food and eating. The next chapter focuses on dietary themes and meanings of food and eating practices throughout the lives of these women, as they were developed and modified by life course experiences and events.
Chapter Six
Dietary Themes in the Lives of Older Women

Numerous food- and eating-related themes emerged from analysis of the narratives of women residing in an independent living retirement community. However, four overarching themes distinguished themselves as approaches that the women took toward their food and eating experiences. These four approaches – dietary morality, dietary wellness, dietary sociability, and dietary duty – were found to varying degrees throughout the lives of each of the women; however, for most of them, one appears to be more prominent than others, as reflected in their pasts and as manifested in their presents. Each of the four themes is presented through a close examination of a particular participant who serves as an exemplar of the theme, with additional summarization and support from the comments of other study participants.

Dietary Morality: The Rules of Food Consumption

Next there should never be any wasted or thrown away that can be turned into account, either for your own family or some family in poor circumstances.

Gillette and Zeimann (1887, p. 540), discussing the proper economy and management of the home kitchen

Figure 6.1: Mrs. Stokes’ Recipe for Diabetic Pumpkin Pie

<table>
<thead>
<tr>
<th>Diabetic Pumpkin Pie</th>
</tr>
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<tbody>
<tr>
<td>1 (no. 2) can of pumpkin</td>
</tr>
<tr>
<td>2 eggs</td>
</tr>
<tr>
<td>1 can condensed milk</td>
</tr>
<tr>
<td>4 packets Sweet-n-Low (more if you like it sweeter)</td>
</tr>
<tr>
<td>1 teaspoon pumpkin pie spice (a little more if you like it spicier)</td>
</tr>
<tr>
<td>1 teaspoon vanilla</td>
</tr>
</tbody>
</table>

Mix all the ingredients together. Pour into a pie shell. Put it in the microwave on high for 45 minutes. Test it with a knife to see if it comes out clean.
Mrs. Stokes was born in an urban area of the Midwest, the oldest child of a German immigrant and his first generation German-American wife. Her parents eventually had three sons and one other daughter (one son died from diphtheria at age three). She helped look after her younger siblings, as well as assisted with other household duties, such as setting the table, drying dishes, and sewing. At the time of the study, Mrs. Stokes was an 88-year-old widow with a pleasant smile and a ready laugh. Her spectacles could not hide the twinkle in her eye, and her easygoing demeanor invited others to engage her. Perhaps her positive personality had helped her to cope with her physical conditions. For the past 25 years, Mrs. Stokes had lived with diabetes. Her mother was diabetic, her husband was diabetic and her 64-year-old daughter was diabetic (diagnosed 10 years ago). When asked for a favorite recipe, it seemed only natural that she readily responded with directions from memory for a pumpkin pie suitable for diabetics. Diabetes created a whole set of “rules” for how Mrs. Stokes needed to manage her diet and lifestyle. Dietary regulation was a large component of her overall management of the disease, and for several years she managed diabetes through diet alone. However, she eventually needed insulin, which she took twice a day, just before breakfast and just before dinner.

However, these are not the only factors influencing food consumption in the life of Mrs. Stokes. She began following one particular dietary rule long before she was ever diagnosed with, and probably before she ever even heard of, diabetes. The rule is not related to health, but rather is related to a high moral (and economic) standard summarized in a well-known proverb: “Waste not, want not.”

**Rule #1: Thou Shall Not Waste Food**

Mrs. Stokes recalled that as a young child, her parents expected her and her younger brothers and sister to eat everything on their plates at meals, to “clean” their plates:

My mother was always telling us about the starving Armenians. No, we were supposed to belong to the clean plate club. In fact, I believe it is a sin to waste food. When you think of all the hungry people in the world. You see these poor kids in Africa.

Her parents, particularly her mother, emphasized the importance of eating what they were
given to eat, and eating it all. There were obviously good economic reasons for not wasting food, especially in a family of seven supported only by their father, a carpenter. Although her childhood occurred prior to the Great Depression, it is very likely that it was still important for her parents to use money and resources frugally. Whether the moral overtones (eat your food because other children in this world are not so fortunate as to have food) were meant simply to motivate children who lacked an understanding of economic issues or whether Mrs. Stokes’ parents actually believed in the moral aspects of wasting food, Mrs. Stokes took from her childhood a moral imperative that wasting food was wrong, even using religious language, that it was a “sin,” to stress the depth of her moral conviction.

As Mrs. Stokes grew up, her parents’ admonitions about wasting food went with her as she ate in school cafeterias. She recalled how the cafeteria workers would “police” the students’ food selections, sometimes not even giving the students a choice:

Mrs. S: And if you didn’t pick the right thing, they told you about it too. [Chuckles, then pretends to be a cafeteria worker] “Don’t you want some of these green beans?”

LC: So they were watching to make sure you were eating okay.

Mrs. S: Yeah, they were watching. I know there was one lady there who was so {unintelligible}. She says, “Now you’re gonna take some of these.” She just put them on your plate. And of course I was taught not to throw food away. That was good for me though, that was really good for me. The other kids wouldn’t eat it if they didn’t want to, but I wouldn’t do that. I would eat it.

Mrs. Stokes graduated from high school, and began working at a laundry. A few years later she married, and the newlyweds lived with his father for a couple of years before moving out on their own. Over the next ten years, a daughter and two sons were born. Mrs. Stokes also told her children about the starving Armenians, laughing about how she had to pass that along, though believing in its moral and authoritative power: “But it was a good thing to tell. I thought it was very effective.” Mrs. Stokes was supposed to belong to “clean plate club” as a child, but she noted that if there was something that she or her siblings did not like, they were still expected to
eat a little bit of whatever it was they did not like. Mrs. Stokes derived her rule of “at least taste a food” from her mother’s rule of “eat a little bit of the food”:

They had to taste it. They didn’t have to eat the whole thing, but they had to taste it. And they’d act like they were gagging and … they put on quite a show. And my husband would sit there, and he says, “Now, you’re going to eat that.” And they would take the littlest portion.

Mrs. Stokes relaxed her childhood rule somewhat from eating a little to just tasting the food. She laughed as she talked about how her children responded to this rule. She also talked about one child who would feed peas to the dog under the table, and of another who would steal cookies and cans of Pepsi cola.

Such was Mrs. Stokes’ indoctrination in the “do not waste food” rule, that if she broke the rule, even at the age of 88 years, she felt guilty. For example, due to a long-time practice of cutting salt out of her diet, Mrs. Stokes was taste sensitive to salt, and she could not eat food that tasted too salty to her. Occasionally, she came across an item in the Dining Room of Colonial Square that tasted too salty: “The dressing is always kind of salty. And I don’t like the French Onion Soup either. That’s always very salty … If it’s just too salty, I don’t eat it. Always feel bad about that too. Because that’s wasting food.”

Other participants spoke of their belief in “not wasting food,” and this belief had various manifestations in their practices and views of others who were perceived as wasting food. Mrs. Florsheim and Mrs. Adams both made use of turkey carcasses from Thanksgiving celebrations, carcasses that their children were not going to put to good use. Mrs. Florsheim recounted what usually happened at Thanksgiving at one of her daughter’s homes:

We ate at our daughter’s, and they cut all the turkey off the carcass that they wanted, but, oh, they left a lot on. A lot. And as we often say, they did not grow up in the Depression. So each Thanksgiving evening, and when we leave, why they’ll say, do you want to take home the carcass? We’ll say yes. They wrap the thing up and we brought it home. So the next day, we unwrapped it and took the big pot that we had brought with us, and put all of the carcass bones into that. First we
cut off a lot of meat – I have four packages in here of frozen turkey. And then we make the turkey broth from the bones.

Mrs. Adams told a similar tale, observing the difference between her sister (who used to always cook the Thanksgiving turkey) and her daughter (who now cooked the Thanksgiving turkey):

And I get the carcass. Ed cuts off for their dinners and sandwiches and things, and then I get the carcass. For my sandwiches, and then I make soup. Michelle doesn’t like – doesn’t have time, and I guess she never did care much about cooking up the carcass. My sister always – she had got more use out of a turkey. And she wanted a big enough turkey so there were plenty of leftovers. There’d be cold sliced turkey to eat, sliced turkey for this recipe and turkey for that recipe, and soup. And, oh boy, did she get all the meat off the bones. Of course she cooked the bones, but … none of that turkey was wasted with my sister.

Both women noted possible reasons for why their children did not cut off more meat and cook the carcass. Mrs. Adams in part attributed this to her daughter’s personal preferences, but also to a lack of time to cook the carcass. Mrs. Florsheim attributed it to the fact that their children did not grow up during the Depression, and therefore presumably did not develop an appreciation for thriftiness, and making sure that nothing went to waste. Technically, Mrs. Florsheim herself did not grow up during the Depression, as she graduated from high school in 1930. But because she graduated from high school in 1930, she might have had an even better appreciation for the Depression, as it would have been a difficult time to be a young adult making the transition to living independently. When asked further about it, Mrs. Florsheim actually credited her upbringing more for her heightened awareness of wastefulness, because growing up, her family did not have much money. This economic and moral philosophy had become second nature to her: “Not because I have to, but because it’s just a part of me, not to waste things. There’s a saying, ‘Waste not, want not.’ ”

As Mrs. Florsheim alluded, societal forces and historical events may be powerful shapers of behavior. The Depression left a lasting impression on those who experienced it. Many of the participants’ adult children grew up in a time of post-World War II affluence in this country,
which could have also left an impression. As parents of young children during this time, the
women made rules similar to those of their parents regarding food, but several perceived
themselves to have been more lenient than their own parents. In addition, although they also
generally portrayed themselves as obedient when it came to cleaning their plates or as unaware
that there could have been any other way (“We just ate what was put before us”), they did not
always portray their own children as such. They told anecdotes about how their children “broke”
the rules, although with some amusement. They likely were not so amused when such incidents
occurred, but are able to laugh and joke about it now that time has distanced them from those
instances of “rebellion” and dimmed the seriousness of the incidents.

Mrs. Adams related how she thought her daughter loved rutabaga, as she always cleared
her plate of it. So she feed her daughter a lot of rutabaga – until she found out that it was actually
the dog that liked rutabaga so much. Mrs. Richardson spoke of how her youngest son put
broccoli in the back of the radiator by the breakfast nook, due to the clean plate rule. However,
she and her husband did not always enforce the rule in its strictest sense, as seen in the following
excerpt:

Mrs. R: But we never dreamed that he would put it in there. Because at that time,
you finished your plate. And thank heavens that went out.
LC: Now what happened if they didn’t finish their plate?
Mrs. R: Well, their father was pretty strict. And he would make them sit there a
while. Now they’re all, all big eaters. And eat everything.
LC: So they had to sit there until they finished?
Mrs. R: Uh, approximately. Until their father got tired of waiting.

When it came to a battle of wills between parent and child, the victor of the power struggle was
sometimes the child. Mrs. Burkhold recalled one of her children getting around the rules, not
through any deception or waiting game, but through simple logic. When told that she would have
to clean her plate before getting dessert, her daughter responded that she did not want dessert and
therefore would not have to finish what was on her plate. Mrs. Burkhold referred to laying down
the law in the way that she did as “a mistake,” because of the legal loophole that her daughter
found.
Mrs. Michaels, like Mrs. Stokes, spoke of being expected to be a member of the “clean plate club” as a girl, but she and her husband consciously decided not to be as strict about that rule with their own children. When asked whether she fixed different food for different family members when she was cooking for her family, she responded:

No, I usually just fixed one meal and if they didn’t want – didn’t eat it, they didn’t have to. I mean … of course you know, a long time ago we were supposed to clean up our plate – you had the clean plate club. And we found out that that wasn’t the best thing to do, and we were more lenient about it … I remember one time we were over in Berea … and they had all these little extra things at first, and our Bill, when we got to the real food, he couldn’t eat it, and his dad said, “Well, this time, it wasn’t your fault,” because they brought all these little things and he had filled up on those. But we always tried to make – if they took it out, they were supposed to eat it. When they were serving themselves. Now if somebody else served them, then that was a different story.

Both Mrs. Michaels and Mrs. Richardson suggested that the “clean your plate” rule was not really a good rule for children anyway. Also, the rule, or the enforcement of the rule, changed according to this shift in attitude, as the women became the ruler-makers. However, they do not seem to have always been the rule enforcers. Mrs. Stokes, Mrs. Michaels and Mrs. Richardson all indicated that their husbands were the enforcers of food rules as they raised their children, whether that was to “make” the children follow the rule or to allow the rule to be broken.

Wasteful practices were not limited to the association with the younger generations or with raising children. Mrs. Brown explained that in the Dining Room of Colonial Square, she tried to only order as much as she knew she could eat, but observed, with a bit of incredulity, that other residents did not follow this practice:

I have found that a number of the people are, particularly the women, are ordering everything that’s on the menu and then maybe take five or six bites and that’s it. It’s been really amazing to me the amount of food that is ordered that goes
untouched. Whether – and I’m not going to ask anybody – whether it appeals
to them at the time and they think that it’s going be good or whether they do it
because, to get their money’s worth. That always has bothered [me] – on cruises,
when you know you have more food than you can shake a stick at – people go
to everything and take everything they can, so they get their money’s worth. Of
course, if it makes them sick, then – they get off and gained 5 or 15 pounds. And
that to me is so silly. I guess I’m a moderate at heart, so …

Mrs. Brown continued, stating that she thought it was ridiculous for people to order so much
food and not eat it, but believed that it was their privilege to do so. In this case, she attributed
the wasting of food to people trying to get the most out of their money, although she attempted
to give some residents the benefit of the doubt. It seemed that some people who did not want to
“waste” their money, actually ended up wasting food in the process.

**Rule #2: Thou Shall Not Consume Bad Foods**

As these women aged, rules regarding food changed from rules about wasting food and
trying foods to rules about what one should and should not eat for health reasons, particularly
because of specific health conditions. Mrs. Stokes, as mentioned, had diabetes, and was
insulin dependent, but also managed the disease through diet. However, she had other physical
conditions for which she made, or was supposed to have made, dietary adjustments, such as
diverticulosis, high blood pressure and congestive heart failure. With regard to diverticulosis, she
was supposed to avoid foods with seeds, such as corn or berries. For high blood pressure, she had
to cut salt. Because of congestive heart failure, she needed to watch her fluid retention.

As a result, she developed another type of dietary morality, resulting in a number of rules
about the right foods and wrong foods to eat. Mrs. Stokes distinguished between good foods and
bad foods, or “no-no’s”:

“My husband just loved fried eggs and bacon for breakfast and potatoes. Real crisp
potatoes. And of course that’s a no-no now.”
“I don’t have her [Mrs. Stokes’ mother’s] butterscotch pie recipe though! Of course, that’s a no-no anyway for me now.”

“And that’s a good [diet] book too, by the way, but he was heavy on cream. You could have cream unlimited. And now, you know, that’s no good.”

“But most of the time it was oats. And they’re so good for you now.”

“Of course, we learned how to eat papayas and all that good stuff. But that’s all good stuff for you.”

She additionally categorized foods as something one may or may not have, based on whether they were good, or at least not bad. Foods or ways of eating that are okay, according to the rules, are “allowed”: “I always have to have a glass of milk and something to eat with it before I go to bed. And I’m allowed to do that, too.” When discussing what she was allowed to eat, her language sometimes became more legalistic: “Of course, I do have the regular orange juice, and I make lemonade with the lemon that you buy in the jar, and then I add sweetener to it. And that’s a legal drink.” Referring to something as legal was evidence of the degree to which her rules for dietary management of diabetes had become dietary laws, such as those that might be found in certain religions.

Who made these rules and decided what was and was not allowed? Mrs. Stokes remarked that “I have to do what they tell me,” following the orders of her doctors and sometimes her daughter, who lived in town and took her grocery shopping. Yet, Mrs. Stokes admitted to sometimes breaking these dietary rules. Occasionally, when her husband was alive, as a fellow diabetic he would be a co-conspirator in flaunting the rules: “Once in a while we would go out, and we would sin a little bit. It’s nice having company when you do that too. I would sin with ice cream, ‘cause I just love ice cream.” Again, the use of religious language regarding the breaking of a dietary rule suggested a fundamental moral orientation that she had taken toward foods.

Mrs. Stokes often accounted for breaking the rules, offering rationalizations for what she did. Occasionally she bought doughnuts, but she took precautions: “And every once in a while, I do get some without any sugar on them. Of course, I ration myself with those.” She acknowledged that even though she was not supposed to eat seeds because of her diverticulosis,
that did not mean that she did not eat foods with seeds, such as strawberries or corn: “Well, I know the doctor told me at the time, ‘Don’t eat corn.’ But now I do a little bit. Of creamed corn. Not very much though.” Presumably, Mrs. Stokes rationalized that doughnuts without extra sugar on them were not as bad as glazed, iced or powdered doughnuts, and in both the case of doughnuts and corn, she limited her intake, careful to consume only a little at a time.

Mrs. Stokes also felt it necessary to account for “wrong” dietary practices in the more distant past. For this accounting, however, she did not use personal justifications, but pleaded ignorance, appealing to the lack of scientific and public knowledge about nutrition: “I always thought I was pretty good, but I guess I wasn’t careful enough. See, we didn’t know years ago about eating.” She continued, referring to her husband’s favorite breakfast trio of fried eggs, fried bacon and fried potatoes, and how that was not a “good” breakfast, but noted “nobody told us that was wrong.”

Ultimately, however, it seemed the reason Mrs. Stokes did not mind sometimes breaking dietary rules was because of her age. When asked if she thought she would change the way she ate in the future, she replied:

No, not really. I’m gonna die happy. I figure I don’t have that much time ahead of me anymore. I might as well enjoy what I’ve got. Of course, the doctor doesn’t agree with that. But I tell him anyway. I think he thinks I’m a cranky old lady. A feisty old lady.

She later reiterated this idea, when asked whether she drank regular or decaffeinated coffee: “Regular. I only drink one cup a day. So I figure I can have that much caffeine. As I said, I’m gonna die happy. And of course I drink milk too.” In subsequent comments, Mrs. Stokes revealed that she drank whole milk instead of low-fat or skim milk, because she liked whole milk better: “Skim milk is practically nothing, you know. And on cereal, forget it. I think I would just as soon put water on it.” In determining that her remaining days were limited, she let her personal preferences and enjoyment of foods take some precedence, using her age as a license to break the rules – albeit in moderation.

All of the women expressed differentiation of foods that were good or bad for health. Some participants classified certain practices as good or bad; for example, cooking techniques
(frying versus baking) or meal patterns (“I really just have two meals a day now, and I think that’s very bad.”). More than a few were of the mindset that moderation was the key when it came to good and bad foods, letting themselves have a little of the foods that were considered bad or at least not so good. “I think anything you do in moderation is not bad” was a common sentiment among the moderates. Mrs. Nichols felt that it was easier for her to avoid eating too many sweets if she let herself have just a little. Occasionally, religious language was used again to denote when something was bad. Mrs. Monroe, for example, considered her love of dark meat to be wrong: “And most of the time they have baked chicken, you can get the dark meat. And that is a sin. Because I like the dark meat better than the light meat, and the light meat is better for you.”

Others also accounted for past behavior that was contrary to current dietary recommendations because of a lack of knowledge about such things in the past. For example, Mrs. Michaels recalled the breakfasts she used to prepare for her husband, and as she listed the foods she made, she prefaced her comments about bacon: “And back earlier, before we knew about fats and cholesterol, we had a lot of bacon.” Mrs. Michaels was a home economics major in college and had previously noted that they did not discuss things such as fats. “And cholesterol wasn’t mentioned. We didn’t know that word really.”

In addition, Mrs. Stokes was not the only woman who used her age as a reason to enjoy foods that might otherwise be “bad.” Mrs. Richardson tried to eat more vegetables than she used to, because she liked them and thought they were healthy, but she also clearly articulated that she did not necessarily restrict herself from bad foods. “They’ll have something and if it’s something that sort of strikes my fancy and I’ll say, mmm. So eat what you want. I don’t try to deprive myself because it’s something I shouldn’t have. I feel like at this age, eat it and enjoy it.” She wished other residents had her same philosophy:

And I was sitting there with six or seven people, and this one gentleman, I’ll never forget him, Mr. Taft. And I said, “I’m going to get up and get dessert. May I get anyone dessert?” And he said, “Oh no, it isn’t good for you.” Mr. Taft is 93. It was not good for you. When I came back at the table with my really fattening dessert, I felt a little guilty, but not guilty enough not to eat it. Do you know three days later
Mr. Taft had died, and I thought, oh, I wish he had eaten some dessert. Because I knew he wanted it, you know.

Although she expressed feelings of guilt for breaking a rule, it seemed her philosophy of “at this age, eat it and enjoy it,” tempered her guilt.

Other women who had health conditions that required dietary adjustments also used moralistic terms to discuss what they should and should not eat. Ms. Carr was diabetic; at the age of 72 she was younger than Mrs. Stokes, and with nine years since diagnosis, had not lived with diabetes as long as Mrs. Stokes. For Ms. Carr, “it is a constant battle with the diabetes.” She sometimes felt overwhelmed because there was so much she had to watch about her diet. Mrs. Stokes, however, felt that much of what she did regarding food had become almost automatic (for example, counting carbohydrates), and it seemed to be less of a “battle” for her. Unlike Mrs. Nichols, the moderate, Ms. Carr thought it was better for her to stay completely off sweets, because when she tried to have a little, it ended up turning into a lot.

Ms. Carr in particular talked about what she was allowed and not allowed to do:

“Well now one of the things they allow me to have is…one slice, twice a week, of angel food cake plain. No icing. And that was fine.”

“I do have permission to drink diet drinks. It [her diet] says I can have as much as I want. Or I’m even allowed to have coffee.”

“And I figure, I can have eggs – well, in fact, this diet I have says I can have eggs two or three times a week…”

“I am allowed a bedtime snack.”

“And it’s very interesting, but seems like people get all upset about the amount of fluid I drink. And I say, well, it’s on the diet, it’s there.”

She referred to the diet that the doctor prescribed for her, which was written out, as an authority to be deferred to, but also to defend herself to others who observed her and her practices. She was bothered by residents who took it upon themselves to make sure that she did what she should
regarding her dietary behavior: “And one resident will come up and say, ‘Well, I’m just checking on what you’re eating. I want to be sure you’re eating right.’ And I thought, well, I don’t say one word to you about what you’re eating.”

Sometimes when Ms. Carr broke her dietary rules, she felt guilty, but at other times, she laughed it off:

And they’re beginning to know us and they know that I’ll accept the chocolate sugar-free pudding. Unless there’s something they have that I just simply can’t turn down. And see, I’ll check my blood sugar before I go down. And if it’s not completely out of whack, why … I know it. I am terrible, I know it. I know it. But I’m rotten. I think I get by with it too. [Laughs]

It almost seemed as if she regarded herself at these times as something of a mischievous child who did “naughty” things but meant no harm. Her swings between a guilty and a devil-may-care attitude were reflective of her “battle” with diabetes. In some way, her struggle was not just a health issue; it was also a moral issue for her, about rules that she should not break but did anyway.

Food rules regarding health and nutrition, reflecting moralistic ideas about food and eating, came later in life for these women. Their regard for the rules also depended to some extent on their views of nutrition – what it meant to eat nutritiously and where they got their information about health and nutrition. The next section goes beyond moral aspects and rules to the broader role of nutrition in their past and present dietary practices.

**Dietary Wellness: Nutrition Advocacy**

*That the flavor of cod-liver oil may be changed to the delightful one of fresh oyster, if the patient will drink a large glass of water poured from a vessel in which nails have been allowed to rust.*

Gillette and Zeimann (1887, p. 494), providing hints regarding health
Figure 6.2: Mrs. Wilson’s Recipe for Granola

<table>
<thead>
<tr>
<th>Granola</th>
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</thead>
<tbody>
<tr>
<td>1 cup raw wheat germ</td>
</tr>
<tr>
<td>2 cups rolled oats</td>
</tr>
<tr>
<td>1 cup oat bran</td>
</tr>
<tr>
<td>¼ cup sesame seed</td>
</tr>
<tr>
<td>½ cup sunflower seed</td>
</tr>
<tr>
<td>1 cup chopped nuts (not fine)</td>
</tr>
<tr>
<td>Mix together. In a separate bowl, mix:</td>
</tr>
<tr>
<td>¼ cup oil (safflower)</td>
</tr>
<tr>
<td>¾ cup honey</td>
</tr>
<tr>
<td>Work throughout the dry ingredients. Bake in 300° oven in roaster sprayed with Pam – for 1½ hours – need to stir every 15 minutes. After cooled, put in plastic bag. Should be a light tan color – don’t over do it, but it needs enough. Towards the end of baking, may want to taste a teaspoon to make sure it is crunchy.</td>
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</tbody>
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Mrs. Wilson went over old recipes that she liked. Some of them were party appetizers, and some were family recipes. She also had some recipes that were particularly healthy:

And granola. Now this dates from when William had his open-heart surgery. Because that’s when I started doing research. That’s when I got the Jane Brody book, and started eliminating, well, egg yolks and fats. You know, downgrading sugar a great deal, and started incorporating the whole oats and grains and things like that.

It was over 24 years ago that Mrs. Wilson’s husband underwent quadruple bypass surgery, an event that lead to a complete and radical change in their diet and the way the Wilsons ate. Since that time they never looked back, allowing themselves the rare treat (e.g. bacon or waffles), but always consistently maintaining their low-fat, low-salt, high-in-fruits-vegetables-and-grains diet.

At the time of this research, Mrs. Wilson was 79 years old, a tall thin woman with a soft voice and sensitive soul. Mr. Wilson was her second husband, although they had been married
for 33 years. She had two children from her first marriage, and three stepchildren. She also had 5 grandchildren, 5 step-grandchildren, 5 great-grandchildren and 7 step-great-grandchildren. Even these young ones were well aware of the dietary practices of their grandparents, as Mrs. Wilson related:

Well, I think I told you about my little granddaughter, who had to write a 3 or 4 page essay. And she wrote, I like to go and visit my grandparents, but there’s just one thing. When you go to their house, you have to eat health food.

Family was very important to Mrs. Wilson, who kept in close contact with all her siblings and the children. Over her lifetime, she often cooked and prepared food for them, at family gatherings and as gifts; she also tried to have a positive influence on their eating habits, sharing her knowledge of nutrition and impressing upon them the importance of good nutrition.

It was Mr. Wilson’s surgery that spurred Mrs. Wilson’s study of nutrition, which resulted in the transition of their eating habits. Before then, Mrs. Wilson’s knowledge and practices were based on how she grew up and what she learned in school. Mrs. Wilson was born and raised in the rural South, with her parents and four other siblings, and for whom cornbread crumbled into milk was a standard meal. The family owned livestock, which supplied them with fresh meat, eggs, milk, butter and clabber. They also cultivated a garden, producing an abundance of fresh vegetables. She described how her mother made fresh biscuits and ground fresh coffee every morning. She also described a favorite dish called pot likker: “You crumble corn bread in a bowl, and pour the juice that you cooked the turnips in, over it. And eat it with a spoon. And that’s what pot likker is. And that was just a favorite. And you can imagine how nutritious, you know, the juice, the broth from cooking turnips, plus the corn bread.” She credited her parents with providing wholesome meals and a variety of foods for the family.

Mrs. Wilson received her first training in nutrition in high school, where she had a health class in which food was discussed. After high school, she went to business school, and then moved to Washington D.C. to take a job in the civil service. It was in Washington that she met and married her first husband, a Northerner, and learned how to cook, because as she put it, she “didn’t know how to boil water.” She prepared standard dinners of meat, potatoes, and one or two vegetables, which was all her husband wanted anyway, meat and potatoes, and at that time, such dinners were
the concept of a well-balanced meal. With her children, she made sure her two boys ate fruits and vegetables, and always kept carrot sticks around, which became a snack staple for them.

They were living in the Northeast when she and her first husband divorced. After the divorce, Mrs. Wilson attended college. Her younger son lived with her, and she asserted:

But with college, we had nutritious food. For instance, we had a lot of tuna fish salad, with a lot of vegetables in it, you know, and we both liked it. We had – on the weekends I would cook full meals, and maybe make a roast and we would have some sandwiches then. But cooking really got to be – we used some frozen foods. Because I worked really hard to get through college … But we did have a healthful diet. I made sure that we got protein and vegetables and fruits.

She married Mr. Wilson a week after graduating from college. At that time, his main meal had been steak and potatoes, a meal that continued to be in their diets, except that Mrs. Wilson added vegetables, salads and desserts in order to provide what she considered a well-balanced meal. When Mr. Wilson retired, they moved from the Northeast to Louisville, Kentucky, where Mr. Wilson had a brother and sister-in-law.

Shortly after they moved to Louisville, Mr. Wilson went to the doctor, sensing that something was wrong with him physically. Subsequently, he was admitted to the hospital for the quadruple bypass surgery. Mr. Wilson’s doctor informed them that if he had had a heart attack, he would have died. Mr. Wilson’s father actually died at the same age from a heart attack. Mr. Wilson recovered well from the surgery, and Mrs. Wilson described his last post-operative appointment with the cardiologist:

I went in after his surgery, after 6 weeks, he’d be going in for his dismissal thing. Well, I went in with my little notebook and pencil ready. And after he [the cardiologist] finished talking with William, I said, “Well, I’d like for you now, if you would please, to tell me what he should – his foods.” He said, “He can eat anything he wants to. I’ve fixed his heart.” And I looked at him. And just got upset. Now, he’s a wonderful fixer. But I had already read that 80 percent of open-heart patients are back in five years for more surgery because they had not
changed their life. So I thought, well maybe he needs more business later on. But that didn’t keep me from believing what I had read.

Her research on nutrition became a very important project for her, and she put her love of reading and study to use in improving her husband’s health:

I subscribed to Prevention magazine, that was one thing, and of course, you know, books from the library on nutrition and all kinds of things. And you know, it was just a matter of reading. Just a matter of reading. And then finally, recipes – and I also found a book to give me suggestions on how to modify recipes. If you have a favorite recipe, how to modify it. So, and, of course, I love to study. I just soak it up. Still do.

Studying up on a health-related topic was not new for her; during her pregnancies, she recalled reading books and following the recommendations. Mr. Wilson’s surgery, however, required a much larger, permanent change in their lifestyles and resulted in a serious plan of action.

Mrs. Wilson cut fats from their diet, reduced their salt and sugar intake, frequented health food stores, added nutrients to already healthy foods (such as adding oat bran and sunflower seeds to plain oatmeal), and learned not only ways to modify recipes but also new ways to prepare healthy and tasty meals, such as stir-frying in a wok. In addition, they began taking supplements, including a multivitamin, vitamins C, D, and E, and folic acid. Mr. Wilson also took an iron supplement, but she did not. She took an additional calcium supplement. They had not cut out desserts, but instead of servings of pie and cake, they chose frozen yogurt or sherbet. Mrs. Wilson was quite happy with the foods that they were able to choose from the Dining Room, peppering her commentary with nutritionally correct jargon:

They use very little salt. There are always choices that are good for William’s diet, which I follow also. They have plenty of vegetables, plenty of fruit. A wide choice of fish. They serve different kinds of fish, and good fish. You know, the kind that has the omega-3. Except catfish, but we eat that anyhow. They have blackened catfish that’s just wonderful. And it does not have omega-3, but we eat it anyhow. But it’s not fried. We don’t eat fried foods at all. But they have good vegetables,
and salads. Now they don’t have whole wheat breads. But they have to please the majority of the people and I understand that the majority of the people don’t want whole wheat bread. So, you know we don’t make a fuss about that. And we have cranberry juice as sort of an appetizer at dinner every night. And they always have some, a fruit plate available, with lovely fresh fruit. And you can have that with cottage cheese or chicken salad or tuna salad.

She was willing to make small concessions (e.g. the whole wheat bread) due to the overall perceived nutritional quality of the food choices available in the Dining Room. The waiters and waitresses in the Dining Room always filled any of their special requests, such as “going light” on a cream sauce, or getting a salad of greens not listed on the menu.

The adjustment in diet and dietary practices was not a very difficult one for them to make, even when Mrs. Wilson was preparing their main meals, because of the seriousness of the situation and the threat to Mr. Wilson’s health, even life. As she said, “William knew and I knew what was at stake.” She remarked that Mr. Wilson never complained, but also that she had been able to prepare food for him that tasted good. Her support, both emotional and instrumental, meant a lot to Mr. Wilson, who credited his wife with his survival: “I’m still here because of her. I wouldn’t have made it without her.” Mrs. Wilson had no complaints about changing her lifestyle either, but for somewhat different reasons:

I’m a very docile person. You know, what suits anybody else, suits me. Well, and of course that’s reflected in William’s situation. When he – it never has crossed my mind to make something for me. I love pecan pie. But he shouldn’t have it, and so I – I wouldn’t think of making anything just for myself. I just – I’m a people pleaser. That’s what I am.

Additionally, this change has not been without its rewards for Mrs. Wilson. In conveying that her husband’s illness made the biggest impact in her lifetime on her eating behavior, she explained why: “I really studied food … I’ve studied it. And have actually made a plan. And I’m very proud of it.” She continued:

I told you that Dr. Harper, his cardiologist, when we first went in to her, and said,
well he had four bypasses, 24 years ago, and he hasn’t had any trouble since, and she was just astounded. She said she had never heard of such a thing. And of course, his food I eat – we eat the same diet. So, it’s been good for me too.

She took pride in the fact that she organized and engineered their dietary transformation. She also had seen success from all her efforts. His cardiologist’s response and the fact that he only recently had any recurring heart troubles proved to her that their diet had been “wonderfully successful.” She evidently believed that she also benefited from the health effects of such a diet, noting that it had been good for her too. Mrs. Wilson even used nutrition to improve her mental health, talking of the time she made an orange juice and yeast concoction, to which she gave some credit for helping to pull her out of an “air of depression.”

She also felt that she had been a good influence on her children and step-children, nutritionally speaking. Although sometimes she saw them eat in ways that she wished they would not, she was secure in her knowledge that they did know good nutritional practices. Mrs. Wilson did not plan to make any future changes in their dietary behavior; she was satisfied with their current eating practices.

Not all of the participants were as staunch believers in the power of nutritious food as Mrs. Wilson. Some even expressed skepticism about dietary recommendations they had come across in various media sources:

And you know, you read articles that supposed to be people in the know and one six months you’re supposed to eat this and that [sic]. Now, margarine for instance. How long you weren’t supposed to eat butter – it wasn’t good for you and you’re supposed to eat margarine. Now butter’s better for you than margarine. And all those changes, you know. I try to keep up with them. But I never did do without my butter. I love butter, sure enough, butter. But that’s just one instance. I mean, often they change – what was good for you one time is not so good for you the next six months. (Mrs. Provost)

I find myself, when I look at the menu here, thinking, oh that’s fried and it’s not going to be as good for me. Now I’ve begun to think about my weight too. But
there have been a lot of food fads through my lifetime, latter lifetime. And we
never paid much attention to those. You know, for instance, eggs for a while were
so bad for you. We continue to have eggs every once in a while. (Mrs. Nichols)

[I read] some articles about nutrition. But they change their mind so often, I don’t
pay any attention to those anymore. Really. That’s true. I think the one thing that
I’ve tried to change is not to eat so much pork. I think that was not good for my
body particularly. But mother, when she ate her meat, she wanted half lean and
half fat. And she lived just about longer than anyone else. Now figure that one out.
I guess she worked it off – I don’t know. (Mrs. Faust)

There was a perception among the skeptics that dietary recommendations changed frequently,
sometimes contradicting or negating previous recommendations, making them difficult to
follow and even more difficult to trust. Other women, such as Mrs. Faust, additionally noted
that someone they knew, be it a parent, an aunt or a sister, lived a very long life on a diet that
by today’s standards might be considered almost deadly. In fact, Mrs. Burkholz, at 86 years old,
found some recommendations did not apply to her at all: “Don’t tell me that pork isn’t good for
you. I grew up on it.” Ever the meat lover, Mrs. Burkholz found that among her peers, she was
something of a nutritional outcast:

Nobody likes to eat like I do. I say anything about grease or pork … They say,
“How on earth can you eat that stuff?” And I say, “Boy, it’s good. Got to have a
little grease go through your bones.”

In the face of the contradictions of experts and physical proof that said otherwise, some women
did not take much stock in the latest nutrition information.

Almost all of the women trusted in the well-balanced meal concept and in moderation,
feeling that it worked for their parents and served them well over the years. In their early years,
participants cited parents as a main source of knowledge about nutrition and healthy food. Except
for the few from urban areas, many of the women’s parents did some type of gardening, resulting
in garden fresh vegetables served at meals. Those who lived on farms also had fresh meat, eggs
and/or dairy products. Additionally, they identified school and clubs, such as 4-H, as places of
learning about food and nutrition, again mostly in terms of food groups and the well-balanced meal. Just over half of the participants mentioned they first learned about nutrition in a health or home economics class.

As the years went on, all but one of the women got married, and all but one of the married women had children. None of them remembered doing anything particularly different as far as their dietary behaviors during their pregnancies (except Mrs. Wilson, although she could not recall specifics). Three of the participants mentioned being unable to drink coffee during their pregnancies, not for health reasons, but because it was unappealing to them. Mrs. Faust had inquired about her diet when she was pregnant, asking her doctor’s advice:

Some people think they have to eat special things when they’re pregnant. I asked my doctor about that and he was a man of few words. He says, “You eat don’t you?” And I thought everybody when they got pregnant had to take vitamins, special vitamins. He said, “You eat, don’t you?”

Nearly all of the women fed their families based on their upbringing and any health classes they had in school. A few recalled perusing women’s magazines, such as *Ladies Home Journal*, in which they read articles addressing nutrition, or procuring nutritional information from a cookbook. The concept was still the same: a well-balanced main meal of meat, potatoes and one or two vegetables. They often served more salads (e.g. vegetable salad, fruit salad or the always-popular jello salad) with the meal, however, than their mothers had served. Dessert after the meal continued to be the custom. The participants did not particularly mention beverages, although three mentioned soda, and reported that they either did not buy much soda when they were raising their children (especially as compared to what they perceived as a high rate of soda consumption by today’s families) or they limited their children to one soda a week.

In later years, the media became a regular source of nutrition information for these older residents, as nutrition became a frequent topic in magazines, newspapers, books, and on television. Friends and peers also began to more often discuss nutrition issues, and shared information and tips. Mrs. Adams explained that she learned about nutrition from reading and from talking to others: “I guess a friend talked about taking vitamin C. She had a lot of colds or something, and she found vitamin C helped her. So I tried that…”
As seen in Table 6.1, the top three vitamin and mineral supplements used by participants were vitamin E, calcium and multivitamins. A number of women, 10 participants, took calcium for bone health, and about two-thirds of the women took at least a multivitamin. Three women took Ocuvite, a supplement with minerals specifically for eye health (e.g. lutein, zinc) and recommended by their ophthalmologists. The majority did not begin to take vitamins and supplements until their later years (with the exception of one who began taking vitamin supplements in high school for extra energy to play basketball). Of those able to estimate how long they had been taking vitamins, three women had been taking supplements for 1–3 years, four for 5–10 years, two for 15–20 years, three for 24–25 years, and the one who began in high school, for 70 years. Often they began on the recommendation of a doctor (10 participants), some took self-prescribed vitamins (5 participants), and two women began based on the counsel of adult children (one step-daughter and one daughter-in-law). Mrs. Adams began to take vitamin E based on a lecture she heard given by a researcher from the University of Kentucky: “I take vitamin E – to avoid the plaques from Alzheimer’s.” She emphasized that she had her doctor approve her use and dosage of vitamin E.

<table>
<thead>
<tr>
<th>Vitamin, Mineral or Other Supplement</th>
<th># of Women Using</th>
</tr>
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<tbody>
<tr>
<td>Beta carotene</td>
<td>1</td>
</tr>
<tr>
<td>Calcium</td>
<td>10</td>
</tr>
<tr>
<td>Folic Acid</td>
<td>2</td>
</tr>
<tr>
<td>Glucosamine</td>
<td>2</td>
</tr>
<tr>
<td>Multi-antioxidant</td>
<td>2</td>
</tr>
<tr>
<td>Multivitamin</td>
<td>11</td>
</tr>
<tr>
<td>Ocuvite</td>
<td>3</td>
</tr>
<tr>
<td>Shark cartilage</td>
<td>1</td>
</tr>
<tr>
<td>Tums</td>
<td>2</td>
</tr>
<tr>
<td>Vitamin A</td>
<td>1</td>
</tr>
<tr>
<td>Vitamin B’s</td>
<td>2</td>
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<tr>
<td>Vitamin C</td>
<td>5</td>
</tr>
<tr>
<td>Vitamin D</td>
<td>3</td>
</tr>
<tr>
<td>Vitamin E</td>
<td>7</td>
</tr>
</tbody>
</table>
Participants reported receiving minimal nutritional advice from health professionals, beyond physician recommendations for vitamin and mineral supplements. Mrs. Provost’s doctor instructed her to drink Ensure, and nurses recommended that she drink green tea; health professionals advised Mrs. Randall and Ms. Carr to drink cranberry juice. For those with high blood pressure or cholesterol problems, nutritional counseling essentially consisted of advice to reduce salt or consisted of a sheet of paper with foods to avoid for reducing cholesterol.

Four women reported receiving nutritional advice from their children. Mrs. Burkholt talked about her daughters and their eating, and then noted: “And they know a lot about nutrition. In fact, they’ve gotten so they tell us.” Mrs. Vossler retired out West, but moved to Colonial Square a year ago to be closer to her daughter, who was a vegetarian. Mrs. Vossler claimed that she learned much from her daughter about nutrition. For her, nutrition seemed to be a family issue. She affirmed she learned from her daughter, when she said: “Because who else was going to teach me? My mother cooked the way I did, you know.” Mrs. Vossler did not become a vegetarian herself, but since her residential transition to Lexington, she incorporated more vegetables into her diet, had come to appreciate meatless meals and was generally more aware of nutritional issues than she had been earlier in life.

All but one of the women generally concurred with Mrs. Wilson’s assessment that the Dining Room of Colonial Square had nutritional options. Two issues that were consistently brought up by the women were: one, a lack of potato selections on the menu, and two, some lack of variety in vegetable selections. Yellow squash and zucchini were perceived as making too frequent appearances on the menu; according to Mrs. Brown: “As everybody says, they’re [food services] addicted to yellow squash.” A related issue was balancing medications and food; for example, Mrs. Adams was on a blood thinner, and consequently had to limit her intake of foods high in vitamin K, found in leafy and green vegetables such as spinach, kale and broccoli, to no more than three cups a week. She expressed concern about this situation. First, it was difficult for her to determine how much 3 cups exactly was, particularly because she was eating mainly in the Dining Room: “And so that would be easier to manage at home, on my own. Like how much is a half a cup of broccoli?” A second difficulty occurred when all the vegetable choices at dinner were high in vitamin K:
All the sudden [they] get peaks of it. And it seems as though, sometimes the alternatives – you have to choose between which vitamin K you will eat that day. And sometimes, you know, they’ll have stuff two, three days in a row. Broccoli, spinach, Brussel sprouts, three days in a row.

Almost none of the women mentioned fruit as an issue, only Mrs. Ford, who would have preferred more fruit be available in the Dining Room at meals.

On the whole, the women varied in their interests in and knowledge of nutrition. They ranged from Mrs. Wilson, a self-taught student of nutrition who practically revolutionized her diet, to Mrs. Burkolt, who gave it little thought, relying on her common sense and daughters’ advice, but really having changed her diet very little since she was a child. Almost all had some heightened nutritional awareness when compared to their awareness at younger ages, although two women qualified their awareness, such as Mrs. Faust who asserted “I’m not a real nutritionist,” or Mrs. Brown who stated she “never made any special study of it.” A number of participants were either skeptics or had no reason to change, feeling that their well-balanced meals and vitamin supplements provided adequate nutrition. If nutritional changes occurred, it was often a conscious attempt to consume more fruits and vegetables, or as part of a plan for weight management (e.g. altering dessert patterns).

Mrs. Wilson also enjoyed cooking, and she had entertained socially quite a bit over the years, welcoming friends and family into her home. The concept of feeding others in social situations was another theme to emerge from the stories of these women.

Dietary Sociability: The Art and Activity of Feeding Others

*I enjoy preparing any kind of meal, but I prefer meals that have a special meaning – meals for guests ... No matter how tired or how busy I may be, I always rise to the occasion when a party is in the offing.*

Vanderbilt (1961, p. viii), from *Amy Vanderbilt’s Complete Cookbook*
For Mrs. Randall, one of the great aspects of the Brunch Casserole was its ease of preparation. Another great feature was that you could make it in huge quantities: “You can see, you can imagine, you can line six pans up and do 125 people, which is what I had to do.” As Mrs. Randall noted when discussing her recipes, the ones she chose were representative. Why she had to make so much Brunch Casserole reflected a major dimension of Mrs. Randall’s approach to food and food preparation. The recipe was about 30 years old and from a friend. Mrs. Randall used it for Holy Week breakfasts at the Methodist church she attended, when many years ago she was the cook. For about 10 to 15 years, she and another woman cooked for church breakfasts, church suppers, wedding rehearsal dinners, wedding receptions, and other special occasions, feeding the congregation. She enjoyed cooking for the church a great deal, and felt she was skilled at it. Mrs. Randall also had 20 years of experience entertaining as a military wife. She was a master at preparing food for social situations, be they entertaining, church functions, social clubs, family gatherings, gift giving, or charitable work.

Mrs. Randall at 73 years of age was one of the younger women of the participant group, but she had lived at Colonial Square the longest, having moved in 18 years ago when the building opened. Born in the rural Midwest, she had little interest in domestic activities or experience with social events when she was a girl. She was rather tomboyish, hunting and fishing with her
father, and even received a shotgun at age 16: “My dad thought I was a boy. For years.” Her first real cooking experience occurred at a restaurant where she worked part-time, after school and on Saturdays. As a teenager, she prepared spaghetti for the bus drivers who frequented the establishment. When she married, she could make spaghetti, fried chicken and chocolate cake. She knew a little more than she thought at the time, as she also was familiar with gardening and cleaning and preparing game.

She met Mr. Randall while at a Midwestern college, and they married after he graduated from dental school. They went on a short honeymoon to Niagara Falls, and then reported for duty at Walter Reed Hospital in Washington, D.C. The next twenty years took them to one foreign country, four states and back to D.C., before settling in Kentucky. The almost simultaneous marital and occupational transitions completely changed their lives. Her new role was not just that of wife, but that of an army officer’s wife. Socially speaking, much was expected of an army officer’s wife during the 1950s and 1960s. Her only previous experience with the military was writing letters and taking cookies to soldiers. As an army officer’s wife, she had to know the social rules of the military, which other, more-experienced wives helped her to learn. She was obligated not only to do private entertaining for other officers and their wives, but also to be involved in social activities involving only wives.

Once she got the hang of it, however, her wifely duties almost became a matter of routine. Mrs. Randall always entertained at home, never at the officer’s club. She organized her entertaining to make it as easy and yet as successful as possible:

When Johnny was in the military, I had about five menus that I knew to the nth [inside and out]. How long it took, what it took ahead of time and so forth. And those were the ones that I pretty much – and it was food I could get – those were the ones I pretty much used the entire 20 plus years of cooking for or entertaining for the military. And we laughed about it – I said, “You know,” I kept saying, “You know, we can’t stay too long here because I’ve gone through all five!” The only thing was, most everybody had left and new people had come in, but we never left, that was the problem, see. So I said, “Well I’ve gone through all five of them, now I’m going to have to figure something different. But, oh well, most
everybody’s gone, you know.” So anyway, it was pretty much the same ones all the time. Typical. The ham dinner, the beef dinner, you know.

In addition to the use of the same menus, she also found that she could use essentially the same social rules, as entertaining was basically the same wherever they were. She characterized some of the various places she and her family lived during her husband’s military career. During the Texas and Hawaii assignments, they struck her as very military and very proper, where tradition was highly regarded and given much emphasis. In D.C., she found the atmosphere to be more executive, and rank was considered to be very important. They also really only associated with other medical officers and their families in Washington. In Europe, there was no officer’s club yet where they were stationed, and she found them to be a very social group that enjoyed getting together at social events. During one of their tours in Texas, she was the one in charge of organizing all the activities for the dental wives (a dental training school was there, and thus many dental wives).

When Mr. Randall retired from the military, he accepted a faculty position at the University of Kentucky. Although not their last residential move, the relocation to Lexington would be the last time they moved to a new town. Mrs. Randall discovered that as a professor’s wife, it was much more relaxed socially. They became involved in coordinating departmental get-togethers about once a semester, and she taught bridge to other faculty wives. She took on the duty of church cook; also through her church, she became involved with Meals on Wheels. Mrs. Randall contributed food to the local food bank, and had contributed food to those in need in the past. She referred to an example when they were living in Texas:

Johnny went hunting down there several times and we got deer, he got venison. And a couple of times, well most of the time, we would keep the tenderloin. Pretty much that was it of the venison. And then we’d give the rest of it to a church or one of the agencies or so on. And they always gave it – they all had families that really loved the venison. And they’d grind it up and put it in a tamale and things. So they were always glad to get it, and we were glad to get rid of it. And it fed someone. You know. And that was a good way to use venison.
Mrs. Randall, of course, was familiar with game and how to clean and prepare it from her days of hunting and fishing with her father.

When Mrs. Randall and her friend stopped working as the church cooks, the church had to hire someone to come in and cook: “Well, we retired and there wasn’t – nobody else was going to do that for nothing! Just us nuts!” She also discontinued her involvement with Meals on Wheels, and her husband eventually retired from the university. Even at Colonial Square, Mrs. Randall still actively cooked for others. Family especially continued to benefit from her skills. She and Mr. Randall had three children. The daughter lived in Lexington, and one son was not far, about a few hours drive away. The other son was in the military and currently in Washington, D.C. Birthdays were usually a family affair, and the whole family got together when they could for the holidays. Mrs. Randall was in charge of Thanksgiving this past year (due to a daughter-in-law’s health problems), which involved not only planning and cooking on Thanksgiving day, but planning the meals for the entire weekend, as family members came into town and stayed through the holiday weekend (but not at Colonial Square). She often made food to give as gifts to family and friends (such as tins of roasted pecan clusters or wrapped-up English shortbread). She always brought food when her bridge club had potluck, from fruit salad to barbeque meatballs.

Mrs. Randall used her extensive culinary experience at Colonial Square, offering advice and suggestions to those in food services. She was able to add insight to the menus, based on her experience as a cook and a long-time resident:

I’ve got a few ideas I’m going to turn over to them shortly. Again. I feel free to offer some suggestions. I think it’s easier for somebody who’s been here also, who knows the problems. You can say, oh well, do my favorite recipe. Well, “my favorite recipe” won’t hold and it won’t multiply. But mine do … And yet I know some short cuts and some things like that.

Mrs. Randall was on the residents’ food services committee in the past, and though she was not on that committee at the tie of the study, she communicated with the staff on her own, suggesting menu items (for example, tuna melts and gingerbread) and changes to the menu cycle (“I suggested several years ago that maybe they needed to add an extra week. Because we
discovered in Meals on Wheels, that we needed really five weeks. ’Cause you don’t want the fourth Monday to be the same.”).

Mrs. Randall and her husband usually had their dinners in the Dining Room, and stocked food for breakfasts and lunches. She prepared items to have on hand, generally soups and salads. She usually had something to start the soup with, such as a can of condensed tomato soup, but always added things to it, such as seasonings, pasta and vegetables. She did the same with cake – started with a box mix, but “doctored” it up. Her creative food tips occurred throughout the interview, such as suggesting that the Brunch Casserole be served with hot salsa on the side, how to make bacon-wrapped green bean bundles tied with red pepper strips, and how to make a tortellini soup.

There were no frozen dinners or other pre-made meals in her kitchen, with the exception of some frozen pizzas that Mr. Randall sometimes had for lunch. She shopped at Meijer because she found they had fresher and more exotic produce in stock, but she occasionally went to Sam’s Club\(^1\), if she was “going to have a mob.” She still had quite a bit of cookware, in fact a very large cupboard (really a small hutch) full of cooking and baking equipment. She gave away the big items – huge stockpots for example. They had the cupboard custom installed in their apartment when they moved in to Colonial Square, knowing that she needed the space for storage of her cookware. She had, for example, six 9”×13” metal baking pans.

Mrs. Randall voiced concerns about contemporary cooking practices, or rather the lack thereof:

Mrs. R: But oh - it’s so much easier now, because – oh, everything is so – you know, you can get spiral sliced ham, and it’s a breeze now. And it’s a darn shame, because people have quit cooking, haven’t they?

LC: Yeah. I would say a lot of them have.

Mrs. R: I think so, because these foods that are packaged and already put together – good grief, you’ve got TV dinners and everything – that are really quite nice.

\(^1\) Sam’s Club is a chain market that specializes in bulk quantities.
Although she was a fan of dishes that were easy to prepare, and made use of items such as canned soup and box cake mixes, her definition of cooking was more than warming up food. She perceived that while there are good pre-made options for meals, it also meant people who bought those foods were cooking less. She perceived homemade meals to be healthier as well:

Mrs. R: We took health classes in high school. And I knew the food groups. And what I was supposed to be eating. I don’t know whether they’re giving those anymore, but they ought to. Maybe we’d have few less fat kids. Seriously. Of course, I don’t think so, because people don’t cook anymore. And you know, we were talking about people who need food, and I know this, and I contribute to God’s Pantry and all these other things. But you know, when they used to give coupons, I don’t whether they still give them – are they giving food coupons to people and they’re using them to buy food?

LC: [Confirms that the program still exists]

Mrs. R: But anyway, I would follow someone through the line who gave those and I didn’t begrudge them that a bit. But their selection of the food they got indicated to me – because they could have gotten – do much more and better food if they had shopped differently. But they weren’t cooking. They were warming up. And I think that’s one of the problems with the microwave.

Her discussion here had tones of “class-ism,” as she specifically targeted low income, food stamp recipients as doing a poor job of food selection in their shopping. She, in a sense, blamed the food industry and technology also, for making it so easy to simply warm up food.

Other participants did not lament the lost art of cooking quite as strongly as did Mrs. Randall. About half of the other women simply heated up food for their meals eaten at home, whether it was a frozen meal or a can of soup. However, Mrs. Brown mentioned that she thought people raising families today were not well-practiced in the “art” of preparing a meal for a family: “Then with the children you definitely tried to make balanced meals and learned to cook in quantity and learned to time things so that everything came out at the same time and that’s an art. It’s an art – a lost art I’d venture.” Two women mentioned that their children and young people today also did not seem to entertain or throw parties like they used to do.
Over three-fourths of the women did not remember their parents doing much entertaining, outside of family get-togethers. Three of the women recalled that their church pastor coming for Sunday dinner about once a month. As children, sometimes whether the participants had friends over was a matter of family economics. Mrs. Adams noted that if her mother served pork chops for dinner, there were only so many to go around, and therefore friends would not be invited to dinner. But if it was leftover roast, then maybe she could have a friend over for dinner.

After they were on their own and had families of their own, for the most part, the women became more involved in preparing food for family gatherings, often hosting holiday celebrations themselves. Friends and neighbors would sometimes get together for dinner, or wives together for lunch. The women became involved in group and organization activities (e.g. PTA, church groups and functions, women’s groups and events), which provided opportunities to host luncheons, bring potluck to suppers, and participate in bake sales. Two of the women mentioned cooking for a group to which their husband belonged, such as the Masons. Four women talked about entertaining because of their husband’s career, a more obligatory type of entertaining for their husbands’ bosses, co-workers and business associates.

The participants’ later years had seen much less private entertaining, particularly after moving to Colonial Square. Mrs. Wilson no longer entertained, other than to have family, and one reason was limited space. If Mrs. Florsheim and her husband had visitors, they ate in the Dining Room or dined out. Mrs. Faust also liked to bring any guests to the Dining Room, as she thought it was nicer than eating out. However, she did have one problem with the current meal accounting system:

They used to let us – we’re invited out quite a bit to friends’ houses, so we don’t use our ticket for that meal. But we invite them to our house, and have them use our unused tickets. But you can’t do that anymore. We have to pay for a months’ worth of tickets, and it has to be us that uses it.

Mrs. Monroe reported a similar difficulty:

And we got tickets in the back [of the ticket book] each month, five extra ones for lunch only. And I used those for my bridge club once a month. I took them
to lunch. They loved it and I loved it. It let me pay back for all the things they do for me, you know. And that [the system change] was a big blow to me. Now they bring out a sandwich, and I make up some tuna fish, and something to eat.

Guests to the Dining Room were scanned as a guest meal to be charged to the resident; guests could not pay for themselves at the Dining Room. Also, any unused meals by residents resulted in a small refund, but they could not be used by anyone else, and there were no more bonus meals. These changes affected patterns of guest invitations and personal systems of reciprocity.

Family gatherings, of course, were still important. All but one of the women mentioned celebrating holidays and other special occasions with children and other family members, but had long relinquished the coordination of such gatherings to their daughters or daughter-in-laws. A couple of the women mentioned that they were not able to get to a family gathering due to physical difficulties. At Thanksgiving, Mrs. Stokes did not join her daughter, because she could not make it up the steps to her daughter’s house. Mrs. Provost’s back and legs kept her from making the two-hour drive to her family’s place. Both had their Thanksgiving dinner at Colonial Square.

Over the life course, women referred to social expressions of affection and compassion through food, such as gift giving and charitable work, mostly in donations to the food bank, though three women mentioned involvement with Meals on Wheels. All but one of the women talked about bringing food to someone in times of sickness or a death in the family, usually either a casserole or baked goods. Some participants mentioned aspects of bringing food to the sick or grieving had changed since moving to Colonial Square, in that they did so less often, partially because it was a fairly common occurrence at Colonial Square for someone to be ill or to know someone who had a death in the family. Mrs. Richardson stated that she did not bring food to a grieving person at Colonial Square, because the provision of food and meals at Colonial Square negated the helpful aspect of bringing food to a grieving person. Mrs. Richardson therefore expressed her sympathies by offering her companionship and prayers.

Not all the women threw themselves into and enjoyed feeding others to the creative extent of Mrs. Randall. For many, cooking was more a matter of obligation and doing what was expected of them. They saw it as part of their job description as a wife and then as a mother, the theme of this next section.
Dietary Duty: Fulfilling the Role of Wife and Mother

*I believe that the ability to prepare and serve good and attractive meals is a delightful feminine virtue.*

Vanderbilt (1961, p. viii), from *Amy Vanderbilt’s Complete Cookbook*

Figure 6.4: Mrs. Brown’s Recipe for Chili

<table>
<thead>
<tr>
<th>Chili</th>
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<tbody>
<tr>
<td>1 pound ground beef</td>
</tr>
<tr>
<td>1 medium onion chopped</td>
</tr>
<tr>
<td>1 can condensed tomato soup</td>
</tr>
<tr>
<td>Chili pepper</td>
</tr>
<tr>
<td>½ can water</td>
</tr>
<tr>
<td>1 large or 2 medium cans red kidney beans</td>
</tr>
<tr>
<td>Catsup</td>
</tr>
</tbody>
</table>

Brown beef and chopped onions. Season with chili pepper. Add tomato soup and water. When well mixed, add kidney beans – including liquid – add 2 or 3 dashes catsup – (add another ½ can water if needed).

Microwave’s the best thing. And the coffeemaker. And I haven’t even had the stove on except to heat the soup. I don’t think I’ve ever had the oven on. I would say about maybe a third of the people prefer to fix their own breakfast or a meal, and there are a few who love to do baking. Just bake every day. But I don’t – that’s one reason I came around here, so I wouldn’t have to cook. I’ve done my duty.

Mrs. Brown’s last sentence in this quote succinctly expressed her current philosophy regarding involvement in food preparation: “I’ve done my duty.” This philosophy did not develop overnight, but rather came about over time, and was a fitting conclusion regarding all her years of putting in her time in the kitchen. It reflected a view of cooking in which she did what had to be done, because it was expected of her in her role as a wife and a mother. She did not resent meeting the expectations of her role, nor did she consider that there could be any other way. That
was life, and as a wife and mother, she shopped, cooked and fed her family. She could do no less. She did not have to do more, however, and if the opportunity arose to do less, and it still allowed her to meet the demands of her role, then she gladly took it. For Mrs. Brown, preparing and serving meals was neither delightful nor a virtue. It was, however, definitely feminine.

Mrs. Brown was 90 years old, and widowed for three years. She moved to Colonial Square a year ago, which for her was “a logical thing to do,” as her sons were beginning to worry and she not only did not want to cook, she also did not want to do as much housekeeping. Cooking did not really become a part of Mrs. Brown’s life until she was married. She grew up in the South, the oldest of four children. Her experience in the kitchen was limited, as her mother “didn’t particularly let us help very often.” She remembered that around the age of 11 or 12, she started making an angel food cake every Saturday for the family to eat on Sunday. As far as learning to cook, she conjectured: “But my mother was an excellent cook and I guess I just picked up a lot of things just from watching her – never did a lot of it at home.” She recalled that her mother served well-balanced meals, always having a meat, potatoes, a green vegetable, salad, and, of course, a dessert.

After graduating from high school, Mrs. Brown enrolled in a nearby university. This was during the Depression, however, and after her third year, she could no longer afford to attend college. She left, and worked for a few years before getting married and becoming a full-time homemaker. She really learned to cook when she became married, now that it was her responsibility as a wife, and soon as a mother. She thought there was some difference in cooking when a couple was first married and when they began to add children to the family: “I think you take a little more care with what you did and maybe had slightly more elaborate recipes. Then with the children you definitely tried to make balanced meals and learned to cook in quantity…”

As Mrs. Brown’s family grew, eventually four sons rounded out the household. By then, cooking for her family had “just become such a matter of habit.” Chili was a meal that was quick and easy to prepare, rather a mainstay for her family, and something her children all liked. It made a regular appearance at the dinner table, showing up, in Mrs. Brown’s estimate, about twice a month. She generally tended toward the quick and easy when it to came to food preparation: “When I was working and the kids were growing up … after that I did anything that was easy. It’s amazing how many things developed in the food field that you could do real quickly
too.” Appreciative of box mixes and canned foods, she took advantage of changes in the food industry that kept her from having to prepare foods from scratch. She wished that technology had developed a little sooner though: “The crock pot and the microwave came along just as everybody left, and I said, if we’d only had those when the kids were all here, it’d been much easier.”

Mrs. Brown continued to prepare the same type of meals that her mother had prepared, serving well-balanced dinners of meat, potatoes, vegetables, salads and desserts (“A meal’s not a meal without dessert.”). Peanut butter was a staple for the boys, and for one in particular. She recalled that one son lived for two years on raisin bread, peanut butter and milk, with the occasional hamburger. This did not bother Mrs. Brown though: “I was glad that he’d eat that … I figured he was getting plenty to eat. By that time I was on the theory that they’ll get by.” She performed other food-related duties, obligingly participating in PTA bake sales and contributing to church cookbooks. Mrs. Brown returned to work after her youngest son started school, which also fueled her desire for quick and easy meal preparation. Being creative was not a priority. During these years, the Browns only occasionally entertained, because Mrs. Brown was too busy to do much entertaining. They occasionally ate out; they also belonged to a country club, where they ate about once a week or so.

As her children began to one by one leave home, she further altered her attitude towards her cooking responsibilities:

And then, of course as they gradually went away, well, and then I went to work too, why, I started doing the easiest things, sort of quick things. I think that really the time that I began to loose my grip, or whatever you want to call it – became more disinterested – was when the two younger boys were both in college and I’d fixed dinner as usual and one of them said, “I’ve got a meeting and I can’t stay,” and the other said, “Well, I promised somebody I was going to do such and such.” So I said, “No more cooking for you all.” If they were going to be there, we’d work something out. But be sure they ate a good substantial lunch at school. Not from the vending machine, but an actual lunch. I’d have things on hand if they wanted
to have something, but they were active in so many things and they were gone a lot.

Although her younger sons were still living at home, their schedules and activities were such that there was no need for her to put the effort into preparing something for them, and it was easier and more efficient for her to keep foods on hand rather than prepare full meals for them.

Eventually all her sons left home, and it she and Mr. Brown were living alone. She felt that things fell into more of a normal routine with regard to meals. A period of additional change occurred, when they ate out more often: “For a while there, just shortly after they were gone and while we were both still were working and then when I first retired, because I retired before Al, we ate out some. As my husband said, I could make three meals out of what I brought home in a doggie bag. Really we did use those a lot.” They also began to eat a lot of soups. But there was a reason it was only for a while that they ate out: “After Mr. Brown’s health started to decline, we stayed home more. It was good, just more a matter of a routine type meal. Can’t even remember what all we had. I still fixed the chili though – he liked the chili.” After Mr. Brown died, she consciously thought about her eating practices:

Well, the one thing I did try to do – because I had told so many other people that you must do it – was to eat three even fairly light meals a day. See, now I’ve changed it since I now only eat two. But I always felt that was an important thing to do. I mean light ones, I would say. And not stand over the sink and eat a cracker with peanut butter on it, but to sit down …

Although she only ate two meals a day at Colonial Square, she made sure she was ready in time each morning to have a substantial meal at the continental breakfast served in the Dining Room, and then had either lunch or dinner in the Dining Room. She stocked little food in her apartment, and her typical supply consisted mainly of soups, crackers, cheeses, bread, butter and carrots, with milk, juice, coffee, tea and hot chocolate for beverages. Regarding her typical food reserve, she said:

Well, I just keep some so in case I – if I think I’m going to eat a scant dinner, then I have some to fix for lunch, and if I eat the lunch, then I’ll simply have maybe just
a soup and crackers or something. I really find that just breakfast and either lunch
or dinner is sufficient.

As remarked earlier, she greatly appreciated her microwave and coffeemaker, but used her
stove only to heat pre-made soup. She had little cookware, and gave away all of her cookbooks,
because she had no need, and no desire, to cook anymore. She seemed satisfied with her food
options in the Dining Room; her only critique was that the selection of vegetables was sometimes
not to her liking.

Mrs. Brown observed that her responsibilities as a wife and mother were common, at
least in her family: “I think we all of us assumed about the same responsibilities. Those were
years when you did. Even if you worked outside the home, you were the one responsible for the
home.” As far as her food-related responsibilities, she did not particular enjoy them, but they
never posed much of a problem for her. She did not mind cooking, “it was just one of those things
you do.” Since she did her tour of duty in the kitchen, however, she was content to let someone
else take charge.

It was no revelation that the women of this study were expected to do the cooking and
other food work of their household because of their female gender. Ms. Carr was young when her
mother died, and after, as the only other female in the family, she assumed her mother’s domestic
responsibilities:

It was really – I mean, I don’t mean that it was cruel, but the woman of the family
was expected to do the cooking and house-like duties and it didn’t matter how
old or young the girl was. I was only 13, not quite 14, when Mother died. And I
assumed the responsibility, almost seemed to believe it was an honor.

Ms. Carr’s case was unusual among the group, as the only one who experienced the death
of a mother at a young age and subsequent assuming of the family’s domestic duties, but she
illustrated the role of “head female of a household.” The women accepted their responsibilities,
and in turn did not expect that men would assist them or be involved in food chores. Regarding
her first husband’s involvement in food preparation, Mrs. Provost remarked, “He had such long
hours and I never expected him to [help with meals]. I thought that was my range.”
For half of the women, their cooking careers could be characterized like Mrs. Brown’s – one in which they merely did their duty as the woman of the house. They had no particular interest in cooking, as communicated so clearly by Mrs. Adams: “I’m not a – someone who just really loves to cook. To me, cooking’s [a] means to an end.” Overall, a number of the women had surprisingly few responsibilities in the kitchen as girls, despite future expectations that they would be running their own kitchens one day, among other domestic chores. Several explained simply that their mothers did not have them help much in the kitchen. Many of them recalled providing minimal assistance, such as setting the table, washing dishes, and sometimes chopping food or stirring pots. Some women, similar to Mrs. Brown, would bake cakes, pies or biscuits. Birth order was used in various ways to explain why they did not help much in the kitchen. Some explained that as the oldest, they were too busy helping to take care of the younger ones to help in the kitchen. Others explained that as the youngest, their older sister got the benefit of helping their mother in the kitchen. More than a few admitted that as young girls, they were not that interested in cooking anyway. Some never really became that interested as they matured and left their parents home, beyond what they felt they had to do for their families and the obligatory social functions that involved food.

As a result of their inexperience in food preparation during childhood, two-thirds of them really learned how to cook when they married, just as Mrs. Brown did. Mrs. Jergens only knew how to make salads; as a girl, that was her contribution to family meals. As it was for others, cooking on her own was somewhat trial and error: “And I ruined one meal … I didn’t have anything that was worth eating. We just sat there and laughed. Nothing, nothing was any good.” Roughly a third of the women mentioned getting a cookbook, such as the *Joy of Cooking* or *Better Homes and Gardens*, from which they learned. Mrs. Randall learned to cook meats from the butcher at the market she went to after she first got married. Three women avoided cooking for six months to several years, because they were living with in-laws or parents. Only Mrs. Stokes seemed to mind this, as she did not like her father-in-law’s cooking. All in all, the ones who learned to cook as they began to set up house were fairly resourceful in how they learned to cook. They essentially did what needed to be done to feed their families, and what was expected of them when there was obligatory cooking as for a potluck or bake sale.
As children grew up and left home, cooking often became less of a priority. A couple women spoke of eating out more, as Mrs. Brown and her husband did. Mrs. Richardson and her husband ate out most of the time after they retired. Regarding the move to Colonial Square, Mrs. Brown was not alone in her current view of cooking; quite a few of the women appreciated that they no longer had to cook much:

I still fix breakfast and we eat a good breakfast usually. And then I fix lunch. And if I feel like cooking, I make something that, you know, requires a little doing … Now, I do enough cooking just, you know, being in the kitchen that I don’t miss [it] – and every afternoon at about four-thirty or five o’clock, I think, oh, isn’t wonderful not to have to think about dinner. (Mrs. Nichols)

You’ll be sitting at a table and everybody’s just fussing about the food, and I’ll think, I didn’t have to cook it and I don’t have to wash the dishes. Enjoy it. (Mrs. Richardson)

I would have to work all day and then come home at night and fix three or four dinners. And the joy of cooking sort of left, and it got to be kind of a chore. So I’m very happy here that we can go downstairs and eat. (Ms. Carr)

One participant found an additional reason to exult in her freedom from cooking for her family:

Mrs. Faust: Phil loves fish. In fact, that’s one of my joys out here. He used to want fish all the time, and I didn’t – wasn’t – well, I don’t care a whole lot for fishy fish …

LC: So an advantage for you of living here then is that he can eat what he wants and …

Mrs. Faust: He can eat whatever he wants, and I can eat whatever I want. And that really is a joy.

As a married woman, Mrs. Faust was now able to eat only the foods she liked, avoiding the foods she did not but that her husband preferred. Some of the unmarried women also appreciated being relieved of some of their cooking duties, because they did not like cooking for one. Ms. Carr, for
example, upon retirement began to pull away from cooking: “It became more and more, easier let’s say, more and more often to go out and get something to eat than for me to go out and buy the groceries and come home and cook for one.” It seemed that changing family and work roles played a large part in the women’s dietary experiences.

Summary

The important overall point of this chapter is that the dietary approaches of the women and their resulting dietary behavior are better understood in terms of their life course experiences. For example, food moralities may be developed at young ages, and carried throughout life. They may also be developed later in life, in response to aging and health changes. The extent to which nutrition is an integral aspect of dietary behavior might be influenced by the extent to which it matters to family members, because of a health crisis or a lifestyle choice, for instance.

Of the four themes, dietary duty was the predominant theme, characterizing about half of the women, as they had performed according to their role requirements, but it was a responsibility that they easily relinquished. All 18 of the women had a sense at some base level that shopping for and preparing food for their husbands, children and/or other family members was their duty, but there were some for whom food and eating was more socially oriented, some for whom cooking and eating were important regarding health and wellness, and a couple for whom food preparation (and consumption) was regulated by moral imperatives. The women who exemplified each of the four approaches represented somewhat of an extreme of the particular theme. Yet these themes were found running in and out of each of the women’s stories of their lives in various manifestations, degrees of strength, and at various times. Mrs. Vossler’s experience could be described as dietary duty until she moved to Colonial Square; this residential transition resulted in a change, where her experience was more a combination of dietary wellness (now that she was close to her vegetarian daughter) and a variation on the theme of dietary sociability (cooking and eating with others). Mrs. Burkholt’s experience was much more stable, with little variation in her preferences and practices over her lifetime, and she truly seemed to fall into a dietary version of the saying “The more things change, the more they stay the same.”
Early life experiences, relationships, work and family roles and transitions in roles, residence and health seemed to have influenced the dietary experiences and behavior of the women in this study. It also influenced the meaning associated with food and eating practices, which was reflected in their various approaches to food and eating. These findings, along with the findings of Chapter Five regarding the various levels of social influence, are discussed in the next chapter.
Chapter Seven
Discussion and Conclusions

Levy (1981) advocated using personal narratives as a key to understanding consumer behavior, and contended that marketing research needed to uncover the meaning and significance of foods, rather than simply survey people about product attributes. He suggested (Levy, 1981, p. 97, 106):

One way to interpret consumer behavior is to consider consumer protocol (remarks made by people about their attitudes and behavior and those of others) as a kind of story to be interpreted, not so much for the facts of consumption, but for an understanding of why a consumer tells a particular tale and what it reveals beyond its literal meaning.

Through the narrative, we see the organization of the behavior, its justifications, and something of the processes by which sheer sensation is made so strangely human.

Similarly, through the narratives of the older women who participated in this study, one can see the organization of dietary behavior, its justifications, its processes and its significance beyond actions themselves. The narratives in particular illustrated the influence of life course factors in developing and modifying the participants’ dietary behaviors, and the importance of social situations as past and present influences on dietary practices. Intrapersonal processes, such as beliefs and attitudes, were relevant, but social experiences interacted with and affected intrapersonal processes over the lifetime to form current dietary practices. This chapter discusses interpretations of the findings in Chapters Five and Six, situates the findings in previous literature, and presents a theoretical model based on the findings, using a life course perspective and integrating elements of symbolic interactionism.

Social Influences on Dietary Behavior: Development and Maintenance Throughout Life

One of the goals of this research was to explore how social milieu affected the development and maintenance of dietary behaviors of older women over their life course. Most
of the women perceived social experiences, especially family life, as highly influential on dietary behavior, and this influence spanned from early in the life course through later years. References to upbringing, parents, other significant family members (e.g. grandparents), and the types of foods and meals served in their childhood were common, and regarded as the basis of current preferences and practices (even if such behaviors represented a rejection of childhood experiences). Participants recalled eating as children the same food that their parents or grandparents ate, with little choice in what they consumed. They were socialized in various ways; for example, Mrs. Provost’s affinity for good Southern cooking was a result of her upbringing and developed as an aspect of her regional and cultural identity. The women were most strongly socialized in the well-balanced meal concept and the serving of meat, potatoes and vegetables for a main meal.

This lifelong preference for a meat-potatoes-vegetables main meal is a prime example of the influence of early life experiences. This was usually the type of main meal served to them as children, that they served to their families (often with the addition of salads), and that they now expected to have in old age. Notions of what constitutes a proper meal expanded for the participants, but the meat, potatoes and vegetables meal was still the preferred proper meal, with contemporary versions of main meals gaining in acceptance, but not fully incorporated into the diet. More contemporary types of meals and foods, such as sandwich wraps, were just not in their repertoire of preferred foods. This meal type preference illustrates a distinct period effect, as the meat-potatoes-vegetables meal option pervaded American society as the ideal of a balanced diet. Because the meat-potatoes-vegetables main meal was considered to be a well-balanced meal, it was therefore nutritionally sound. Nutritional concepts learned earlier in life frequently provided the foundation for ideas about nutrition for most of their life, with a few exceptions. Mrs. Ford believed that her training in nutrition in college, particularly using the food groups, to prepare well-balanced meals had been the biggest influence on the way she ate. Others cited the well-balanced meal concept as the basis of their nutrition concepts, learned from parents and health classes in high school and college.

A number of women reported trying to keep up, at least somewhat, with changing dietary recommendations. The addition of salads to the main meal perhaps reflected the increasing emphasis of dietary recommendations on food groups (and number of fruit and vegetable
servings) that began when they were young wives (Davis & Saltos, 1999). However, the nutritional skepticism exhibited by the elders in McKie et al.’s (2000) research was also found among the participants of this study, as several of these women questioned the reliability of nutrition information and contrasted nutrition advice with conflicting personal experiences. The fact that recommendations did change, combined with evidence to the contrary (e.g. someone they knew who had regularly consumed fatty meat and had a long life), caused several of the women to mainly trust the one premise that they had always known, that seemed to remain constant among the various versions of dietary recommendations, and that had essentially become habit to them: the well-balanced meal of meat, potatoes and vegetables. Additionally, these women were already in middle age when the media and public really made nutritional science a topic of lay conversation. Several women noted that no one discussed issues of cholesterol, fats and sodium when they were younger. This clearly demonstrates a cohort development added onto period effects.

The influence of early life can also be seen in their approaches to food and eating. For example, a few of the women had developed a dietary morality regarding wasting resources, particularly food, at a young age, socialized into this orientation by their parents and influenced by the events of the Depression. This moral imperative was an underlying principle regarding their food consumption all throughout life, affecting both their actions and feelings toward food and waste even now. However, this moral principle was not considered to have been always passed on to children, and in some cases, the women purposely did not emphasize the food waste rule to their children, believing that it was better for children to not be forced to eat food, but only try food. This could partially be the result of post-World War II affluence, when many of the women were raising children, and when abundance in resources did not necessitate the conservation efforts required of families during and before the war. Therefore, ultimately economic forces could have altered the transmission and socialization of this particular food morality to the next generation. Moral meanings of food and eating are further discussed below.

Findings such as these are consistent with the findings of Devine et al. (1998) study of fruit and vegetable trajectories. The lasting “food roots” from early life experiences and food upbringing as a key influence were two of their findings that accurately describe social influences uncovered in this research. Additionally, Lupton (1996) had contended that childhood
patterns of dietary preferences and practices never completely disappear, based on her research and her assessment of others’ research. The findings of this research also appear to support the contentions of some researchers regarding the importance of childhood as a critical period for the development of health behaviors. Although parents were predominant influences, other family members such as grandparents were recalled as influences also, indicating that a focus in research on parents alone might be misleading or at least incomplete. Socialization processes seemed to occur in childhood for the participants, and parents and family in a sense modeled dietary behavior, although a lack of choices regarding food perhaps indicates more of a social control mechanism. Clearly, the social relations that are connected with food early in life were influential.

Social Relationships and Interaction

Family relationships in childhood were apparently quite important as influences on the development and maintenance of dietary behavior. Relationships with spouses and children also played a role in the women’s evolving dietary behavior. Food preferences of husbands and children to some degree influenced what the women ate when they were raising their families. In the women’s later years, adult children became a source of nutritional information for some, whether offering advice on how to eat, or introducing them to vitamin and mineral supplement use. Adult children could also be an influence on food consumption; Mrs. Vossler, for example, had come to appreciate meatless meals because of her vegetarian daughter. However, she continued to consume her well-balanced meals when eating in the Dining Room with other residents. This suggests that dietary practices might be adapted depending on the relationship with the mealtime companion and/or on the social situation. Mrs. Vossler had additionally mentioned that her husband never would have tolerated a meatless meal. Social support of husbands regarding dietary practices might have also played a role. This is further illustrated in the mutually supportive relationship of Mrs. and Mr. Wilson, and how they have stayed with the dietary changes they made after his heart surgery.

Interactions with health professionals have influenced practices for some, most notably in terms of vitamin and mineral supplementation. Health professionals have recommended a few alternative dietary treatments for illness, such as green tea or cranberry juice. This possibly
suggests that social support from doctors and other health professionals could have positive effects on the practices of older adults, although this could alternatively represent a cohort effect, whereby the perceived authority of doctors and health professionals is deferred to by this generation of women.

Relationships with other older women and residents were another source of nutritional information, but social interaction with friends and other residents were also an important part of dietary experiences for the participants. The Dining Room afforded opportunities for mealtime companionship at least once a day. Social arrangements related to dining at Colonial Square reflected a loose social organization of these relationships, as some women joined certain companions or groups in the Dining Room, and others avoided attaching themselves to groups. A few women mentioned that there were residents who they particularly avoided sitting with at mealtimes, generally because the resident was perceived as being a negative person.

Although the details of the social organizational aspects of retirement community life that Keith Ross (1977) had observed in France were different from what was reported and observed at Colonial Square, the Dining Room at Colonial Square was the main arena for public contact among residents, and a central place for meeting other residents, as it was at Les Floralies. However, residents at Colonial Square did not all dine at the same exact time as they did at the noon meal at Les Floralies, and so social integration (or lack of integration) was not quite the public display that it was at Les Floralies.

Mrs. Randall exemplified how social relationships were an important motivation behind the development and use of her culinary talents, shaping her social orientation toward cooking and food preparation. But her cooking also was an aspect of her social roles, whether she was an army officer’s wife or a church cook. Social relationships generally entailed associated social roles, which also emerged as significant influence on dietary practices.

Social Roles and Statuses

In their role as parent, some women acknowledged attempting to positively influence their children’s eating, and to teach them to eat “good” (healthy) foods, through modeling healthy eating and socializing children in principles of nutrition and balance. For the participants of this study, this often meant relying on the well-balanced meal, but for Mrs. Ford, for example, it
meant actively teaching principles of nutrition and use of the food groups. This supports Lupton’s (2000) findings, in which parents saw themselves as responsible for their children having a healthy diet. Mrs. Wilson still tried to emphasize healthy eating to her grown children, and even grandchildren, but for a few, roles in this sense have reversed, as the adult children, particularly daughters, are conveying nutritional advice to their parents, and watching after the health of their parents, sometimes by monitoring how they are eating.

Gender effects on practices were detected among the participants, particularly in terms of social and family roles. The women of this study generally had traditional roles as wives and mothers, and even Ms. Carr, who never married, took over homemaking duties after her mother passed away. Food preparation was a central obligation in the role of wife and/or mother (or head female). Husbands’ occupations sometimes added the responsibility of hostess to their job description as wife, as occasionally their spouses’ careers required at-home entertaining of colleagues and business associates. Husbands’ social activities, such as membership in a men’s lodge, might have involved their wives in food work and hostessing for their groups. Similarly, children’s activities, at school and/or extracurricular, might have involved them with PTAs, scouting or fundraisers and associated food work.

A number of the women learned to cook when they married, in order to fulfill role expectations as a wife. The women who began their cooking careers in the theme of dietary duty generally carried that view of food preparation with them across their life course, and disclosed the salience of their family role as it related to food activities of their household, as well as the obligatory nature of the performance of such activities. In this view, cooking was necessary because it was a role expectation of the mother, wife or female head of the home, and while it was not to be resented, it also was not an activity that they reveled in; it was considered a fact of life. When duty demands lessened, however, the women acted accordingly, lessening their efforts. The relief of that duty for many of these women brought about a new freedom, not only from the chores, but also from having to put their preferences and wants on the “backburner.” The duty to cook at Colonial Square was minimal, and the duty-oriented women easily adjusted, happily turning the duty over to someone else.

Marital status continued to play a part in dietary practices during the participants’ residence at Colonial Square. The married women, though demands lessened due to the use
of the Dining Room, continued to fill remaining food roles of the family. They attended to the
other meals, and even when their husbands helped themselves in the kitchen, the married women
made sure that their husbands had foods that could be heated up, dished out or easily assembled.
The men did not completely take over even non-main meal preparation. Food shopping was still
generally in the women’s domain, although Mrs. Florshiem’s husband was the one exception, for
whom shopping became an activity, something for him to do after he retired. He illustrated a
possible reason why older retired men might become more involved in food purchasing, a finding
by Schafer and Schafer (1989), who had thought it was perhaps because the men had more time.
In this case, Mr. Florsheim had more time, but his wife turned over the responsibility so that
he would have something productive to do with his time. It was not just having time; it was the
meaning of what they did with their time. Additionally, Mrs. Faust articulated the idea that it was
better if she did such things as shopping anyway, because she was better at it, a justification that
has been found in the literature (Brown & Miller, 2001).

The widowed and single women were most minimally involved in food-related activities,
with the exception of Mrs. Donovan, for whom baking was a hobby and leisure activity initiated
in an attempt to fill the time that used to be consumed with caring for her husband before
his death. Generally, the widows mirrored much of what was found in the literature about
widowhood and dietary practices regarding the use of convenience foods and the lost meaning of
cooking (Shahar et al., 2001; Sidenvall et al., 2000; Valentine, 1999).

The women did have the appearance of having a gatekeeper role in their families
regarding food and eating as described by Lewin (1943), although it seemed to be somewhat of
a false appearance, as put forth by McIntosh and Zey (1998). About a third of the women were
homemakers and therefore were completely economically dependent on their husbands – a few
even spoke of having a food allowance or budget when they were in their early years of marriage.
Additionally, many women did want to please and accommodate their families, and showed some
deerence to their husbands’ tastes, but also a good bit of deference to their children’s expressed
preferences. However, for some this accommodation needed to have its rewards, and when cost
outweighed benefit for women such as Mrs. Brown, the effort put into food activities decreased.
The gatekeeper role is not an accurate description for the married women in their residence at
Colonial Square, as the food services department in a sense becomes the gatekeeper for main meals.

Learning to cook for such women came about because of a life course transition, becoming married, and demands generally lessened in response to life course transitions, such as child launching. Transitions from married to widowed also affected dietary practices. Life course transitions and such consequent effects on dietary patterns were additionally identified in this research.

Life Course Transitions: Modification of Dietary Behavior

A second aim of this research was to examine if and how life course transitions potentially modified dietary behavior. Several transitions appeared to alter dietary practices. Family life course transitions were important initiators of change. Marriage, for example, was the catalyst for some to learn how to cook. Although somewhat surprising that they were not socialized in actual cooking practices before then, this transition clearly had implications for their dietary behavior, thrusting them into a role that required them to be responsible for food duties that they had not previously had. Learning to cook, and sometimes shop, were two changes that accompanied marriage. Because their husbands also enjoyed meals of meat, potatoes and vegetables, cooking was not perceived generally as problematic, and few dietary differences were recalled.

The addition of children introduced a resolve to teach proper eating behavior, as discussed above, and shifts in how and how much they cooked. The launching of children meant reduced quantities of food to prepare, and an overall reduction in food preparation demands. The loss of a spouse or co-resident family members (as in the case of Ms. Carr) resulted in a number of changes, and was a significant transition. Eating alone was a difficult adjustment, and one that was eased by eating in the Dining Room of Colonial Square.

For many of the participants, health-related transitions influenced their dietary practices. For some women, health-related changes might be rather subtle, and therefore not recognized necessarily as having much of an impact on dietary behavior, such as taking calcium supplements to treat (or prevent) osteoporosis. At least four women reported that changes in health shaped dietary behavior, though the health transition could be a family member’s – it did
not have to be the woman herself who experienced a change in health. The change in the health of Mrs. Wilson’s husband obviously had a large impact on both his and her dietary trajectories, changing the theme of her dietary life course into one of dietary wellness, in which healthy eating became a lifestyle and nutrition became a hobby. Mrs. Stokes and Ms. Carr’s diagnosis of diabetes created a new dietary morality theme in their lives, where rules about good and bad foods became prominent.

The transformation of Mrs. Wilson’s and her husband’s diets demonstrated how life course transitions in the lives of significant others, most particularly family members, have the potential to result in alterations in behavior and approaches to food and eating. The occupational transition early in Mrs. Randall’s husband’s career began the evolution of Mrs. Randall from a country tomboy into the ultimate social hostess, who turned serving food to others into an art form. Subsequent career and residential transitions influenced the incorporation of regional foods and ways of cooking into Mrs. Randall’s and her families’ foodways. Changes in a husband’s occupational trajectory variously affected the women who had been or were currently married. A husband’s retirement resulted in a residential transition for a few of the women, either seasonal or permanent; for example, Mrs. Stokes and Mrs. Ford relocated to Florida, where they incorporated citrus and other Florida produce into their diets, and Mrs. Richardson moved to a southern Atlantic coastal town, which resulted in the incorporation of seafood into her diet.

The experiences of the women in this research are similar to those of the older adults of Quandt et al.’s (1997) study, in that they also perceived various processes that affected their current eating patterns, such as changes in work patterns, family life, health and health awareness. Food had social meanings that related to gender and family roles for the respondents of Quandt et al.’s study, and life course changes in these roles brought about changes in meal patterns (e.g. the loss of a spouse, followed by fewer cooked meals), and in the social meanings of food and meals. This was confirmed in this research as well, with the women acknowledging changes in behavior and in social meaning associated with life changes.

Devine et al.’s (1998) results suggested that life course transitions are times when food choice systems may undergo change, and illustrated the importance of role transitions and social status, especially familial. Role and family transitions, such as childbearing, marriage, divorce, employment, empty nest and return nesters, affected fruit and vegetable trajectories in their
study. Similarly, the findings of this study indicated that family and occupational life course transitions affected dietary behavior, but residential transitions as an influence emerged from this research as well.

The dietary experiences of the participants during their residence at Colonial Square demonstrated that a residential transition to a retirement community, particularly one where dining services were available, had an effect, albeit in different ways, on the food- and eating-related experiences of the women, and their current dietary behavior. The findings suggest that the ways in which the transition and the new social and environmental context affected the women depended on the previous life experiences of the women, and then their particular experiences in that environment.

The Retirement Community: Shaping Current Dietary Behavior

The third aim of this research was to explore the influence of the retirement community environment in shaping dietary behavior. This study demonstrated that relocation to Colonial Square certainly and variously impacted the participants’ dietary practices and experiences. The residential transition modified approaches to food; for example, Mrs. Vossler became much more socially engaged after her move to Colonial Square, and this was reflected in her dietary experiences, as she emphasized dietary duty much less, and dietary wellness and sociability much more. Meals and food-related responsibilities, such as grocery shopping, became social occasions for Mrs. Vossler, and her daughter’s vegetarianism influenced her new nutritional awareness. Additionally, as mentioned, social opportunities and social relationships at Colonial Square influenced the social aspects of meal times.

A focus on living alone versus not living alone, which some studies have used (e.g. McIntosh and Shifflett, 1989), would be too narrow to apply to the women of this study. Although some of them live alone, they still dine with others at least once a day, and have social interaction and relations with others (e.g. family members, health professionals) that have influenced them. Living alone might have fostered more reliance on convenience and frozen foods than if they lived with someone, but the community environment and their social network constitute a broader context that is important to take into account when examining the effects of living arrangements on dietary behavior of these older women. It also could be that gender made
a difference, as Horwath (1989) contended, who also found that living alone did not adversely affect the diets of women. The findings regarding older women who live alone in this study additionally support the conclusions of research such as Schlettwein and Barclay’s (1995).

How Colonial Square affected the participants’ dietary practices could be considered in terms of how the community both liberated and constrained their dietary actions. In some ways, the structural characteristics of the community created new freedoms, or liberations for the women, but in other ways, created constraints that they had not previously known.

**Structural Characteristics: Liberations**

Several structural factors of the Colonial Square environment produced new liberations (or opportunities) for many of the women. These freedoms and enhancements included: freedom from food-related responsibilities and catering to family members’ preferences, food security, social interaction opportunities, and easier entertaining. All of the women cooked much less than they had before moving to Colonial Square, if they cooked at all. For some of the women, the Dining Room and meal service provided a new freedom from the chores of planning meals, cooking meals and cleaning up from meals. Those women whose lives were characterized by dietary duty found this especially liberating, because, just as Mrs. Brown stated, they had done their duty. They were no longer in a role that prescribed they coordinate meal preparation, and seemed to rather easily put as little effort as possible into the preparation of non-main meals. This also gave them more time to enjoy activities they really liked, more than cooking and baking, and/or released them from duties that became more physically difficult to do. The women who were still married discovered another new freedom related the freedom from cooking – the freedom from having to cater to the food preferences of family members. Mrs. Faust expressed this sentiment when she related her joy in not having to prepare fish for her husband any more. They could both eat whatever they wanted to eat at Colonial Square.

The liberation related to food security is more in the sense of a freedom from worry and fear. Food security in terms of having enough food is not the issue per se, but rather in terms of the ability to prepare food for oneself and others. Mrs. Vossler, for example, enjoyed the fact that a prepared meal was available whenever she needed it, and all she had to do was walk downstairs. A couple of the married women took comfort in food security for their husbands, for whom a
lack of skills, inclination or physical strength would render them less able to prepare meals if their wives were not able to do so for them. For these women, the Dining Room was an insurance policy, guaranteeing that their husbands’ dietary needs would be taken care of, should anything happen to them and their ability to perform their wifely duties. The dining services, combined with other services such as housekeeping, gave them some peace of mind about the care of their husbands, in terms of some instrumental activities of daily living.

For many of the women, the enhanced opportunities for social interaction were a very positive aspect of living at Colonial Square. Social activities involving food (the majority of activities) provided social interaction. However, eating in the Dining Room was an important and main mechanism for social interaction for the women, and particularly for the widowed and single participants. The Dining Room was a place to not just have a meal, but to share a meal. They enjoyed the companionship of others at mealtimes. Residents visited with one another and caught up on daily happenings in other residents’ lives and in the community. Current events might be discussed, but past history was just as likely to be discussed, thus reaffirming stories from the past, and keeping memories alive. Cohort experiences might have also provided a sense of connection with others who could appreciate what it was like, for example, during World War II. In any case, the simple act of being with others (whose company they enjoyed) at meals was important and illustrated an important social function of mealtimes for many women. Another social function of meals was being able to continue to practice the civilities associated with a meal. For some residents, this meant, for example, sitting down at a table and having a “proper” meal, instead of standing over the sink or in front of the television, eating cheese and crackers. In the Dining Room, residents dressed nicely, sat down with their companions, and ate a proper meal, even if this was not done for the other meals.

Having an easily accessible place to eat such as the Dining Room additionally made entertaining easier for the women, even if it was only family that visited. Food and meals were an important aspect of entertaining guests. Residents of Colonial Square could bring their guests to the Dining Room to fulfill this entertaining “obligation,” instead of preparing meals and food at their home. Additionally, a couple of women had taken advantage of the private dining room for family functions. In this way, even for those for whom food preparation was difficult, they felt that they were able to continue to be hospitable to guests. It also met the needs of some
for reciprocity purposes. By taking visitors to the Dining Room, some women were able to reciprocate for what others did for them. Mrs. Provost’s fictive daughter shopped and ran errands for her. She took her to lunch often when she came to visit; Mrs. Provost considered it a nice treat to take her to the Dining Room and buy her lunch.

Structural Characteristics: Constraints

In some ways, structural characteristics put constraints on entertaining and reciprocity. Structural factors of life at Colonial Square also constrained the participants in terms of: a lack control over when and what they would eat, getting to meals, and social pressure (e.g. peer pressure to follow group norms or as paternalistic concern). As for entertaining, there really was not enough physical space inside the apartments to have many people over at one time, although this seemed to be a more minor issue, as many of the women appeared to prefer not to put the effort into entertaining that they perhaps once had. Social reciprocity was not as easy to fulfill with dining services as it had been in the past, because of changes in the accounting system. The change to an electronic system and stricter enforcement of meal allocations meant that a few women were less likely to bring guests because they could no longer give away unused meals or extra lunch tickets.

A lack of a certain amount of control regarding dietary practices was another constraint resulting from features of the system at Colonial Square, and could be manifested in different ways for different women. To some extent the Dining Room hours and consideration of the perceived needs of the young men and women who worked in the Dining Room determined when the women dined. A continuous seating system as described by Nickels (2000) would alleviate the schedule constraints felt by some of the participants. What they ate was limited to what was offered and served in the Dining Room. For some women, this could create difficulties in terms of nutritional and medication management, personal preference, and personal control. A lack of control over items served could be problematic for someone like Mrs. Adams, who had to monitor her vitamin K intake, due to an anticoagulant medication she took. She was unable to control how many items high in vitamin K were served, and had difficulty determining how much of an item was served to her. Mrs. Wilson and Mrs. Richardson both preferred more green and leafy vegetables as menu items, for nutritional reasons.
Personal preferences played a role for Mrs. Ford, who finds the food preparation and options at Colonial Square to be different from what she is used to. This is likely due at least in part to regional differences in food preparation, and her taste for Northeastern styles of foods and food preparation. Actual item choices were limited, but more food than was normally consumed at home for a main meal was available. Having four courses, breads and tempting desserts tested the willpower of several women, and a few gained weight. Because they could not control the amount and types of foods available to them, they tried to learn to better control their impulses, with varying degrees of success. Changes in quantities of food consumed for some and types of foods for others contradict findings such as Cluskey (2001b), whose survey of retirement community residents resulted in the finding that food intake had not changed as a result of living in the community. The types of questions asked and the survey method itself perhaps was inadequate to uncover changes in food consumption in Cluskey’s study.

For older women such as Mrs. Stokes, the physical design of the building was a constraint in the sense that her long walk to the Dining Room required she left her apartment with enough time to make her journey, because of all the rest breaks she took along the way. This also meant that she did not venture to main public areas of the building often, as it was too tiring to go back several times a day. Physical design could be an issue even for those not as far from the Dining Room, as physical capacity and disability could make even short trips tiring. It seemed that in some ways living in such a retirement community offered less flexibility in accommodation of physical changes and lowering activities of daily living (ADLS) and instrumental activities of daily living (IADLS) with age as they influence dietary behaviors. This is one element for which living in an independent home in the larger community may be somewhat advantageous for an older person.

Social pressures put some level of constraint on the women. Pressure to conform to the dress code, although viewed by many of the women as appropriate, caused the need to account for a lack of close adherence to the code. Mrs. Michaels offered her age and the physical difficulty of dressing as a justification for her leniency when it came to the dress code. Pressure from other residents regarding dietary behavior can also be perceived as intrusive. Ms. Carr expressed her perturbation with residents who found it their business to keep a watchful eye on her dietary practices, noting that she did not tell others what to eat or not eat. Her health
conditions apparently prompted some residents to paternalistically monitor Ms. Carr’s eating patterns. Although it did not necessarily mean Ms. Carr felt pressured to eat in a certain way, it could have added stress to an already stressful circumstance for her.

Further Considerations

As far as intrapersonal factors affecting dietary-related actions of the women are concerned, psychological processes appeared in the narratives, with references to moods, feelings and personal preferences, but the women more frequently and strongly mentioned physical aging effects on their dietary practices. Physical mobility-related issues, such as shopping for food and getting to the Dining Room, came out, as well as issues related to the use of assistive devices, particularly the social stigma of dependence on such devices, presumably because the use of walkers, mobile electric carts, etc. represented morbidity, mortality, and perhaps less than successful aging in the eyes of other residents.

The effect of health concerns and medical conditions on food choices and behaviors observed in Rainey et al. (2000) and by the International Food Information Council (2001) appeared to also affect the participants’ dietary behavior, but to varying degrees. Health concerns played a major role for Mrs. Wilson and her husband, because of his heart condition, whereas health concerns played a much lesser role for Mrs. Brown, who simply took a multivitamin for her health, because her doctor recommended it, and because she thought it was a good idea since she was getting older. All the women in the study took vitamins regularly, and past studies have shown that being female and Caucasian is associated with supplementation (Daniel et al., 1995).

Aging had a non-physical effect in the sense that at least two women acknowledged their age as a license to break food rules, according to an internalized food morality of what one should and should not eat. Food and moral meaning did emerge in the narratives of the participants, in terms of a food morality developed earlier in life regarding wasting food and then later in life regarding foods that are good and bad for one’s physical health, which in essence reflected one’s moral health. These findings confirm Manton’s (1999) assertion that guilt is usually first linked with food in childhood, due to parents’ tales of starving children and emphasis on the importance of not wasting food. They also provide further proof for the existence of the “should syndrome” identified by Paisley et al. (2001). Lupton (1996) discussed
a moral discourse in which the consumption of “bad” foods was a sign of moral weakness. This too is indicated in the narratives of some of the women, particularly in the use of religious language to convey the consumption of “bad” food and the concomitant breaking of a rule, e.g. “sinning” by eating dessert.

Rules are culturally defined ways of ordering life, and the rules identified in this research are perhaps strongly associated with not only the individual’s own cultural identity in life (e.g., Southern, Anglo-American, Protestant), but with the local culture of the retirement community (e.g. dress code), and even the Lexington or Kentucky culture. Such rules are intimately related to a person’s cultural identity, and mediated by a host of other cultural factors that are part of the person’s lived environment. It should be noted that I have discussed only a few of many possible dietary rules. Additional “rules” regarding dietary behavior might include the importance of certain meals (e.g., the noon meal is the main meal), the timing of meals (e.g., some cultures would not think of eating dinner/supper until just before bed), or the content of meals (e.g., all dinners must have soup and bread).

There are a number of additional significant linkages that can be made between the findings of this research and of previous research. Regarding dietary behaviors of older adults, several points made in the literature showed up in the participant sample. In terms of food acquisition, shopping among the women who were physically capable was sometimes more of a leisure activity, whether shopping was enjoyed for the sake of the activity itself, seen in Bonnel (1999) or because of the company enjoyed on such trips, illustrating that shopping trips can be an avenue for social contact, as noted in Read and Schlenker (1993). For those who were more physically disadvantaged, shopping was problematic, because of lessened strength and stamina, also noted in the literature (Read & Schlenker, 1993; Sidenvall, Nydahl & Fjellstrom, 2001). The participants demonstrated a variety of strategies in acquiring and purchasing food, including the use of their own cars, use of the retirement community’s transportation, going with family, friends and neighbors, and having family, friends, neighbors and/or a hired aide pick up items at the store. The use of employed workers was not in the literature.

Similar to the older women in Sidenvall et al.’s (2001) study, some of the participants purchased convenience foods, such as frozen dinners, to lessen food preparation work. Another way that participants made food preparation easier was by the use of the microwave oven, a
strategy that appeared in Bonnel’s (1999) research. Although meals structured the day for the participants as it did for the women in Brombach’s (2001a) study of German older women, the structure was in some sense imposed because of the set hours during which they could eat in the Dining Room. The women therefore accordingly structured the timing of their meals based on when they planned to have their main meal, and when they could have their main meal, incorporating personal preference for timing to the extent that they could.

With a few exceptions, the participants ate three meals a day, and all had breakfast, which are the reported common patterns for older adults (Read & Schlenker, 1993). The exceptions were two participants who generally ate two meals a day, and one who sometimes had four small meals a day. However, of those who reported three meals a day, a number had at least one meal that was considered a light meal. The “heaviness” or “lightness” of meals of older adults has not been widely investigated. Occasionally, the participants consumed meals away from home. For Mrs. Adams, it was a weekly ritual with her family, eating either at her daughter’s home or going out to eat. Mrs. Randall and her husband generally ate out each week after church. For most of the participants, eating out at a restaurant was not a common occurrence, and even some preferred to eat with family and friends in the Dining Room. The participants of this study were not compared to younger age groups, but their patterns on the whole on the surface support findings that older adults do not eat out very much. Fast food was infrequently mentioned and even looked down upon by at least three of the participants, one of whom said she had fast food only because her sons took her to get fast food, but it would never be her choice.

Development of a Theoretical Model

The findings and previous discussion indicate that social influences throughout life, including earlier life experiences, affect the development of behavior, that life course transitions have the potential to modify behavior, and that the context of a living environment, such as a retirement community, instigates the renegotiation of certain aspects of behavior for female residents. Taken together, these points suggest the usefulness of a life course perspective for understanding dietary behavior. Additionally, as the meaning associated with behavior is important to the performance (or non-performance) of behavior and an emphasis on roles and interaction emerged as important influences, a framework such as symbolic interactionism
provides valuable elements to incorporate into a life course perspective. Therefore, in an effort to advance theorizing health behavior and aging, focusing on dietary behavior, I developed a theoretical model of influences on older women’s dietary behavior, utilizing primarily a life course perspective and integrating symbolic interactionist elements.

Figure 7.1: A Theoretical Model of Influences on Dietary Behavior of Older Women

This model of processes of influence on dietary behavior is socially focused, derived from the findings of the study and guided by the theoretical foundations of this research. The model has five components: Precursor Influences, Filters, Actions, Outcomes, and Feedback Influences. The precursor influences consist of four elements: the person, social roles, social relations, and contexts. Filters include temporal processes and meaning systems. Actions involve the dietary practices as performed by the individual, and outcomes are physical and psychosocial well-being, which ultimately contribute the individual’s quality of life. The feedback influences indicate how processes of influence are not linear, but “loop” back on each other, such that the outcomes of behavior can affect behavior performance and/or the precursor influences. The behaviors themselves in turn can affect the precursor influences.
Precursor Influences

The precursor influences more fully encompass and feature various mechanisms of social influence than previous theories. The four elements of Person, Social Roles and Statuses, Social Interaction and Relations, and Contexts interact, and reciprocally influence one another. Though social in focus, the model retains the potential for psychological and biological influence, encapsulated under Person factors. The Person element groups together characteristics of the individual. Psychological processes encompass internal phenomena, such as cognitions, beliefs, feelings, and values, and also includes personal preferences and tastes. Physiological processes are further included under this element. Physical aging, health and illness, and food sensitivities are clearly involved in behavior performance. However, these sets of processes interact with social factors and contexts. For example, a “taste” or preference for Southern food can be interpreted as a socially constructed preference, because of regional context and socialization by significant others into that particular food culture.

Social Roles and Statuses refer to the positions within social systems that the individual occupies, and the roles that may be attached to those statuses. For example, a participant may have been a wife and mother, and therefore acted according to the role expectations of those family statuses. This element also includes the broader social categories of gender, seen as an influence in this study particularly as related to social roles, and presumably would include class and race as they affect roles and statuses.

Social Interaction and Relations embrace interpersonal processes that influence dietary behaviors. Social relationships and interactions reinforce patterns of stability or stimulate change in dietary behavior. This might occur through various mechanisms, such as socialization, social support, and social control. The others in these relations are frequently significant in some way, whether in power and authority and/or emotional attachment. The influence can result in a negative response on the part of the individual. For example, someone could model behaviors that the individual consciously rejects and decides not to imitate. Relationships are important influences on roles too, in that they to some extent can determine roles. For instance, one has the status and role of a wife only if one is in a social relationship with a husband. There may, however, be exceptions to this in lagged behaviors following life course transitions. A woman may publicly lose the role of wife, for example, with the death of a husband, but she may retain
her personal identity as wife, with some associated behaviors, for some period of time as she adjusts to widowhood.

Contexts are the background influences such as place (the physical environment and geographic areas), culture, policy (from the level of national dietary recommendations down to Colonial Square regulations), and economics (market forces such as cost, availability, but also personal resources). The Colonial Square spatial and political environment is a context that exerts a strong influence currently on the participants, both constraining and liberating residents in the performance of dietary practices and modification of dietary patterns.

Filters

The two elements under Filters, time and timing, and meaning systems, represent two particular processes by which the experiences of the precursor influences are “filtered” and ultimately affect behavior. The time and timing element represents at one level, an intersection of age, period and cohort effects, at another level, aspects of stability and change, and at a third level, the timing of transitions and events and duration within a particular state. The time and timing of the previous four elements affect how an individual responds to those influences. Continuing with the example of the role of a wife, the role may change with age (e.g. the wifely role at 25 may be different from the wifely role at 75) and it may change over historical time (e.g. the role of wife in 1950 is different from the role of wife in 2002). The timing of taking on the role of a wife has different effects, as becoming a wife at age 18 has different implications than becoming one at age 30, but the timing of losing the role and duration of time in the role may also be relevant.

Such influences of time, i.e. timing of a lost role in conjunction with duration in a role, may potentially be very important regarding the previously mentioned notion of lagged change in behaviors and adjustment processes. The widowed woman might have lost the role of a wife socially, but psychologically is still in the role and acts accordingly. As she mentally accepts her new social circumstances, her behaviors may then begin to alter at that time. Alternatively, there could be the potential for psychological disengagement from a role prior to the actual loss of the role and in anticipation of the transition, the individual makes preparations for the change. Thus the individual could possibly modify behaviors before an actual event and/or transition occurs.
An additional consideration regarding this particular filter is the time and the timing of events and transitions in the lives of others significant to the individual. As illustrated in this research, changes associated with husband’s occupations and health affected the married woman and her behaviors.

Meaning systems comprise the second filter. The meaning attached to influences and transitions, in other words, how they are interpreted and defined by the individual, will affect the meaning and performance (or non-performance) of the behaviors. The themes of dietary morality, dietary wellness, dietary sociability and dietary duty reflect meanings assigned to food and eating practices, which impact the approaches to dietary behavior performance. For example, moral meanings attached to food and eating practices developed through social interactions with others (e.g. parents and health professionals), and according to the era (e.g. reinforced by the Depression), affected behavior performance (following or not following rules), and consequently feelings associated with behavior performance (e.g. guilt for breaking a rule). These feelings are an aspect of psychosocial well-being, and thus ultimately quality of life.

**Actions**

Dietary behavior encompasses the food- and eating-related practices performed by individuals. This includes a wide range of behavior, from meal planning, food purchase and food preparation, to actual eating and drinking (including the use of supplements), to aspects such as the storage of cookware and “dressing” for dinner. Meal schedules and social arrangements for dining are examples of temporal and social aspects of dietary behaviors.

**Outcomes**

Physical well-being encompasses the general condition and functioning of the body and its physiological processes. Good physical health indicates physical well-being and an overall lack of physical problems, whereas poor physical health, including illness and disease, indicates bodily problems. The meaning and definition of health, in terms of physical well-being, are also relevant to dietary behavior, as what constitutes “good” health is dependent to some degree on subjective interpretation.
Psychosocial well-being refers to the general condition and functioning of the individual’s mind (internal state), and social relations and circumstances. Psychosocial well-being indicates psychological and social well-being and a general lack of problems and difficulties, whereas poor psychosocial well-being indicates psychological problems and/or difficulties in social relationships or situations. Again, people define psychological and social well-being in unique ways, and what may be a satisfactory social situation for one person maybe unsatisfactory for another.

I conceive of both of these concepts as contributing to overall quality of life. Certainly dietary behavior which contributes to good physical health and/or manages health conditions, can lead to reduced morbidity, delayed mortality and increased physical functioning – all aspects that can be factors in quality of life. However, for many people, there is more to life than living longer and in “good” physical health. It is as important (and maybe for some people more important) to have psychosocial well-being, for which a concept such as life satisfaction is one indicator of this aspect of quality of life. Due to the profound social meanings and relevant social aspects related to food and eating, and the psychosocial implications of food-related experiences, to be able to enjoy one’s dietary practices and experiences can greatly contribute to psychosocial well-being and thus quality of life.

For example, for Mrs. Stokes, who sometimes broke her dietary rules regarding the management of her diabetic condition, it appeared that her psychosocial well-being, in terms of her enjoyment of food, was a more important contributor to her quality of life than physical well-being. It was sometimes more important in her view to enjoy food than to be concerned about possible physical consequences of not strictly adhering to her dietary regimen. She in part determined this through the lens of time; her age and the amount of time that she thought she likely had left in her life weighted psychosocial factors in quality of life issues as related to food.

Feedback Influences

As mentioned, the feedback loops indicate how processes of influence are not simply linear, but can be circular, such that the outcomes of behavior can affect behavior performance and/or the precursor influences, and behavior performance can affect the precursor influences. These loops add necessary complexity to the model, because of the non-linearity of interactions
among the various components. The feedback mechanism also allows for greater ability to address temporal dynamics, for example, adjustment to life course transitions and events.

**Summary**

This theoretical model highlights social influences on dietary behavior, an aspect generally treated rather superficially in previous models applied to health behavior. It also incorporates temporal considerations, to account for change or stability over time, and meaning-making, reflective of the processes of interpretation applied to influences and behavior; these are again neglected facets in theorizing about health behavior. These aspects represent strengths of using a life course perspective, supplemented by symbolic interactionist elements, to better understand dietary practices of older women. To view behaviors in terms of quality of life issues further informs understanding at the concrete and theoretical levels. A final point to bear in mind is that these influences can be in both positive and negative directions with regard to dietary practices. In other words, dietary actions or changes in dietary actions may be such that they worsen physical or psychosocial health, resulting in lessened life quality life, or they may improve physical and psychological health, resulting in overall improved quality of life.

The model is at this time gender-specific and older adult-oriented. These are two possible limitations of the current form of the model, although there is not presently reason to think that it would not apply to men or other age groups. The limitations of the model are limitations of the research overall, which have implications for future investigations. These and other implications for research and practice, along with brief self-reflection, are considered next.

**Conclusions**

Dietary behavior appears to occupy a very socially situated place in the lives of older women. This study showed that psychological and physiological processes are indeed relevant in understanding behavior over time, but cannot be divorced from social processes at both micro and macro levels of concern. Moreover, application of social theoretical perspectives proved useful in thinking about the development and progression of dietary practices. With these points in mind, I conclude, considering implications of this study for future research and practice. Additionally, as this dissertation was about biographical stories of women and began with an
autobiographical note, it seems appropriate to end autobiographically, with a few words about what it meant to me personally as I went through the research process and gathered these stories.

Implications of the Research

A number of key elements emerging from this dissertation research would benefit from more focused study. Particular life course transitions or various sequences of transitions appear in this research as potentially strong factors influencing dietary behavior. For example, widowhood is a significant life course change that has repercussions for all facets of life, including food and eating. Such a transition causes immediate alteration in the social setting of meals, and there is evidence that loneliness impacts food preparation (e.g. less effort) and eating habits (e.g. perhaps increased food consumption if feeling bored or decreased food consumption if suffering from depression). The ramifications of widowhood for dietary practices, and potential alleviation of negative impact on practices, are only just beginning to be understood. In another example, residential transitions are inadequately addressed by research in terms of the effects of dietary patterns. These effects may stem from adjustments to new and different food choices and costs, areas of food preparation, or sociocultural milieus. This research showed some effects of a residential transition to a retirement community, but a specific focus on seasonal migration or transitioning to co-residency with an adult child could provide valuable additional insight to how residential change and adjustment potentially acts to modify dietary choices and behaviors. Furthermore, such research could be expanded to explore the influence of other types of residential settings, as more and more older adults relocate to age-segregated communities. These communities evolve quite differently; there are numerous and varied models of independent retirement living communities, based on an array of management styles with various food and dining service arrangements. Understanding how different features of these residential contexts affect the dietary practices and quality of life for residents can reveal which features may be more liberating, or at least less constraining, for residents.

Although this dissertation research included only women as participants, there was strong indirect evidence suggesting important gender differences. The roles and statuses of men, their social relationships and the contexts in which men live may differentially influence their dietary behavior. Future studies should consider men, and should explicitly probe gendered life course
elements. Such studies may shed valuable light on the notions of power in the family, and how power and control might shift through life, thus informing dietary choice, food preferences, and eating behavior. Likewise, studies that examine other social classes and races/ethnicities would be instructive for understanding variation in social experiences and the effects of life course factors and transitions. If subgroups of elders are thought to have different nutritional needs, then there is no reason to think that they would not also have different dietary practices also. Differences in dietary behavior may be based on differences in factors such as upbringing, education, economic resources and cultural identity.

An interesting idea which research might follow-up on regards how people deal with conflicting dietary rules (i.e., expressed normative perceptions and behaviors that are considered right or wrong, beneficial or deleterious). For example, a rule to clean one’s plate may be based on long-term familial influence, but a local cultural rule is to eat only enough to satisfy the appetite. Which rule takes precedence? Individuals living in a retirement community that offers communal dining are immediately placed in conflict between rules of personal cultural identity and rules of the institution, and additionally with cultural norms of community and region if a distant residential relocation has occurred. How do they react to the conflicting rules? Given the duration of which elders have lived with their own rules, it might be conjectured that adjustment to different norms of behavior might be more difficult than for younger adults. Independently living elders (i.e., those living in their own homes as they have throughout life) do not have such conflicts to deal with. Their meals are basically private affairs, and are governed by rules established almost solely within the family unit and/or maintained as individuals living alone. Such a line of research might be meritorious, not only theoretically in our understanding of cultural diversity and conflict, but in our abilities to better accommodate and provide for the dietary needs of institutionalized elders.

All of these suggested directions in research would add to the theoretical model presented in this study, illuminating aspects that need improvement and refinement, and strengthening existing factors that continually emerge from data. This research has demonstrated the value in applying socially-oriented theoretical frameworks to conceptualize processes that develop and support or transform dietary practices. Further elaboration of particular components or interactions among components would be informative.
I have suggested several lines of research thus far. I now provide a few examples of potential findings of such research endeavors. The examples I use are hypothetical, and based on how I extend my findings, and the findings found in the literature, to future eventualities. For example, expanding on the notion of identity and food rules, personal cultural identity is dramatically variable, as are other imposed institutional, local, and regional cultures. If an older woman lived in her own long-time home in a community at large, she does not encounter conflicting rules, issues related to physical distance from a dining facility, and she does not have to abide by the temporal schedules of meals as she would living in a retirement community such as Colonial Square or various other age-segregated residential settings. In these ways, she is “freer” at home than if she lived in a retirement community. However, with advanced age, she may experience malnutrition, due to decreased physical abilities for shopping and cooking or a lack of social meaning of meals, and especially if she is widowed, divorced, otherwise living alone, or of limited economic means. Thus there are also constraints for community-dwelling elders that retirement facility residence might help them avoid.

In another example, an older woman may live at a community such as Colonial Square, but is East Asian and accustomed to light meals, high in certain complex carbohydrates (e.g. rice), diverse vegetables, and fish. She also has a low educational level. Her personal rules may immediately be at conflict with institutional/local/regional rules, but her exposure to others at Colonial Square may enhance (albeit late in life) her knowledge of nutritional needs and result in possibly valuable changes in her dietary behavior. However, she might suffer psychosocially if she is unable to obtain her preferred ethnic foods and meals or to enact social customs tied to food in her culture.

The participants of this research had profound experiences from both the pre-WWII depression and post-war economic largess. Interestingly, they seemed more influenced by the Depression (controlling for their family’s relative economic situation), given the clean plate club principle. So the age at which they experienced the period event (the cohort-period interaction) appears to be quite important, but so too is the parental cohort-period interactions. Thinking about the future of Baby Boomers, it is possible to speculate along the same lines using anecdotal observations of contemporary middle-aged adults. Consider first the example of a male born in the mid-1950s, who could be considered a member of the clean plate club, but only because of his
parents, who were both young children of the Depression, but post-war lived in relative poverty because both their fathers had died. Most of this boomer’s friends, childhood and currently, were not really of the clean plate ilk because their parents had gained full benefit of post-war economic recovery. Although the clean plate notion stayed with him, he has changed because of a period (post-Vietnam) emphasis on college education. He still holds a meat-and-potatoes meal as a preference (due to his upper Midwest upbringing), though such meals are now few and far between; they have not been eliminated, but their frequency decreased because he is more familiar with the meaning and value of balanced nutrition. He now believes that people cannot live on meat and potatoes alone.

As far as this baby boomer’s dietary behavior in the future is concerned, it seems likely that cohort and family effects will maintain the clean plate motif. Period effects will moderate that motif in that he is willing to spend more money on better foods (but will logically take smaller servings because of his education). Some of his friends (and maybe the more typical Boomer and Boomer child) will be equally concerned about nutrition value, but not so concerned with waste, and so they may be less likely to overeat. However, the pace and style of recent economic development has more deeply commodified time, leading to the rise of fast foods and rapid meal preparation, often with the sacrifice of nutritional value. Structural response to commodified time has been increased advertising for fast foods, and increased competition among fast food chains to seemingly offer the most food for the lowest price. So, people look for the bargain (the notion of economic rationality, seen also in the popularity of restaurant buffets), and tend to eat and drink more than is nutritionally necessary. This seems to have become habit for many in our society and, as individuals grow older, they either suffer from more heart disease or diabetes, are faced with greater problems of adjustment in later life to a better dietary lifestyle, or simply die from chronic inattention to dietary needs. Furthermore, there are the individual experiences that serve as a persistent influence in addition to period and cohort effects. The boomer in this example participated in professional sports in high school and college, and the constant exercise and weight loss habits remain with him. The exercise is beneficial, but the weight loss may be deleterious in that even now he easily suppresses hunger sensations and can go for days without eating.
In a brief second example, a peak boomer woman became vegetarian in her 30s. Her decision to become vegetarian had less to do with health and more to do with her respect for animal life. Her vegetarian diet excludes meats, but she does eat dairy products. Although her life has been characterized by risk-taking ventures, the societal dietary climate renders such a choice less of a social risk, as society now seems more accepting of such alternative diets, and vegetarian options are increasingly available in grocery stores and restaurants. Such diversity will need to be reflected in the options available to future generations of elders. Diversity in terms of foods of other cultures may also need to be reflected in menus, as a variety of ethnic foods have become, and continue to become, more mainstream in typical American gastronomies. Fast food restaurants now offer quick Chinese, Mexican and Italian meals. Mall food courts offer Japanese, Greek and Middle Eastern cuisines in addition to burgers, subs and pizza.

Similarly, retirement communities and senior meal programs of the future may need to serve foods such as tofu burgers, sushi, gyros, sesame chicken, and enchiladas to satisfy the tastes of their clients – even if the clients are middle class, white elders. However, dishes such as meatloaf and macaroni and cheese or pot roast and mashed potatoes have recently been termed “comfort” foods, because for many Baby Boomers these meals are reminiscent of what their mothers used to prepare, and carry with them some sentimentality and nostalgic sense as foods eaten in the “good old days” and simpler times. Therefore, these meals may still make occasional appearances at dinner times in Baby Boomers’ futures, in addition to the dietary diversity embraced by many.

These are specific examples among a population of almost infinite heterogeneity. My conclusions from these examples are that the life course influences associated with age, period, cohort, and unique person experiences all shape the dietary behaviors of individuals. This has implications for both theory and practice, in terms of accounting for behavior and satisfactorily meeting the dietary needs of older adults, both physically and psychosocially.

The research implications proposed thus go far beyond this research and its limitations in content. Methodologically, investigations might employ similar methods when studying older adult populations, as the narratives and probing for participant perceptions, in addition to observational techniques, revealed a full and rich picture of the phenomena under study. Additionally, the gathering of recipes from participants seemed to be an effective method to
use for informational and recall purposes. Incorporation of other methods, such as food diaries, might also be insightful. Prospective types of studies, which, for example, interview an older adult before and after a later life transition, could be valuable for revealing what aspects of the transitions cause change, and if they do not cause change, why they do not. Health transitions would difficult to anticipate, but a residential move often can be anticipated.

Some practical applications of research need to be based on some assumed generalizability. The establishment of generalizability is not generally a strength of qualitative research, but more the forte of quantitative methods, such as surveys. Some concepts uncovered in this research that may be suitable for exploration by survey methods include quality aspects of meals rather than quantity (e.g. heavy versus light meals), aspects of eating out, strategies used for food acquisition and food preparation in age-segregated independent residential settings, and the notion of constraints and opportunities related to food and eating in retirement communities.

As indicated above, the research additionally has implications for practice, as this and future research might assist practitioners in better meeting and accommodating the dietary needs of older adults. More specifically, just as Levy (1981) suggested that collecting interview narratives from consumers would benefit market research, ultimately enabling companies to better serve consumers, I suggest that conducting dietary histories and collecting food narratives from incoming residents might help retirement communities, assisted living facilities and nursing homes better serve residents. Food and eating has been recognized as an area of much import when considering overall quality of life at residences, and improving satisfaction with food and eating experiences would improve overall quality of life. As mentioned above, the identification of features of community contexts that are perceived as constraining or facilitating would allow communities to work on rendering the residential context as facilitative as possible with respect to food and dining services. Dietary narratives and improvements to systems would boost public relations and marketing efforts, and need not be costly to implement.

This research suggests that interventions on a broader level may need to be less focused on physical well-being indicators of quality of life. Dieticians and health professionals would better serve their clients by increasing efforts to consider and include psychosocial well-being as an outcome in health education and promotion. Reducing morbidity and improving function may mean very little to an elder who is miserable because of dietary restrictions. Furthermore,
understanding that dietary practices are not solely a matter of “choice,” and understanding aspects such as moral meaning associated with practices, may enhance the effectiveness of educational efforts to improve the food choices and dietary quality of older adults. Practitioners who are informed about the contexts of behavior (including social structural factors), and how an individual is socially situated can prevent prescribing dietary recommendations for older adults that could potentially cause elders to feel frustration, disappointment, and self-reproof if they are unable to follow the experts’ advice. Finally, practitioners should consider the skepticism in which older adults may hold them and their recommendations. It may not be possible to earn the trust of those who do not “believe,” but it would be important to know why they are skeptical and how far reaching their skepticism is. The practitioner can then work with the older adult within those limits.

Reflections on the Research Experience

On a final note, conducting this research was a process of discovery that was personal as well as academic. I learned much about the topic, which is, of course, a main purpose of the dissertation. I found out much about the conduct of research, learning from mistakes, taking impromptu opportunities, and gaining confidence from successes. I obtained practical knowledge about working with older women and using a retirement community as a research site. I also learned some things about myself.

Interviewing the women in particular forced me to confront my own assumptions, biases and moralities regarding food and eating. For example, I realized I had always assumed that older women learned to cook at very young ages, but the finding that some did not learn until they became married unearthed this assumption and debunked it. I had also assumed that older women generally enjoyed cooking, part of a grandmotherly stereotype. This is also not accurate, and no longer in my personal assumptions inventory.

I realized I have particular biases in my notions about food. One participant shared that she loved anything made with ground beef, because ground beef was one of her favorite foods. I am not a particular fan of ground beef, but accepted that someone could rate it as a top food preference. However, when she went on to describe how she used to pinch off a bit of raw beef when she made meatloaf, I was somewhat incredulous. She continued, relating a story about
how a few years back she went to a local grocery store and at the meat counter, asked if she could have a taste of raw beef. The man refused her request, but she went back later and found another man who gave her a bite. Although she admitted that it did not taste quite as good as she remembered, I found myself quite repulsed at the thought of someone eating raw ground beef. I was raised on well-done meat, and ventured into medium/medium rare only when I was out on my own in life, though raw beef was still out of the question. Yet, I find it perfectly acceptably to eat sushi. I realize had I shared my love of raw fish with this participant, she likely would have turned up her nose at the thought of it.

Finally, the intense study of dietary practices and nutrition provided me little time to follow ideal dietary practices myself. I rationalized and justified the laxness in my own dietary patterns, certain that I could adjust course once I finished my project. I therefore found that I too was subject to the “should syndrome” of eating and attendant feelings of guilt. Although easy to justify the guilt away, it periodically came back and would need to be rationalized away again. I greatly enjoyed talking with the participants of this study and knew that some of them took pleasure in sharing their stories as much as I took pleasure in listening to them. Though they may have benefited in some small way, research and the field of gerontology gained in a much larger way, the recipient of these women’s valuable insights into themselves and society. This research was a fruitful enterprise personally, produced useful academic understanding and will be a rich source scholarship and direction in future research endeavors.
Appendix A

Consent Form

Consent to Participate in a Research Study

Understanding Health Behaviors of Older Women in a Family Life Course Perspective

WHY AM I BEING INVITED TO TAKE PART IN THIS RESEARCH? You are being invited to take part in a research study about the health behaviors of older women. You are being invited to take part in this research study because of the insights that you can offer from your personal experiences as an older woman about women’s health and health behaviors throughout life. If you volunteer to take part in this study, you will be one of about 10–15 women to do so.

WHO IS DOING THE STUDY? The person in charge of this study is Lisa Curch, M.A., a doctoral candidate in the Gerontology Ph.D. program at the University of Kentucky. She is being guided in this research by John F. Watkins, Ph.D. There may be other people on the research team assisting at different times during the study.

WHAT IS THE PURPOSE OF THIS STUDY? The purpose of the study is to learn about the health practices of women throughout life and particularly in later life. I hope to learn more about how and why certain behaviors are practiced (exercise and diet), and how family and family changes influence health practices. Learning more about influences on lifelong patterns of health behaviors may ultimately help health professionals to understand how to best encourage healthy behavior among older adults.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST? The interview sessions will be conducted face-to-face at your home, or wherever you and I agree will be most convenient and comfortable. Each interview session will last about two hours, and there will be at least two, possibly three, interview sessions scheduled. The total amount time you will be asked to volunteer for this study is 4–6 hours over the next month.

WHAT WILL I BE ASKED TO DO? You will be interviewed about your health, health behavior (exercise and diet) and family histories. There will be two or more face-to-face interview sessions scheduled. Each interview session will be tape-recorded. If you would like a copy of the interview tapes, we will provide those copies at no cost.

ARE THERE REASONS WHY I SHOULD NOT TAKE PART IN THIS STUDY? The only reason that you might not be able to volunteer is if you have memory loss.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS? To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life.
WILL I BENEFIT FROM TAKING PART IN THIS STUDY? There is no guarantee that you will get any benefit from taking part in this study. However, some people have experienced insights into their own health practices and enjoyment from talking about things that matter to them and from participating in research. We cannot and do not guarantee that you will receive any benefits from taking part in this study.

DO I HAVE TO TAKE PART IN THE STUDY? If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to volunteer. You can stop at any time during the study and still keep the benefits and rights you had before volunteering. If you decide not to take part in this study, your decision will have no effect on the quality of services you receive as a resident of Richmond Place.

IF I DON’T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES? If you do not want to be in the study, there are no other choices except not to take part in the study.

WHAT WILL IT COST ME TO PARTICIPATE? There are no costs associated with taking part in this study.

WILL I RECEIVE ANY PAYMENT OR REWARDS FOR TAKING PART IN THIS STUDY? You will not receive any payment or rewards for taking part in this study.

WHO WILL SEE THE INFORMATION THAT I GIVE? Your information will be combined with information from other people taking part in the study. When we write about the study to share it with other researchers, we will write about the combined information we have gathered. You will not be identified in these written materials. We may publish the results of this study; however, we will keep your name and other identifying information private. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if we believe that you are a danger to yourself or someone else. Also we may be required to show information which identifies you to people who need to be sure we have done the research correctly; these would be people from organizations such as the University of Kentucky. We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information, or what that information is. For example, your name will be kept separate from the information you give, and these two things will be stored in different places under lock and key.

CAN MY TAKING PART IN THE STUDY END EARLY? If you decide to take part in the study you still have the right to decide at any time that you no longer want to continue. You will not be treated differently if you decide to stop taking part in the study. The individuals conducting the study may need to take you off the study. They may do this if you are not able to follow the directions they give you, if they find that your being in the study is more risk than benefit to you, or if the agency funding the study decides to stop the study early for a variety of scientific reasons.
WHAT HAPPENS IF I GET SICK OR HURT DURING THE STUDY? If you believe you are hurt or sick because of something that is done during the study, you should call Lisa Curch at (859) 245-9509 immediately. It is important for you to understand that the University of Kentucky will not pay for the cost of any care or treatment that might be necessary because you get hurt or sick while taking part in this study. That cost will be your responsibility. Also, the University of Kentucky will not pay for any wages you may lose if you are harmed by this study. Medical costs that result from research-related harm cannot be included as regular medical costs. The University of Kentucky is not allowed to bill your insurance company, Medicare, or Medicaid for these costs. You should ask your insurer if you have any questions about your insurer’s willingness to pay under these circumstances. Therefore, the costs related to your care and treatment because of something that is done during the study will be your responsibility.

WHAT IF I HAVE QUESTIONS? Before you decide whether to accept this invitation to take part in the study, please ask any questions that might come to mind now. Later, if you have any questions about the study, you can contact the researcher, Lisa Curch at (859) 245-9509. If you have any questions about your rights as a research volunteer, contact the staff in the Office of Research Integrity at the University of Kentucky at (859) 257-3138. We will give you a copy of this consent form to take with you.

WHAT ELSE DO I NEED TO KNOW? The Donovan Scholars Program of the University of Kentucky is providing partial financial support and/or materials for this study. You will be told if any new information is learned which may affect your condition or influence your willingness to continue taking part in this study.

I understand my rights as a research participant and I voluntarily consent to participate in this study.

__________________________________________________________  ________________
Signature of person agreeing to take part in the study           Date

__________________________________________________________
Printed name of person taking part in the study

__________________________________________________________  ________________
Name of person providing information to the participant        Date

__________________________________________________________
Signature of Investigator
Appendix B
Interview Guides

Life History Questions and Probes
In today’s interview, I would like to talk about your life history. I am interested in your life story, and your experiences throughout life, from childhood to the present. If at any time it helps you to remember by pulling out and looking at items such as photo albums or other family records, please feel free to do so.

Opening
Why don’t you begin with telling me about yourself, and your life recently.

Other
Let’s talk now about your past experiences, starting as far back as you can remember. Begin by telling about where you were born and what you remember about your early days of growing up.

Listen for and probe for
Parents: both parents alive and at home while growing up, education, occupation, ethnicity/culture (were they immigrants), religion, where they grew up, health status

Siblings: How many brothers and sisters, birth order

Spouse(s): education, occupation, ethnicity/culture, religion, where grew up, health status

Children: how many, gender, birth order

Other important family relationships, e.g. grandparents

Family transitions and influences: changes in family composition (births, deaths), changing marital status, leaving home, having children, launching children

Historic events, e.g. Great Depression, World War II: rationing, working, what sacrifices associated with them

Past environment: whether the participant grew up in the country or city, and what region
Rural: was it a farm, were there animals and crops
Urban: was it an ethnic neighborhood, were there corner groceries, meat markets

Present environment: how did participant come to be at Richmond Place, were they always in that apartment in at Richmond Place, spaces used in Richmond Place
Spatial transitions: changes in residence, where lived before coming to Richmond Place

Other personal info: education, occupations, ethnicity/culture, religion, recreation/leisure pursuits, health status & conditions
Food History Questions and Probes
In this interview, I would like to talk about your food and eating experiences throughout your life. I am interested in what influences you think have affected the way you eat at different times in your life.

**Opening:**
I would like to start with talking about the recipes that I asked you to have ready to discuss. (Talk about the recipes the participant chose to share, asking about significance, where they got it, how old it is, when they use (or used) it, why it is a favorite.)

**Other questions:**
Over your lifetime, what do you think has influenced the way you eat? What you eat?
During different times in your life, how do you think family has affected the way you eat?
Have any traditions influenced the way you eat? How? (Listen for holidays, familial, ethnic, etc.)
Have your religious or spiritual beliefs affected the way you eat now or in the past? How?
Has your health or any physical conditions affected the way you eat now or in the past?

During your life, what influence do you think you have had on the ways others eat?
(If mentions choosing foods for others, e.g. children) Is there a difference in how you have chosen foods for others from how you have chosen for yourself? Why?

Tell me about the food-related responsibilities you have had throughout your life.
How are they similar to the food-related responsibilities other women in your family have had?
How are they different?

Tell me about how you learned what you know about food.
Probes: shopping, choosing foods, and preparing foods
Tell me how you learned what you know about nutrition and health.

How do you think the way you eat has been affected by living here at Richmond Place?
(Listen for where they get their food, other than the dining room.)
Do you think that where you have lived in the past affected the way you eat? How?
Tell me about other places where you eat.

Do you think the way you eat has changed over your lifetime?

Have there been times when you have bought or prepared food other than for feeding yourself or your family?
Probes: charity (food drives, soup kitchens), fundraisers, entertaining, gifts (reciprocity or not)

Do you think there will be any changes in the way you eat in the future? How far into the future?

Meals: What meals and meal times were like (e.g. did the family sit down together, what was eaten at lunchtime in school), snacks and snack times, what family recipes are remembered the most, did the family have a garden, canning and preserving of food
Appendix C
Sample Weekly Menus

Words and spellings have been copied exactly from menu flyers.

November 18-24, 2001

Sunday
Salad: Pineapples & Cottage Cheese
Entrees: Fried Chicken, Meat Loaf, and Baked Cod
Vegetables: Mashed Potatoes, Yellow Squash with Tomato, Corn, and Green Beans

Monday
Salad: Pasta Salad
Entrees: Bar-Que Chicken Breast, Italian Sausage, and Fried Shrimp
Vegetables: French Fries, Sour Kraut, Fresh Blend, and Peas & Carrots

Tuesday
Salad: Seafood Salad
Entrees: Chicken Crepes, Veal Parmesan, and Flounder
Vegetables: Stewed Tomatoes, Spinach, Zucchini & Yellow Squash, and Pasta

Wednesday
Salad: Ambrosia
Entrees: Chicken Pot Pie, Beef A Roni, and Seafood Newburg
Vegetables: Lima Beans, Brussel Sprouts, Fresh Blend, and Cauliflower

Thursday
Salad: Cranberry Delight
Entrees: Turkey, Glazed Ham, and Salmon
Vegetables: Baked Sweet Potatoes, Acorn Squash, Southern Green Beans, and Corn O’Brien

Friday
Salad: Broccoli Salad
Entrees: Roast Beef, Grilled Chicken, Fried Seafood Plate
Vegetables: Roasted Garlic Potatoes, Broccoli, Fresh Blend, and Peas

Saturday
Salad: Calico Bean Salad
Entrees: Pepper Steak, Chicken Monterey, and Baked Tilapia
Vegetables: Rice, Beets, Mixed Vegetables, and Okra & Tomatoes

**Menu subject to change based on availability and quality**
November 25-December 1, 2001

**Sunday**
Salad: Ginger Pear Salad
Entrees: Walnut Chicken, Sesame Beef, Fried Shrimp
Vegetables: Fried Rice, Broccoli & Carrots, Sugar Snap Peas, Spaghetti Squash

**Monday**
Salad: Strawberry Delight
Entrees: Oven Roasted Chicken, Grilled Ham, Fried Cod
Vegetables: Red Potatoes, Mixed Vegetables, Cauliflower, and Zucchini

**Tuesday**
Salad: Cucumber Salad
Entrees: Italian Chicken, Spaghetti with Meat Sauce, Flounder
Vegetables: Augratin Potatoes, Lima Beans, Spinach, and Fresh Blend

**Wednesday**
Salad: Spinach Salad
Entrees: Chicken Tenders, Beef Liver, and Shrimp Creole
Vegetables: Rice, Mixed Vegetables, Green Beans, Corn

**Thursday**
Salad: Sunshine Salad
Entrees: Herb Chicken Breast, Bar-Que Pork Chops, and Sole
Vegetables: Fresh Blend, Baked Potatoes, Brussel Sprouts, and Stewed Tomatoes

**Friday**
Salad: Shrimp and Rice Salad
Entrees: Chicken Oscar, French Dip, Trout
Vegetables: Mixed Vegetables, Roasted Garlic Potatoes, Pinto Beans, and Peas

**Saturday**
Salad: Cole Slaw
Entrees: Baked Catfish, Swiss Mushroom Burgers, and Hot Dogs with Sour Kraut
Vegetables: French Fries, Baked Beans, Corn on the Cob, Fresh Blend

**Menu subject to change based on availability and quality**
January, 6-12, 2002

**Sunday**
Salad: Spinach Salad
**Entrees:** Roasted Chicken, Grilled Ham & Pineapples, and Sole
**Vegetables:** Sweet Potato Casserole, Lima Beans, Corn and Fried Okra

**Monday**
Salad: Carri Fruit Salad
**Entrees:** Grilled Chicken & Mushrooms, Ground Sirloin, and Fried Shrimp
**Vegetables:** Garlic Roasted Potatoes, Peas, Yellow Squash & Tomatoes, and Mixed Vegetables

**Tuesday**
Salad: Seafood Salad
**Entrees:** Pepper Steak, Italian Chicken, and Fried Cod
**Vegetables:** Rice, Spinach, Mixed Vegetables, and Butter Beans

**Wednesday**
Salad: Three Bean Salad
**Entrees:** Chicken Monterey, Beef Liver & Onions, and Tilapia
**Vegetables:** Sautéed Mushrooms, Onion Rings, Macaroni & Cheese, and Mixed Vegetables

**Thursday**
Salad: Peaches & Cottage Cheese
**Entrees:** Garlic Chicken, Ham & Cheese Soufflé, and Mahi-Mahi
**Vegetables:** Red Potatoes, Brussel Sprouts, Fresh Blend, and Carrots

**Friday**
Salad: Strawberry Delight
**Entrees:** Country Fried Steak, Chicken Pacatia, Trout
**Vegetables:** Baked Potatoes, Vegetables Casserole, Pinto Beans, and Stewed Tomatoes

**Saturday**
Salad: Pasta Salad
**Entrees:** Grilled Hamburgers, Hot Dogs & Sour Kraut, and Fried Catfish
**Vegetables:** Baked Beans, French Fries, Mixed Vegetables, and Zucchini

**Menu subject to change based on availability and quality**
January 20-26, 2002

**Sunday**
*Salad:* Cole Slaw  
*Entrees:* Fried Chicken, Meat Loaf, and Baked Cod  
*Vegetables:* Green beans, Mashed Potatoes, Stewed Tomatoes, and Mixed Vegetables

**Monday**
*Salad:* Ginger Pear Salad  
*Entrees:* Pork Loin, Sesame Chicken, and Garlic Shrimp  
*Vegetables:* Vegetables Rice Pilaf, Cabbage, Carrots, and Peas

**Tuesday**
*Salad:* Spinach  
*Entrees:* Chicken Casserole, Baked Ziti, Blackened Catfish  
*Vegetables:* Fried Mushrooms, Zucchini, Fresh Blend, and Pasta

**Wednesday**
*Salad:* Marinated Vegetables  
*Entrees:* Chicken Tenders, Lasagna, and Tuna Melt  
*Vegetables:* French Fries, Brussel Sprouts, Yellow Squash & Tomatoes, and Mixed Vegetables

**Thursday**
*Salad:* Sun Shine Salad  
*Entrees:* Chicken Livers, Salisbury Steak, and Flounder  
*Vegetables:* Pinto Beans, Macaroni & Cheese, Onion Rings, and Mixed Vegetables

**Friday**
*Salad:* Anti-Pasta Salad  
*Entrees:* Beef Pot Pie, Veal Parmesan, and Lemon Scrod  
*Vegetables:* Rice, Corn, Broccoli and Cauliflower

**Saturday**
*Salad:* Broccoli Salad  
*Entrees:* French Dip, Sweet & Sour Chicken, and Fried Shrimp  
*Vegetables:* Mixed Vegetables, Spinach Soufflé, Baked Potatoes, and Baked Tomatoes

**Menu subject to change based on availability and quality**
February 3-9, 2002

Sunday
Salad: Deviled Eggs
Entrees: Fried Chicken, Pork Loin, and Baked Scrod
Vegetables: Mixed Vegetables, Mashed Potatoes, Lima Beans, and Fried Okra

Monday
Salad: Cole Slaw
Entrees: Hamburgers, Hot Dogs & Kraut, and Tilapia
Vegetables: French Fries, Corn on the Cob, Baked Beans, and Peas & Carrots

Tuesday
Salad: Marinated Tomatoes
Entrees: Chicken Marsala, Spaghetti & Meat Sauce, and Flounder
Vegetables: Yellow Squash, Baked Apples, Spinach, and Italian Green Beans

Wednesday
Salad: Sunshine Salad
Entrees: Grilled Chicken, Skillet Pork Chops, and Fried Shrimp
Vegetables: Rice, Black Eyed Peas, Brussel Sprouts, and Mixed Vegetables

Thursday
Salad: Three Bean Salad
Entrees: Chicken Burrito, Pepper Beef, and Blackened Catfish
Vegetables: Rice, Black Beans, Corn, and Fresh Blend

Friday
Salad: Peaches & Cottage Cheese
Entrees: Roasted Chicken, Grilled Ham, and Fried Seafood Plate
Vegetables: Stewed Tomatoes, Sweet Potatoes, Southern Green Beans, and Mixed Vegetables

Saturday
Salad: Spinach Salad
Entrees: Barbeque Ribs, Hawaiian Chicken, and Fried Cod
Vegetables: Zucchini, Baked Potatoes, Vegetable Casserole, and Pinto Beans

**Menu subject to change based on availability and quality**
May 13-19, 2002 HAPPY MOTHERS DAY

**Sunday**
Salad: Carrot Raisin
Entrees: Cornish Hen, Sliced Beef, Stuffed Salmon
Vegetables: Asparagus, Mashed Potatoes, Corn, Baked Apples

**Monday**
Salad: Cottage Cheese & Peaches
Entrees: Hot Dogs & Sauerkraut, Chicken Pasta Sauté, Swordfish
Vegetables: Fresh Blend, Scalloped Apples, French Fries, Baked Beans

**Tuesday**
Salad: Ambrosia
Entrees: Veal Parmesan, Chicken Picatta, Baked Trout
Vegetables: Augratin Potatoes, Buttered Pasta, Spinach Soufflé, Yellow Squash

**Wednesday**
Salad: Marinated Vegetables
Entrees: Vegetable Omelet, Chicken Oscar, Shrimp Creole
Vegetables: Broccoli, Potato Lyonnaise, Stewed Tomatoes, Rice

**Thursday**
Salad: Tomato Aspic
Entrees: Roast Beef and Cheddar Wrap, Grilled Halibut, Chicken Strips
Vegetables: Fried Zucchini, Pinto Beans, Dilled Carrots, Macaroni & Cheese

**Friday**
Salad: Artichoke Salad
Entrees: Spaghetti & Meat Sauce, Chicken Fajitas, Blackened Catfish
Vegetables: Peas, Black Beans, Fiesta Rice, Fresh Blend

**Saturday**
Salad: Marinated Carrots
Entrees: Chicken Salad Croissant, Cabbage Rolls, Fried Oysters
Vegetables: Spinach, Zucchini and Mushrooms, Scalloped Potatoes, Corn O’Brien

**Menu subject to change based on availability and quality**
Appendix D  
Participants’ Life Course Outlines

(?) – indicates a best estimate

Mrs. Adams

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1914</td>
<td>Born in the Northeast</td>
</tr>
<tr>
<td>1917</td>
<td>Family moved to Mid-Atlantic</td>
</tr>
<tr>
<td>1932</td>
<td>Graduated from high school; started college</td>
</tr>
<tr>
<td>1936</td>
<td>Graduated from college; worked for girls organization in the South</td>
</tr>
<tr>
<td>1937</td>
<td>Worked in children’s hospital in Northeast</td>
</tr>
<tr>
<td>1942</td>
<td>Graduated library school; worked as librarian in Washington, D.C. area</td>
</tr>
<tr>
<td>1943</td>
<td>Married; moved to Florida</td>
</tr>
<tr>
<td>1945</td>
<td>Daughter born; full-time homemaker</td>
</tr>
<tr>
<td>1946 (?)</td>
<td>Moved to Washington, D.C. suburb</td>
</tr>
<tr>
<td>1948 (?)</td>
<td>Moved to Northeast; bought house</td>
</tr>
<tr>
<td>1950</td>
<td>Back to library work part-time</td>
</tr>
<tr>
<td>1963</td>
<td>Husband died; full-time librarian</td>
</tr>
<tr>
<td>1984</td>
<td>Retired</td>
</tr>
<tr>
<td>1988</td>
<td>Moved to Lexington; lived in an apartment</td>
</tr>
<tr>
<td>2000</td>
<td>Moved to Colonial Square</td>
</tr>
</tbody>
</table>
**Mrs. Brown**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event/Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1911</td>
<td>Born in the South</td>
</tr>
<tr>
<td>1929</td>
<td>Graduated from high school; started college</td>
</tr>
<tr>
<td>1931</td>
<td>Left college; director of girl’s organization</td>
</tr>
<tr>
<td>1933</td>
<td>Started teaching elementary school</td>
</tr>
<tr>
<td>1936</td>
<td>Married; became full-time homemaker</td>
</tr>
<tr>
<td>1938</td>
<td>1st son born; moved to the Midwest</td>
</tr>
<tr>
<td>1941</td>
<td>2nd son born</td>
</tr>
<tr>
<td>1943</td>
<td>Moved in with her parents while husband served in war</td>
</tr>
<tr>
<td>1945</td>
<td>Husband returned; moved to different Midwestern state</td>
</tr>
<tr>
<td>1946</td>
<td>3rd son born</td>
</tr>
<tr>
<td>1947</td>
<td>4th son born</td>
</tr>
<tr>
<td>1953</td>
<td>Moved to Lexington; secretary for healthcare organization</td>
</tr>
<tr>
<td>1973(?)</td>
<td>Retired</td>
</tr>
<tr>
<td>1976(?)</td>
<td>Husband retired</td>
</tr>
<tr>
<td>1998</td>
<td>Husband died</td>
</tr>
<tr>
<td>2000</td>
<td>Moved to Colonial Square</td>
</tr>
</tbody>
</table>
Mrs. Burkholter

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915</td>
<td>Born in Kentucky</td>
</tr>
<tr>
<td>1927</td>
<td>Moved to another town in Kentucky</td>
</tr>
<tr>
<td>1933 (?)</td>
<td>Graduated from high school; started college</td>
</tr>
<tr>
<td>1935</td>
<td>Graduated from junior college; moved back home</td>
</tr>
<tr>
<td>1936 (?)</td>
<td>Moved to a large city with friends; worked in an office</td>
</tr>
<tr>
<td>1938</td>
<td>Moved back home</td>
</tr>
<tr>
<td>1943</td>
<td>Married; full-time homemaker; lived with parents while husband in the war</td>
</tr>
<tr>
<td>1944</td>
<td>Moved to the Midwest; 1(^{st}) daughter born</td>
</tr>
<tr>
<td>1949</td>
<td>2(^{nd}) daughter born</td>
</tr>
<tr>
<td>1960</td>
<td>Moved to Lexington</td>
</tr>
<tr>
<td>1962</td>
<td>Bought business; became office manager for business</td>
</tr>
<tr>
<td>1982 (?)</td>
<td>Quit working</td>
</tr>
<tr>
<td>1986</td>
<td>Mother died; Husband retired (?); started wintering in FL (?)</td>
</tr>
<tr>
<td>1997 (?)</td>
<td>Stopped wintering in FL</td>
</tr>
<tr>
<td>1999</td>
<td>Moved to Colonial Square</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------------------</td>
</tr>
<tr>
<td>1929</td>
<td>Born in Lexington</td>
</tr>
<tr>
<td>1936</td>
<td>Family moved to rural area outside of town</td>
</tr>
<tr>
<td>1937</td>
<td>In bad accident (hit by car)</td>
</tr>
<tr>
<td>1941 (?)</td>
<td>Family moved back to city</td>
</tr>
<tr>
<td>1943</td>
<td>Mother died</td>
</tr>
<tr>
<td>1947</td>
<td>Graduated from high school; started college</td>
</tr>
<tr>
<td>1951</td>
<td>Graduated from college; taught secondary school</td>
</tr>
<tr>
<td>1952</td>
<td>Taught elementary school</td>
</tr>
<tr>
<td>1952–54</td>
<td>Camp director part time</td>
</tr>
<tr>
<td>1960</td>
<td>Graduated from graduate school</td>
</tr>
<tr>
<td>1961–63</td>
<td>Taught special education</td>
</tr>
<tr>
<td>1963</td>
<td>Full-time state consultant in special education</td>
</tr>
<tr>
<td>1968</td>
<td>Father died</td>
</tr>
<tr>
<td>1972</td>
<td>Brother died</td>
</tr>
<tr>
<td>1980</td>
<td>Retired</td>
</tr>
<tr>
<td>1981 (?)</td>
<td>Moved to a retirement village apartment</td>
</tr>
<tr>
<td>1983</td>
<td>Car accident</td>
</tr>
<tr>
<td>1984</td>
<td>Lived in nursing home</td>
</tr>
<tr>
<td>1986</td>
<td>Moved to Colonial Square</td>
</tr>
<tr>
<td>1992</td>
<td>Diagnosed as diabetic</td>
</tr>
<tr>
<td>2001</td>
<td>Car accident</td>
</tr>
</tbody>
</table>
Mrs. Donovan

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1913</td>
<td>Born in Kentucky; family lived on a farm</td>
</tr>
<tr>
<td>1931</td>
<td>Graduated from high school</td>
</tr>
<tr>
<td>1936 (?)</td>
<td>Moved to Midwest; job as bookkeeper</td>
</tr>
<tr>
<td>1943</td>
<td>Married</td>
</tr>
<tr>
<td>1947</td>
<td>Mother-in-law died; moved back to Kentucky to live on farm with father-in-law</td>
</tr>
<tr>
<td>1949</td>
<td>Started college</td>
</tr>
<tr>
<td>1953</td>
<td>Daughter born</td>
</tr>
<tr>
<td>1954</td>
<td>Graduated from college</td>
</tr>
<tr>
<td>1957 (?)</td>
<td>Started teaching elementary school</td>
</tr>
<tr>
<td>1965</td>
<td>Father-in-law died</td>
</tr>
<tr>
<td>1970</td>
<td>Husband retired; started wintering in Florida</td>
</tr>
<tr>
<td>1974 (?)</td>
<td>Retired; moved to condo in Florida</td>
</tr>
<tr>
<td>1994</td>
<td>Moved to Colonial Square</td>
</tr>
<tr>
<td>1998</td>
<td>Husband died</td>
</tr>
</tbody>
</table>
Mrs. Faust

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1924(?)</td>
<td>Born in Kentucky; family lived on farm</td>
</tr>
<tr>
<td>1927(?)</td>
<td>Moved to town</td>
</tr>
<tr>
<td>1929</td>
<td>Moved back to farm</td>
</tr>
<tr>
<td>1941(?)</td>
<td>Father died</td>
</tr>
<tr>
<td>1942</td>
<td>Graduated from high school</td>
</tr>
<tr>
<td>1942</td>
<td>Attended college where sister taught</td>
</tr>
<tr>
<td>1943–1945</td>
<td>Attended college in Lexington; job as lab assistant</td>
</tr>
<tr>
<td>1946</td>
<td>Married, lived with another couple; worked at research center</td>
</tr>
<tr>
<td>1947</td>
<td>Moved into own house</td>
</tr>
<tr>
<td>1949</td>
<td>1st daughter born; became homemaker; office manager for husband’s business</td>
</tr>
<tr>
<td>1950(?)</td>
<td>Moved to a bigger house</td>
</tr>
<tr>
<td>1951</td>
<td>1st son born</td>
</tr>
<tr>
<td>1953(?)</td>
<td>Moved to a different house</td>
</tr>
<tr>
<td>1954</td>
<td>2nd daughter born</td>
</tr>
<tr>
<td>1954(?)</td>
<td>Moved to final house before Colonial Square</td>
</tr>
<tr>
<td>1956</td>
<td>2nd son born</td>
</tr>
<tr>
<td>1959</td>
<td>3rd daughter born</td>
</tr>
<tr>
<td>1975/76</td>
<td>Mother died</td>
</tr>
<tr>
<td>1977–1987(?)</td>
<td>Real estate work</td>
</tr>
<tr>
<td>1987–1990(?)</td>
<td>Church bookkeeper</td>
</tr>
<tr>
<td>1995(?)</td>
<td>Husband (and she) retired</td>
</tr>
<tr>
<td>1999</td>
<td>Moved to Colonial Square</td>
</tr>
</tbody>
</table>
Mrs. Florsheim

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1912</td>
<td>Born in Kentucky</td>
</tr>
<tr>
<td>1918</td>
<td>Moved to father’s homeplace in a different county</td>
</tr>
<tr>
<td>1930</td>
<td>Graduated from high school; started college in Lexington</td>
</tr>
<tr>
<td>1931</td>
<td>Taught elementary school in home county</td>
</tr>
<tr>
<td>1938</td>
<td>Married; moved to apartment in husband’s home county; 1st daughter born</td>
</tr>
<tr>
<td>1941</td>
<td>Started back to college part-time</td>
</tr>
<tr>
<td>1944</td>
<td>Returned to part-time elementary teaching</td>
</tr>
<tr>
<td>1946</td>
<td>Bought house</td>
</tr>
<tr>
<td>1947</td>
<td>2nd daughter born</td>
</tr>
<tr>
<td>1963</td>
<td>Graduated from college</td>
</tr>
<tr>
<td>1968</td>
<td>Mother died</td>
</tr>
<tr>
<td>1972</td>
<td>Retired</td>
</tr>
<tr>
<td>1978</td>
<td>Husband retired</td>
</tr>
<tr>
<td>1998</td>
<td>Moved to Colonial Square</td>
</tr>
</tbody>
</table>
Mrs. Ford

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1917</td>
<td>Born the Northeast</td>
</tr>
<tr>
<td>1933</td>
<td>Graduated from high school</td>
</tr>
<tr>
<td>1937</td>
<td>Graduated from college; worked for extension agency</td>
</tr>
<tr>
<td>1939</td>
<td>Married; started teaching secondary school</td>
</tr>
<tr>
<td>1946</td>
<td>Son born; resigned from teaching</td>
</tr>
<tr>
<td>1947</td>
<td>1\textsuperscript{st} daughter born</td>
</tr>
<tr>
<td>1949</td>
<td>2\textsuperscript{nd} daughter born</td>
</tr>
<tr>
<td>1950</td>
<td>3\textsuperscript{rd} daughter born</td>
</tr>
<tr>
<td>1955 (?)</td>
<td>She and husband ran a greenhouse</td>
</tr>
<tr>
<td>1962</td>
<td>Back to teaching</td>
</tr>
<tr>
<td>1975</td>
<td>Husband retired</td>
</tr>
<tr>
<td>1977</td>
<td>Retired; wintered in Florida</td>
</tr>
<tr>
<td>1978</td>
<td>Sister moved in</td>
</tr>
<tr>
<td>1986</td>
<td>Husband died</td>
</tr>
<tr>
<td>1988</td>
<td>Stroke; broke vertebrae</td>
</tr>
<tr>
<td>1998</td>
<td>Moved to Colonial Square; summered in North</td>
</tr>
<tr>
<td>1999</td>
<td>Broke back</td>
</tr>
<tr>
<td>2001</td>
<td>Broke hip</td>
</tr>
</tbody>
</table>
Mrs. Jergens

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915</td>
<td>Born in Kentucky</td>
</tr>
<tr>
<td>1916</td>
<td>Family moved to the Midwest</td>
</tr>
<tr>
<td>1918</td>
<td>Family moved back to Kentucky</td>
</tr>
<tr>
<td>1932</td>
<td>Graduated from high school</td>
</tr>
<tr>
<td>1936</td>
<td>Graduated from college; married; rented apartment; began substitute teaching &amp; tutoring</td>
</tr>
<tr>
<td>1938</td>
<td>Quit working; built duplex</td>
</tr>
<tr>
<td>1944</td>
<td>Daughter born; husband in the war; lived in duplex with parents on the other side</td>
</tr>
<tr>
<td>1946</td>
<td>Husband back home</td>
</tr>
<tr>
<td>1950</td>
<td>Built house; rented out their side of duplex</td>
</tr>
<tr>
<td>1952</td>
<td>Father died</td>
</tr>
<tr>
<td>1953</td>
<td>Moved back to duplex where Mother still lived</td>
</tr>
<tr>
<td>1969</td>
<td>Moved to a house (mother moved with them)</td>
</tr>
<tr>
<td>1976</td>
<td>Husband retired</td>
</tr>
<tr>
<td>1984</td>
<td>Husband died</td>
</tr>
<tr>
<td>1988</td>
<td>Mother in nursing home</td>
</tr>
<tr>
<td>1989</td>
<td>Moved to a townhouse closer to mother</td>
</tr>
<tr>
<td>1990</td>
<td>Mother died</td>
</tr>
<tr>
<td>2000</td>
<td>Fall; moved to Colonial Square</td>
</tr>
<tr>
<td>2001</td>
<td>2nd fall</td>
</tr>
</tbody>
</table>
Mrs. Michaels

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1912</td>
<td>Born in Kentucky</td>
</tr>
<tr>
<td>1918(?)</td>
<td>Family moved in with grandmother, on farm</td>
</tr>
<tr>
<td>1920(?)</td>
<td>Grandmother died; moved back to own farm</td>
</tr>
<tr>
<td>1930(?)</td>
<td>Graduated from high school</td>
</tr>
<tr>
<td>1931</td>
<td>Started college in Lexington</td>
</tr>
<tr>
<td>1934</td>
<td>Left college to teach elementary school</td>
</tr>
<tr>
<td>1936</td>
<td>Back to college</td>
</tr>
<tr>
<td>1937</td>
<td>Graduated from college; started teaching secondary school in a rural county</td>
</tr>
<tr>
<td>1939</td>
<td>Married; had house built; taught secondary school in Lexington</td>
</tr>
<tr>
<td>1940</td>
<td>Husband in war; worked in occupational therapy; father died</td>
</tr>
<tr>
<td>1942</td>
<td>Husband returned home; returned to teaching</td>
</tr>
<tr>
<td>1947</td>
<td>1st son born; full-time homemaker</td>
</tr>
<tr>
<td>1951</td>
<td>2nd son born</td>
</tr>
<tr>
<td>1957</td>
<td>Taught elementary and special education</td>
</tr>
<tr>
<td>1962</td>
<td>Mother died</td>
</tr>
<tr>
<td>1963</td>
<td>Retired from teaching</td>
</tr>
<tr>
<td>1972</td>
<td>Husband retired</td>
</tr>
<tr>
<td>1979</td>
<td>2nd son died</td>
</tr>
<tr>
<td>1988</td>
<td>Wintered in FL</td>
</tr>
<tr>
<td>1998</td>
<td>Husband died</td>
</tr>
<tr>
<td>2000</td>
<td>Moved to Colonial Square; sold house to grandson</td>
</tr>
<tr>
<td>2001</td>
<td>Hip fracture</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>1912</td>
<td>Born in the Northeast</td>
</tr>
<tr>
<td>1918</td>
<td>Family moved to a new town</td>
</tr>
<tr>
<td>1930</td>
<td>Graduated from high school</td>
</tr>
<tr>
<td>1931</td>
<td>Married</td>
</tr>
<tr>
<td>1934</td>
<td>1st son born</td>
</tr>
<tr>
<td>1939/40</td>
<td>2nd son born; parents and brother lived with them briefly</td>
</tr>
<tr>
<td>1944</td>
<td>Daughter born</td>
</tr>
<tr>
<td>1953</td>
<td>Began working as a clerk</td>
</tr>
<tr>
<td>1956</td>
<td>Father died</td>
</tr>
<tr>
<td>1957</td>
<td>Husband started with same company; transferred to Lexington; bought house</td>
</tr>
<tr>
<td>1967 (?)</td>
<td>Husband retired, worked as manufacturing representative</td>
</tr>
<tr>
<td>1977</td>
<td>Retired; wintered in Florida</td>
</tr>
<tr>
<td>1982</td>
<td>Husband died</td>
</tr>
<tr>
<td>1991</td>
<td>Moved to Colonial Square</td>
</tr>
<tr>
<td>1995 (?)</td>
<td>2nd son died</td>
</tr>
<tr>
<td>1999</td>
<td>Sold house</td>
</tr>
</tbody>
</table>
Mrs. Nichols

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1915</td>
<td>Born in the Midwest</td>
</tr>
<tr>
<td>1923</td>
<td>Family moved from city to suburb</td>
</tr>
<tr>
<td>1927</td>
<td>Father died</td>
</tr>
</tbody>
</table>
| 1932 | Graduated from high school  
      | Started junior college |
| 1934 | Transferred to four-year college in Kentucky |
| 1936 | Graduated from college; worked for local government office in Lexington |
| 1939 | Mother moved to Lexington |
| 1940 | Married; started traveling with husband and his job around Kentucky |
| 1944 | 1st daughter born |
| 1945 | Moved in with mother-in-law |
| 1947 | 2nd daughter born |
| 1949 | 1st son born |
| 1951 | 2nd son born |
| 1952 (?) | Husband started job as stockbroker |
| 1957 | Mother-in-law died; bought house in Lexington |
| 1980 | Husband retired |
| 1992 | Mother died |
| 1996 | Broke hip |
| 1997 | Moved to Colonial Square |
### Mrs. Provost

<table>
<thead>
<tr>
<th>Year</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1907</td>
<td>Born in Kentucky</td>
</tr>
<tr>
<td>1922</td>
<td>Looked after Mom &amp; home instead of high school</td>
</tr>
<tr>
<td>1926</td>
<td>Started high school</td>
</tr>
<tr>
<td>1931(?)</td>
<td>Graduated from high school; attended beauty school</td>
</tr>
<tr>
<td>1932(?)</td>
<td>Began work as a beautician</td>
</tr>
<tr>
<td>1935</td>
<td>Married; became full-time homemaker</td>
</tr>
<tr>
<td>1935-1960</td>
<td>Moved often with husband’s job in various states of the South</td>
</tr>
<tr>
<td>1958</td>
<td>Graduated from junior college in Kentucky</td>
</tr>
<tr>
<td>1961</td>
<td>Graduated from a four-year college in Kentucky; father died</td>
</tr>
<tr>
<td>1962</td>
<td>Mother died</td>
</tr>
<tr>
<td>1964</td>
<td>Graduated from graduate school in Kentucky; began working as a college librarian in Kentucky</td>
</tr>
<tr>
<td>1967</td>
<td>Husband died</td>
</tr>
<tr>
<td>1977</td>
<td>Married 2nd husband</td>
</tr>
<tr>
<td>1978</td>
<td>Retired</td>
</tr>
<tr>
<td>1980</td>
<td>Divorced; moved to large city in Kentucky</td>
</tr>
<tr>
<td>1994</td>
<td>Moved to Colonial Square</td>
</tr>
<tr>
<td>1999</td>
<td>Fell and broke arm</td>
</tr>
<tr>
<td>2001</td>
<td>Hurt back</td>
</tr>
</tbody>
</table>
Mrs. Randall

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1928</td>
<td>Born in the Midwest</td>
</tr>
<tr>
<td>1933(?)</td>
<td>Family moved to a new town</td>
</tr>
<tr>
<td>1943</td>
<td>Started working part time jobs after school and on Saturdays</td>
</tr>
<tr>
<td>1946</td>
<td>Graduated from high school</td>
</tr>
<tr>
<td>1948</td>
<td>Graduated from college; worked in health care</td>
</tr>
<tr>
<td>1949</td>
<td>Married; moved to Washington, D.C.; lived with in-laws (6 months), then rented an apartment</td>
</tr>
<tr>
<td>1950</td>
<td>Moved to suburb of Washington, D.C.</td>
</tr>
<tr>
<td>1952</td>
<td>Moved to Europe</td>
</tr>
<tr>
<td>1954</td>
<td>1st son is born</td>
</tr>
<tr>
<td>1955</td>
<td>Moved to West coast; lived in military quarters</td>
</tr>
<tr>
<td>1958</td>
<td>Moved to Texas; lived in military quarters</td>
</tr>
<tr>
<td>1959</td>
<td>2nd son is born</td>
</tr>
<tr>
<td>1962</td>
<td>Daughter born</td>
</tr>
<tr>
<td>1965</td>
<td>Moved to Hawaii; lived in military quarters</td>
</tr>
<tr>
<td>1968</td>
<td>Moved to Washington, D.C.</td>
</tr>
<tr>
<td>1969</td>
<td>Moved to Lexington; husband took job as a professor</td>
</tr>
<tr>
<td>1971-1976</td>
<td>Worked as research assistant</td>
</tr>
<tr>
<td>1984</td>
<td>Moved to Colonial Square</td>
</tr>
<tr>
<td>1985</td>
<td>Mother-in-law moved to Colonial Square</td>
</tr>
<tr>
<td>1986</td>
<td>Parents moved to Colonial Square</td>
</tr>
<tr>
<td>1989(?)</td>
<td>Husband retired</td>
</tr>
<tr>
<td>1990</td>
<td>Mother-in-law died</td>
</tr>
<tr>
<td>1992</td>
<td>Parents moved to assisted living</td>
</tr>
<tr>
<td>1994</td>
<td>Mother died</td>
</tr>
<tr>
<td>1996</td>
<td>Father died</td>
</tr>
<tr>
<td>1997</td>
<td>Both hips replaced</td>
</tr>
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Mrs. Richardson

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1917</td>
<td>Born in the South</td>
</tr>
<tr>
<td>1935</td>
<td>Graduated from high school; married</td>
</tr>
<tr>
<td>1936</td>
<td>1st son born</td>
</tr>
<tr>
<td>1940</td>
<td>Daughter born</td>
</tr>
<tr>
<td>1941</td>
<td>Husband in the service</td>
</tr>
<tr>
<td>1943</td>
<td>Husband returned home</td>
</tr>
<tr>
<td>1946</td>
<td>2nd son born</td>
</tr>
<tr>
<td>1950s</td>
<td>Worked for federal government program</td>
</tr>
<tr>
<td></td>
<td>Very ill, in hospital in the Mid-Atlantic for several years</td>
</tr>
<tr>
<td>1965 (?)</td>
<td>Moved to Atlantic coast in the South</td>
</tr>
<tr>
<td>1975 (?)</td>
<td>Husband died</td>
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<tr>
<td>1997</td>
<td>Moved to Colonial Square</td>
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Mrs. Stokes

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1913</td>
<td>Born in the Midwest</td>
</tr>
<tr>
<td>1931</td>
<td>Graduated from high school; started laundry job</td>
</tr>
<tr>
<td>1934</td>
<td>Married; became full-time homemaker; lived with father-in-law</td>
</tr>
<tr>
<td>1936</td>
<td>Moved to own house</td>
</tr>
<tr>
<td>1937</td>
<td>Daughter born; father died; mother moved in</td>
</tr>
<tr>
<td>1940</td>
<td>1st son born</td>
</tr>
<tr>
<td>1941</td>
<td>Bought house</td>
</tr>
<tr>
<td>1945</td>
<td>2nd son born</td>
</tr>
<tr>
<td>1945–1948</td>
<td>Various retail sales jobs</td>
</tr>
<tr>
<td>1950</td>
<td>Mother died</td>
</tr>
<tr>
<td>1955(?)</td>
<td>Newspaper job</td>
</tr>
<tr>
<td>1958(?)</td>
<td>Bookkeeper</td>
</tr>
<tr>
<td>1959(?)</td>
<td>Billing</td>
</tr>
<tr>
<td>1964</td>
<td>Card company job</td>
</tr>
<tr>
<td>1965</td>
<td>Husband retired; moved to Florida</td>
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<tr>
<td>1970</td>
<td>Office manager/bookkeeper</td>
</tr>
<tr>
<td>1976(?)</td>
<td>Diagnosed as diabetic</td>
</tr>
<tr>
<td>1980</td>
<td>Retired</td>
</tr>
<tr>
<td>1989</td>
<td>Husband died</td>
</tr>
<tr>
<td>1990</td>
<td>1st son died</td>
</tr>
<tr>
<td>1992</td>
<td>Moved to Colonial Square; suffered stroke</td>
</tr>
<tr>
<td>1993</td>
<td>Broke hip</td>
</tr>
<tr>
<td>2001</td>
<td>Heart problems</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------</td>
</tr>
<tr>
<td>1916</td>
<td>Born in the Midwest</td>
</tr>
<tr>
<td>1934 (?)</td>
<td>Graduated from high school</td>
</tr>
<tr>
<td>1935</td>
<td>Married</td>
</tr>
<tr>
<td>1936</td>
<td>Son born</td>
</tr>
<tr>
<td>1939/40</td>
<td>House built</td>
</tr>
<tr>
<td>1954</td>
<td>Daughter born; son married and moved out</td>
</tr>
<tr>
<td>1957</td>
<td>Moved in with mother-in-law; father died</td>
</tr>
<tr>
<td>1965</td>
<td>Mother-in-law died</td>
</tr>
<tr>
<td>1979</td>
<td>Husband retired; moved to the Southwest; bought house</td>
</tr>
<tr>
<td>1985</td>
<td>Husband died</td>
</tr>
<tr>
<td>1986/87</td>
<td>Married 2\textsuperscript{nd} husband</td>
</tr>
<tr>
<td>1992</td>
<td>2\textsuperscript{nd} husband died</td>
</tr>
<tr>
<td>2000</td>
<td>Moved to Colonial Square</td>
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Mrs. Wilson

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1922</td>
<td>Born in the South</td>
</tr>
<tr>
<td>1939</td>
<td>Graduated from high school; mother died; started business school; worked as nanny</td>
</tr>
<tr>
<td>1940</td>
<td>Worked as secretary</td>
</tr>
<tr>
<td>1941</td>
<td>Entered civil service in Washington, D.C.</td>
</tr>
<tr>
<td>1942</td>
<td>Married 1st husband; lived on a boat</td>
</tr>
<tr>
<td>1944</td>
<td>Moved to house in suburb of Washington, D.C.</td>
</tr>
<tr>
<td>1945</td>
<td>1st son born</td>
</tr>
<tr>
<td>1950</td>
<td>2nd son born</td>
</tr>
<tr>
<td>1951</td>
<td>Traveled around Europe and Scandinavia</td>
</tr>
<tr>
<td>1953</td>
<td>Moved to Northeast</td>
</tr>
<tr>
<td>1954</td>
<td>Trip around the world with 1st son</td>
</tr>
<tr>
<td>1959</td>
<td>Divorced; she and 2nd son move into new house</td>
</tr>
<tr>
<td>1963</td>
<td>Started college</td>
</tr>
<tr>
<td>1968</td>
<td>Graduated from college; married 2nd husband; moved into husband’s house</td>
</tr>
<tr>
<td>1977</td>
<td>Husband retired; moved to Kentucky</td>
</tr>
<tr>
<td>1988</td>
<td>Moved to Lexington; had retirement house built</td>
</tr>
<tr>
<td>2000</td>
<td>Moved to Colonial Square</td>
</tr>
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Appendix E
Participants’ Recipes

List of Recipes

Mrs. Adams: Dump Jello Salad
Butterscotch Brownies

Mrs. Brown: Chili
Oatmeal Squares

Ms. Carr: Chili

Mrs. Donovan: Applesauce Muffins
Zucchini Muffins
Coconut Pie
Butterscotch Pie
Raisin Pie
Strawberry Pie
Blue Grass Pie

Mrs. Faust: Chicken Judy
Ruby Sue’s Lime Cheese Jello

Mrs. Florsheim: Yummy Oatmeal Cookies
Corn Pudding
Turkey Hash
Sweet Potatoes in Orange Shells

Mrs. Ford: Anzac Biscuits
Cranberries Goodin’ Pudding
Raisin Roughs

Mrs. Jergens: Hot Chicken Salad
Cranberry Salad
Coconut Torte
Pecan Pie

Mrs. Michaels: Oatmeal Chocolate Chip Cookies
Asparagus Casserole

Mrs. Monroe: Speedy Pie
Lemon Squares

Mrs. Nichols: Chicken Mexicaine
Charlotte Russe

Mrs. Provost: Spoon Bread
Good September Relish
Apple Pudding

Mrs. Randall: On-the-Wing Appetizers
Mystery Slaw
Brunch Casserole
English Shortbread
Roasted Pecan Clusters

Mrs. Richardson: Sourdough Bread

Mrs. Stokes: Diabetic Pumpkin Pie
Smothered Chicken

Mrs. Vossler: Bean Salad
Old Fashioned Apple Crisp

Mrs. Wilson: Third Church Chicken
Granola
Abbreviations used in recipes:  lb. = pound
t. = teaspoon
T. = tablespoon

Mrs. Adams:

Dump Jello Salad
1 cup boiling hot water
1 packet lime jello
1 container fat free yogurt
1 can crushed pineapple
¾ cup walnuts, chopped (the size of peas)


Butterscotch Brownies
¼ cup corn oil
1 cup light brown sugar (packed)
1 egg
¾ cup sifted flour
1 t. baking powder
½ t. salt
½ t. vanilla
½ cup walnuts, coarsely chopped

Mrs. Brown:

Chili
1 lb. ground beef
1 medium onion chopped
1 can condensed tomato soup
Chili pepper
½ can water
1 large or 2 medium cans red kidney beans
Catsup

Brown beef and chopped onions. Season with chili pepper. Add tomato soup and water. When well mixed, add kidney beans – including liquid – add 2 or 3 dashes catsup – (add another ½ can water if needed).

Oatmeal Squares
Butter
Brown sugar
Oatmeal

Melt butter and brown sugar. Stir in instant oatmeal. Pour into buttered pan – Let set until firm and cut in squares. (Can add marshmallows or peanuts if desired)
Ms. Carr:

**Chili**  
1 package of pasta (e.g. elbows, shells)  
1 T. chili powder  
1 big green pepper, chopped  
1 medium onion, chopped  
2 cans red kidney beans  
2 small cans tomato sauce  
1 large can diced tomatoes  
1 1/2 lb. ground sirloin steak (or other beef)

Cook pasta, set aside. Cook onion in a large skillet, then add pepper and cook. Cook meat, and add beans. Stir only with a wooden spoon. Stir in tomato sauce and diced tomatoes. Add chili powder. Stir in pasta slowly. Cover and simmer on low for a half hour or so.
Mrs. Donovan:

**Applesauce Muffins**

\[\frac{2}{3}\text{ cup soft oleo (margarine)}\]
\[1\frac{1}{2}\text{ cups sugar}\]
\[4\text{ eggs}\]
\[2\text{ t. vanilla}\]
\[2\frac{2}{3}\text{ cups flour}\]
\[2\text{ t. baking powder}\]
\[1\text{ t. soda}\]
\[1\text{ t. salt}\]
\[2\text{ t. cinnamon}\]
\[1\text{ t. nutmeg}\]
\[\frac{1}{4}\text{ t. cloves}\]
\[1\frac{1}{2}\text{ cup applesauce}\]
\[1\text{ cup nuts}\]
\[1\text{ cup raisins}\]

Cream the oleo and sugar. Mix in the eggs and vanilla. Add the next 7 ingredients alternately with the applesauce. Fold in the nuts and raisins. Bake at 350° for 25 minutes. Makes 24.

**Zucchini Muffins**

\[3\text{ eggs}\]
\[2\text{ cups sugar}\]
\[1\text{ cup oil}\]
\[1\text{ T. vanilla}\]
\[2\text{ cups flour}\]
\[1\text{ t. zest}\]
\[1\text{ t. cinnamon}\]
\[\frac{1}{4}\text{ t. baking powder}\]
\[\frac{1}{4}\text{ t. soda}\]
\[1\text{ t. salt}\]
\[1\text{ cup nuts}\]

Coconut Pie
Baked pie crust
1 cup sugar
¼ cup cornstarch
2 cups milk
3 egg yolks
1 t. vanilla
½ stick oleo (margarine)
1 cup coconut
Meringue:
3 egg whites
3 T. water
3 heaping t. sugar

Combine sugar and cornstarch in a saucepan and add a little milk to moisten. Stir in egg yolks, and then add rest of the milk. Cook until thick. Add vanilla, oleo and coconut. Pour into a baked pie shell.
To make meringue: beat egg whites until frothy and add water. Continue beating egg whites until they form firm peaks but are not dry. Gradually add sugar. Beat until whites are thick and glossy. Spread meringue on top of pie filling. With the back of a spoon, spread the meringue to cover the filling completely. Bake at 325° until golden brown.

Butterscotch Pie
Baked pie crust
1 cup firmly packed brown sugar
¼ cup cornstarch
½ t. salt
1½ cups milk
3 egg yolks
3 T. butter
1 t. vanilla
¼ t. maple flavoring
Meringue:
3 egg whites
3 T. water
3 heaping t. sugar

Combine sugar and cornstarch in a saucepan and add a little milk to moisten. Stir in egg yolks, and then add rest of the milk. Cook until thick. Add butter, vanilla and maple flavoring. Pour into a baked pie shell.
To make meringue: beat egg whites until frothy and add water. Continue beating egg whites until they form firm peaks but are not dry. Gradually add sugar. Beat until whites are thick and glossy. Spread meringue on top of pie filling. With the back of a spoon, spread the meringue to cover the filling completely. Bake at 325° until golden brown.
Raisin Pie
2½ cups raisins (1 box)  
1½ cups water  
1 T. cornstarch (in a little water)  
¼ cup oleo (margarine)  
4 packets of Sweet-n-Low  
Unbaked pie crust

In a saucepan, boil the raisins and water for 10 minutes. Add the cornstarch, oleo and artificial sweetener. Place in an unbaked pie crust. Bake at 325° for 30 minutes.

Strawberry Pie
Baked pie crust  
1 cup sugar  
2 T. cornstarch  
1¼ cups water  
1 package strawberry jello  
1 T. butter  
Strawberries

Combine sugar, cornstarch and water in a saucepan. Cook until thick. Add the jello and butter. Let it almost gel. Pour over berries in a baked crust.

Blue Grass Pie
½ stick butter  
¼ cup brown sugar  
½ cup white sugar  
2 T. flour  
½ cup corn syrup  
1 t. vanilla  
¼ cup bourbon  
1 cup chopped English walnuts  
1 cup chocolate chips

Cream the butter and sugar. Add eggs one at a time and mix well after each. Add the syrup, vanilla and bourbon. Flour the nuts and chips. Fold in the floured nuts and chips. Pour into an unbaked pie crust. Bake at 375° for 35 minutes.
Mrs. Faust:

**Chicken Judy**
1 (4-oz.) jar of dried beef
6 boned chicken breasts
1 can cream of mushroom soup
1 cup sour cream

Wrap dried beef around each breast, and put in a shallow casserole. Blend the soup, sour cream and some black pepper. Pour over the chicken. Bake for 3 hours at 275°.
Serving suggestion: Serve over rice.

**Ruby Sue’s Lime Cheese Jello**
1 large package lime jello
1 cup miniature marshmallows
2 cups boiling water
2 (8-oz.) packages cream cheese
4 T. lemon juice
1 large can crushed pineapple
8 oz. whipping cream
1 cup chopped nuts

Mix the first three ingredients and let thicken some. Then add the next three ingredients. When that begins to thicken, add whipping cream and one cup chopped nuts.
Mrs. Florsheim:

Yummy Oatmeal Cookies
1 cup margarine or butter, softened
1 cup granulated sugar
1 cup brown sugar, firmly packed
2 eggs
1 t. vanilla
2 cups all purpose flour
1½ t. cinnamon
1 t. baking soda
1 t. salt
3 cups quick oats
1 cup nuts or raisins

Cream butter or margarine and sugars until smooth. Beat in eggs and vanilla. Combine and blend thoroughly flour, cinnamon, baking soda and salt, beat into creamed mixture. Stir in oatmeal and raisins. Drop by rounded teaspoonfuls onto greased baking sheet.
Preheat oven to 375 degrees. Bake 12 to 14 minutes. Makes 6 dozen cookies. Batter very thick.

Corn Pudding
2 cups of fresh or canned corn
2 T. flour
1 t. salt
3 T. butter
3 beaten eggs
2 T. sugar
1¾ cups milk

Blend butter, sugar, flour, salt. Add eggs, stir in corn and milk. Pour into a buttered casserole.
Bake 45 minutes at 325°. Stir once while cooking. Pudding should be a nice warm brown, and should be done when a silver knife inserted in it comes out clean.
Turkey Hash
½ cup butter
½ cup flour
4 cups milk or broth from turkey bones
3 cups diced cooked turkey
½ cup diced cooked potatoes
½ cup diced cooked carrots
½ cup diced cooked celery
Salt
Pepper
Parmesan cheese topping (optional)

Melt butter. Add flour and milk slowly. Mix in the turkey, vegetables, salt, pepper and cheese, and bake at 350° until bubbly.

Sweet Potatoes in Orange Shells
1 (15 oz.) can of sweet potatoes, mashed.
Brown sugar
Spices
Butter
Orange juice
Marshmallows
Orange shells (rinds of oranges)

To the sweet potatoes, add brown sugar and spices to taste, also a little butter and orange juice. Top with marshmallows and bake until very hot. Serves 12 in ½ orange shell. Use very small oranges.
Mrs. Ford:

Anzac Biscuits
1 cup quick oats
⅛ cup coconut
1 cup flour
1 t. baking soda
1 cup sugar
½ cup margarine
1 T. light corn syrup
2 T. boiling water

Combine oats, flour, coconut and sugar. Melt syrup and margarine together. Mix baking soda with water. Add to mix. Mix into dry ingredients. Place by tablespoon on well-greased sheet. Bake at 325° for 20 minutes.

Cranberries Goodin’ Pudding
1 cup cranberries
⅛ cup chopped nuts
1 egg
½ cup sugar
⅛ cup sugar
⅛ cup flour
⅛ cup melted butter or margarine

Grease well an 8” pie plate. Spread cranberries over the bottom of the plate. Sprinkle ¼ cup sugar with nuts thoroughly mixed in. Beat egg well and add gradually to sugar. Add flour and melted butter or margarine to the egg-sugar mixture. Pour batter over the cranberries and nuts. Bake 45 minutes at 325° until golden brown. Cut like a pie. Serve warm or cold.
**Raisin Roughs**
1 cup sifted flour
1¼ t. salt
¾ t. baking soda
2 t. cinnamon
1 cup shortening
½ c. peanut butter
2 cups sugar
3 eggs
¼ cup milk
2 t. vanilla
3½ cups quick cooking oats
2 cups raisins

Mrs. Jergens:

Hot Chicken Salad
2 cups chopped cooked chicken
2 cups (or 1½ c.) celery
2 T. chopped pimento
½ cup toasted almonds
1/3 cup chopped green pepper
1 can mushroom soup
3 T. chopped onion
½ t. salt
2 T. lemon juice
½ cup mayonnaise
⅓ cup grated sharp cheese

Blend chicken, celery, nuts, pimento, green pepper, soup, onion, salt, lemon juice, and mayonnaise. Put in 2 quart casserole. Top with cheese and Ritz cracker crumbs that have been stirred in butter. Bake at 350° about 25–30 minutes. Serves 6.

Cranberry Salad
2 (3 oz.) packages of raspberry jello
1¾ cups boiling water
1 (16 oz.) can of whole (or jellied) cranberry sauce
1 (20 oz.) can of crushed pineapple (in own juice), undrained
1 c. sour cream (room temperature), whipped up

Dissolve jello in boiling water; stir in cranberry sauce and undrained pineapple until sauce melts (about 3 cups plus mixture). Put half in 9×13 pan and congeal. Leave other half at room temperature. Stir sour cream well and spread over congealed gelatin gently. Gently spoon remaining jello mixture on top of sour cream. Let stand in refrigerator overnight.

Coconut Torte
1 cup coconut
¼ t. salt
4 egg whites
1 cup crushed graham crackers
½ cup chopped pecans
1 t. vanilla
1 cup sugar

Beat egg whites with salt and vanilla until foamy. Gradually add sugar until whites are stiff peaks. Add graham crackers and nuts. Fold into greased pie pan and bake at 350° for 30 minutes (325° if using Pyrex). Put pecan or caramel ice cream on each serving.
Pecan Pie
1 cup sugar
½ cup corn syrup
¼ c. butter, melted
3 eggs, well beaten
1 cup pecans
1 unbaked 9" pie shell

Combine sugar, syrup and melted butter. Add beaten eggs and pecans to syrup mixture, mixing thoroughly. Pour filling into pie shell. Bake in 375° oven for 40 to 45 minutes. Cool.
Mrs. Michaels:

**Oatmeal Chocolate Chip Cookies**
1 cup butter or oleo
¾ cup brown sugar
¾ cup white sugar
2 eggs
2 cups oatmeal
1½ cups flour
1 t. salt
1 t. soda dissolved in tap water
1 t. vanilla
1 (12 oz.) package chocolate chips (I often halve this)
1 cup nuts – optional

Mix in order given. Bake on an ungreased cookie sheet at 375° for 10 minutes.

**Asparagus Casserole**
1½ cups cracker crumbs
1 stick oleo (margarine), melted
½ cup slivered almonds
1 (no. 2) can cut asparagus or 1 package frozen, cooked until tender

Sauce:
4 T. butter
3 T. flour
1 t. salt
1½ cups milk
15 oz. glass old English cheese

Combine cracker crumbs and butter. Place ¾ cup on bottom. Place cut asparagus on top. Sprinkle with almonds. Pour on cheese sauce. Top with crumbs. Bake 12 minutes in preheated oven at 450°.
Mrs. Monroe:

**Speedy Pie**
1 cup flour, self-rising  
1 cup sugar  
1 cup milk  
1 stick butter, melted

Beat all together. Pour in 8-inch square or 9-inch round greased pan. Put drained canned fruit or fresh fruit or berries on top. Bake at 400°. Can also make this with vegetables instead of fruit.

**Lemon Squares**
½ cup xxxx sugar  
1 cup margarine  
2 cups flour

Blend together and spread in 9”×13” pan. Pat down with fingers, making ½” side crust. Bake in a 350° oven for 15 minutes.

4 eggs  
2 cups sugar  
1 t. baking powder  
¼ t. salt  
2 t. grated lemon peel  
¼ cup fresh lemon juice

In meantime, beat eggs and set aside. Do not over beat. Mix sugar, baking powder, salt, grated lemon peel, and lemon juice. Fold this into eggs. Pour over hot crust and bake 20–25 minutes more in 350° oven. Cool in pan. While hot, sift powdered sugar over top. Do not cut until thoroughly cold. You can score while warm if desired.
Mrs. Nichols:

**Chicken Mexicaine**
4 lbs. chicken breasts
3 cups water
1 T. salt
1 T. butter
1 medium onion, chopped fine
1 green pepper, chopped
clove of garlic, minced
1 lb. can of stewed tomatoes
2 small cans mushrooms, drained
4 T. parsley, chopped
1 t. pepper
1 t. chili powder
½ t. oregano
2 T. cornstarch

Put chicken in 3 cups of water with 1 tablespoon of salt. Cover and bring to a boil. Simmer until tender. Cool in broth. Remove from broth and remove bones. Boil broth to 2 cups; strain. Melt 1 tablespoon butter in a skillet, add 1 medium onion chopped fine, 1 green pepper chopped, 1 minced clove of garlic, and sauté. Add 1 pound can of stewed tomatoes, 2 small cans drained mushrooms, 4 tablespoons chopped parsley, 1 teaspoon pepper, 1 teaspoon chili powder, ½ teaspoon oregano and chicken broth. Cook uncovered 15 minutes. Mix 2 tablespoons cornstarch with cold water, add and cook 1 minute, stirring constantly.

Divide chicken in casserole, add sauce, cover with foil and store in the refrigerator. Use the next day. Set casserole at room temperature for 2 hours before placing in a 400° oven for half an hour before serving. Serves 8 of you have potatoes and vegetables.

**Charlotte Russe**
1 package unflavored gelatin
¼ cup cold water
2 eggs
½ cup sugar
1 t. vanilla
Bourbon to taste (3+ T.)
Salt
1 pint whipping cream
2 packages ladyfingers (one is enough if it has 8 ladyfingers in the package)


Serves 8. Recipe can be doubled. Will keep for several days in the refrigerator.
Mrs. Provost:

**Spoon Bread**
- 2 cups sweet milk, scalded
- ½ t. salt
- 1 T. sugar
- 1 cup cornmeal, added slowly
- 1 stick butter or margarine
- 3 large egg yolks, well-beaten
- 3 large egg whites, beaten until stiff

Mix the first 5 ingredients and when thick, add the egg yolks. When mixture is cool, fold in egg whites. Pour into a well-greased casserole. Bake for 35 minutes in a 350° oven. Serve immediately, for it falls as soon as air hits it.

**Good September Relish**
- 4 apples
- 4 medium onions
- 4 sweet green peppers
- 2 quarts ripe tomatoes, peeled
- 1 cup cider vinegar
- ¼ t. black pepper
- Bit of cayenne pepper (or red hot pepper)
- 2 cups brown sugar
- ½ t. ground cloves
- 1 t. cinnamon
- Bit of salt

Chop apples, tomatoes, onions and peppers. Add vinegar, sugar, black pepper, cloves and spices. Cook, stirring occasionally, until thick – about 2 hours. Can in sterilized jars.

**Apple Pudding**
- 1 cup sugar
- ¼ cup butter
- 1 egg
- 2 or 3 apples, chopped
- 1 cup flour
- 1 t. baking soda
- 1 t. cinnamon
- ¼ t. cloves
- Dab of salt
- ½ cup nut meats

Cream the sugar and butter. Add the egg and apples. Add mixed together the flour, soda, cinnamon, cloves and salt. Add the nuts. Bake in 350° oven for 30 minutes in a square pan. Serve warm with whipped cream or vanilla ice cream.
Mrs. Randall:

**On-the-Wing Appetizers**

30 (about 2½ lbs.) chicken wing drums or small legs  
½ t. salt  
¼ cup soy sauce  
¼ cup spiced peach or apricot syrup  
2 T. honey  
¼ t. Accent  
½ t. ground ginger  
1 T. lemon juice  
5 drops Tabasco  
1 clove garlic

Marinate for about 8 hours (or overnight). Roast at 350° for 1 hour on a flat pan. Baste twice with marinade during roasting. Can be frozen. Can be doubled or tripled.

**Mystery Slaw**

3 cups shredded turnips (2 lbs)  
1½ cups shredded carrots  
½ cup raisins  
½ to ¾ cup mayonnaise  
1 T. lemon juice

Combine all ingredients in a large bowl. Stir well. Cover and chill. 6 to 8 servings.

**Brunch Casserole**

12 slices white bread – crusts trimmed, buttered on both sides, cubed  
1 lb. cooked sausage, crumbled  
½ lb. shredded cheddar cheese  
4 to 6 eggs, lightly beaten  
3 cups milk  
½ t. salt – pepper

Butter 9×13 baking pan or dish. Sprinkle sausage and cheese over bread cubes. Combine remaining ingredients. Pour over bread cubes. Cover and refrigerate overnight. Bake covered for 45 minutes to 1 hour at 350°. Serve immediately.
**English Shortbread**
4 cups all purpose flour  
2 cups butter, softened  
1¼ cup 10X sugar  
1 t. baking powder  
¼ t. salt  

Preheat oven 325°. In a large bowl, measure all ingredients. With hand, knead ingredients until well blended. (Good to beat butter before adding other ingredients). Pat dough into two 9-inch round or square cake pans. Prick dough in many places with prongs of fork. Bake 35 to 45 minutes or until golden. While warm, with sharp knife, cut into small pieces. This is very rich. Cool in pans or wire racks. Store in tightly covered containers. Lasts for weeks. Can also be baked in a 9×13 pan.

**Roasted Pecan Clusters**
3 T. butter or margarine  
3 cups pecan pieces  
12 (1 oz.) squares chocolate flavored candy coating  

Mrs. Richardson:

**Sourdough Bread**

1 cup starter  
1½ cups water  
½ cup oil  
2 T. sugar  
2 T. salt  
5–6 cups bread flour

To the first 5 ingredients, add 4 c. flour and mix with a spoon. Add one more cup of flour. Knead 10 minutes. Add flour as needed. Put in an ungreased bowl, cover lightly overnight or until double in size.  
Next day, pound down and divide into 3 loaves. Let rise for 5 hours. Then bake at 350° for 35 to 40 minutes in a greased pan.

You need to re-feed the starter every 5 to 8 days. Take 1 cup hot water and dissolve in it 2 tablespoons of potato flakes, ½ cup of sugar and 1 cup of bread flour. Add to the starter, cover lightly, let stand overnight, and then refrigerate.
Mrs. Stokes:

Diabetic Pumpkin Pie
1 (no. 2) can of pumpkin
2 eggs
1 can condensed milk
4 packets Sweet-n-Low (more if you like it sweeter)
1 t. pumpkin pie spice (a little more if you like it spicier)
1 t. vanilla

Mix all the ingredients together. Pour into a pie shell. Put it in the microwave on high for 45 minutes. Test it with a knife to see if it comes out clean.

Smothered Chicken
Chicken thighs, cooked (can use breasts)
1 can cream of chicken soup, diluted with half of a liquid (usually milk, can use water)
1 cup peas and onions, chopped up
1 cup green beans
1 cup carrots
1 cup potatoes

Put the chicken and vegetables in a casserole and pour the soup mixture over it. Put it in the microwave on high for 45–50 minutes. You have to test it.
Mrs. Vossler:

**Bean Salad**
1 can kidney beans
1 can green beans
1 can wax beans
1 can garbanzo beans
1 large onion, sliced
1 red or green pepper, chopped
1 bunch celery, cut up
½ cup salad or olive oil
1 t. salt – pepper
½ cup cider vinegar

Mix and let sit. Lasts one month or 6 weeks.

**Old Fashioned Apple Crisp**
½ to ¾ cup sugar
1 t. cinnamon
4 cups Jonathan apples, cut and sliced

**Topping:**
½ cup sugar
½ cup flour
½ cup butter
½ cup uncooked oatmeal

Combine sugar and cinnamon with apples and place in a 9×9 pan. Blend together sugar, flour, butter and oatmeal until mixture resembles small peas. Sprinkle on apples. Bake at 350° for 30–45 minutes or until apples are tender and top is lightly browned. Serve hot with ice cream, whipped cream or sharp cheddar cheese slices. Delicious as it comes plain from the oven. Makes 6–8 servings.
Mrs. Wilson:

Third Church Chicken
First cook, bone and cut up chicken in chunks (she cooks a whole fryer with peppercorns, cabbage, celery, and carrots until tender – takes the skin off)

1 small container sour cream
1 can mushroom soup
1 can sliced mushrooms
1 can sliced water chestnuts
4 cups of chopped chicken

Mix first four ingredients and then mix chicken in.

8 oz. pkg. Pepperidge Farm stuffing
½ stick of margarine
Put in 1 cup of broth
Add 1 cup of pecans (optional)

In buttered casserole, put in mix and top with stuffing mix. Bake uncovered at 325° for 30 minutes or 350° and watch it, if in a hurry.
Freezes and reheats well. If using white meat only, 3 big chicken breasts will work.

Granola
1 cup raw wheat germ
2 cups rolled oats
1 cup oat bran
¼ cup sesame seed
½ cup sunflower seed
1 cup chopped nuts (not fine)

Mix together. In a separate bowl, mix:
¼ cup oil (safflower)
¾ cup honey

Work throughout the dry ingredients. Bake in 300° oven in roaster sprayed with Pam – for 1½ hour – need to stir every 15 minutes. After cooled, put in plastic bag. Should be a light tan color – don’t over do it, but it needs enough. Towards the end of baking, may want to taste a teaspoon to make sure it is crunchy.
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EDUCATION:
UNIVERSITY OF SOUTH FLORIDA, Tampa, Florida
   M.A. Gerontology, May 1997
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HOLLINS UNIVERSITY, Roanoke, VA
   B.A. Psychology, May 1994 magna cum laude

HONORS & AWARDS:
• Honorable Mention, Southern Gerontological Society Student Paper Awards, 2001
• Sigma Phi Omega Annual Student Paper Award, 2001
• Sigma Phi Omega Annual Student Paper Award, 2000
• Master’s degree comprehensive exam passed “with distinction,” 1996

FELLOWSHIPS & SCHOLARSHIPS:
• Donovan Scholarship in Gerontology, 2001–2002
• Kentucky Opportunity Fellowship, 2000–present
• Research Challenge Trust Fund Fellowship, 1999–2000
• Mensa Scholarship, 1996–1997

TEACHING:
Teaching Experience
Part-time faculty; Eastern Kentucky University, Department of Family & Consumer Sciences
   • CDF 441: Adulthood and Aging, Fall 2001
Instructor, University of Kentucky
   • A&S 300: The Aging Experience (introduction to gerontology), Spring 2000
Teaching-Related Activities

- Graduate Assistant, Teaching and Learning Center, University of Kentucky, May–September 2000
- Course work in teaching and professional development (3 courses)
- Involved in the Association for Gerontology in Higher Education
- Participant, First Annual Symposium on the Scholarship of Teaching, University of Kentucky, September 1999.

RESEARCH:

Research Interests

- life course perspectives on family, environment and health
- environmental aspects of aging
- health and aging (particularly health behaviors and health decision making)
- qualitative methods (particularly narratives and ethnography)
- pedagogy

Presentations and Abstracts


Annual Meeting of the Association of American Geographers, Pittsburgh, PA, April 2000. (with J. F. Watkins) To Have and To Hold Until We Are Old: Divorce and Mobility in Later Life.
Entering the Maze: Barriers for Older Adults in the Hospital Environment and Implications for Education. Annual Meeting of the Association for Gerontology in Higher Education, Myrtle Beach, SC, February 2000.

Publications in Progress
Team Teaching in Gerontology Education: Potential and Promise. Manuscript in preparation, for submission to Educational Gerontology.

Research Experience
Research Assistant, Sanders-Brown Center on Aging, University of Kentucky, 1998–1999

LEADERSHIP & SERVICE:

Committees
• Student Representative, Student Committee, Southern Gerontological Society, 2001–2002
• Student Representative, Membership Committee, Gerontological Society of America, 2000–2002
• Student Representative, Research, Education & Practice Committee, Gerontological Society of America & Association for Gerontology in Higher Education (joint committee), 2000–2002
• Member, Student Task Force, Association for Gerontology in Higher Education, 2000–2002
• Student representative, Gerontology Ph.D. Program Steering Committee, University of Kentucky, January 1999–May 2000
• **Student Representative**, Academic Search Committee, Aging & Social/Behavioral Sciences Faculty Line, Sanders-Brown Center on Aging, University of Kentucky, Fall 1999

**Other Activities**

• **Ph.D. Student Editorial Advisor**, *Coming of Age* (Gerontology newsletter), University of Kentucky, 1999–present

• **Editor/Creator**, *Orientation Guide for New Gerontology Ph.D. Students*, University of Kentucky, 1999–present

**PROFESSIONAL EXPERIENCE:**

• **Admissions & Marketing Director**, Harborside Healthcare Center, Sarasota, FL, 1997–1998

• **Intern**, Gerontology Department, Sarasota Memorial Hospital, Sarasota, FL, January–May 1997

• **Graduate Assistant**, Department of Gerontology, University of South Florida, Tampa, FL, 1995–1996

**Professional Affiliations**

• Gerontological Society of America

• Southern Gerontological Society

• Sigma Phi Omega (gerontology honor & professional society)