Understanding Factors Affecting Food Intake in Elderly Women Living in the Community

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Understanding Some Factors Affecting Food-Intake in Senior Women Living in the Community

ABSTRACT

Many community-dwelling seniors are reported to have inadequate dietary intakes. Factors affecting food intake have been studied mainly from the perspectives of health professionals. As the reasons for adequate food intake are complex, understanding the seniors' perspective could provide further help in understanding their needs.

Three semi-structured interviews were conducted with each of eight community-dwelling women aged 73 to 91 who were at-risk of malnutrition. A qualitative analysis showed the women were reporting three essential aspects: struggling to maintain their independence (i.e., frustration with health care, stereotyping seniors, simplifying cooking); learning new ways of functioning (i.e., adapting to health limitations, simplifying meals etc) and; taking control (i.e., planning own meal and food supplies, monitoring health and keeping physically and mentally active). Finally, this qualitative research paradigm was useful and it demonstrated how careful listening could help to understand the individual needs of free-living seniors at risk of malnutrition.

Comprendre les facteurs affectant l'alimentation des femmes agées vivant dans la communauté.

RÉSUMÉ

Plusieurs aînés vivant dans la communauté ont un apport alimentataire inadéquat. Les facteurs affectant l'apport alimentaire des ainés fut étudié principalement du point de vue clinique des professionnels de la santé. Puisque les éléments contribuant à un apport alimentaire adéquat sont complexes, une compréhension du point de vue des aînés aiderait les intervenants en santé à mieux répondre aux besoins de leurs clients.

Trois entrevues partiellement structurées furent conduites avec chacune des huit femmes de 73 à 91 ans, vivant dans la communauté, et qui étaient à risque de malnutrition. Trois aspects essentiels rapportés par ces femmes émergent de l'analyse qualitative: combativité (c.-a-d. frustration vis-à-vis des soins de santé, stéréotypes face aux aînés, simplification de la préparation des repas, etc...), apprentissage de nouvelles façons de faire (c.-a-d. adaptation aux limites que leur impose leur santé, simplification des repas, etc...) et prise de contrôle (c.-a-d. planification des repas et de l'approvisionnement en nourriture, faire le suivi de leur santé et rester actif physiquement et mentallement). Finalement, le modèle de recherche qualitative fut utile et a permis de démontrer que l'écoute attentive peut aider à comprendre les besoins individuels des aînés autonomes.

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CHAPTER 1: INTRODUCTION

Statistical Background on Elderly Health

The World is aging (Swanson, 1999). The world population of the elderly people (age 60 and over) was 550 million in 1996 and is expected to reach 1.2 billion by 2025 (Swanson, 1999). Canadian seniors follow this trend as well. According to the latest report by Statistics Canada, Canadian seniors' life expectancy has risen while death rates have dropped (Statistics Canada, 1999).

There is a great importance to appropriately address to the nutritional needs of community-dwelling seniors. This is because of several reasons. According to Payette, Coulombe, Boutier & Gray-Donald (2000), the aging population results in a growing economical concern of providing long-term institutional care for certain groups of the elderly population. Statistics Canada (1999) found that close to one third of all seniors was living alone in a private household. From this group, 78.0% of men and 84.9% of women reported having at least one long-term health condition such as: diabetes, heart disease, cataracts, high blood pressure, arthritis, back problems etc. Also, some of the diseases mentioned have nutrition affects and some can be alleviated by dietary change (Herne, 1995). In addition, food intake tends to decrease with aging (Shatenstein, Nadon & Ferland, 2004). Altogether, nutrition plays an important role in maintaining the health of seniors, especially those who are living alone and with chronic health problems.

Importance of Nutrition

Nutritional well-being is an integral part of overall health, independence, and quality of life of the elderly (Posner, 1993; Weimer, 1998). Maintaining proper nutrition of our seniors is challenging for several reasons: the nutritional demand is higher with increasing age (Stechmiller, 2003); malnutrition in the elderly is common (Allard, 2001; Pirlich and Lochs, 2001) and seniors suffering from illness are vulnerable to nutritional deficits (Payette, Gray-Donald, Cyr and Boutier, 1995).

It has been suggested that poor nutritional status is a key determinant of morbidity and mortality in the elderly (Shatenstein et al, 2001). This is important since a high percentage of the elderly consume inadequate amounts of nutrients (Bartali, Salvini,

Turrini, Laurentani, Russo et al 2003) and also, community-dwelling frail seniors consume subadequate protein and energy (Payette et al, 1995)

Nevertheless, undernutrition, due to inadequate food intake is reversible (Morley, 1997). Therefore, to prevent the occurrence of poor nutrition, it is important to learn the risk factors of malnutrition as well as to understand the personal factors affecting food intake in seniors.

Health professionals, particularly nutritionists have worked hard to identify risk factors for malnutrition in the elderly. This is a challenging task because malnutrition is difficult to define (Azad, Murphy, Amos & Toppan, 1999). Nonetheless, a number of screening tools have been created to provide health providers a quick, simple method to identify the risk of malnutrition in seniors. The following paragraphs will discuss the main tools commonly used by health providers.

CHAPTER 2: LITERATURE REVIEW

Nutrition Screening Tools

The most commonly recognized nutrition screening tools are: Mini-Nutritional Status exam (known as MNA) (Guigoz, Vellas & Garry, 1994) ; Nutrition Screening Initiative (known as NSI) (Posner et al, 1993); Seniors in the Community: Risk Evaluation of Eating and Nutrition (known as SCREEN) (Keller et al, 2000) and Elderly Nutrition Screen, more commonly known as Payette's Tool (Payette et al, 1995).

Mini-Nutritional Assessment (MNA)

MNA was designed by Guigoz et al (1994) to provide health providers single, rapid assessment for institutionalized elderly (Stechmiller, 2003), particularly for the group considered as 'frail' elderly (Vellas, Guigoz, Garry, Nourshashemi & Bennahum. et al (1999). According to Vellas et al (1999), frail elderly are older adults who have functional impairment, mobility, hearing or cognitive disorders and also, lives alone and/or in nursing homes (Vellas et al, 1999). MNA contains 18 questions including these components: anthropometric measurements (including weight, height, weight loss); dietary intake and food habits; overall, global health (including, lifestyle, medication, mobility) and several subjective questions about self-perception of health and nutrition. The responses yield a series of scores and the total of which determine ones' nutritional status. There are 3 categories in MNA: nourished, at-risk of malnutrition and malnourished.

Nutrition Screening Initiative (NSI)

The Nutrition Screening Initiative, commonly known, as NSI was designed to help predict nutrition adequacy and overall perceived health of non-institutionalized elderly (Posner, Jette, Smith & Miller, 1993). These 10-yes/no questions inquired about these areas: presence of illness; oral health; economical status; unintentional weight changes; physical activity and status. Each question was weighed differently such that a 'yes' for having not enough money to buy food as needed has a score of 4 whereas a 'yes' for taking 3 or more prescription drugs everyday has score of 1. A score between 3

and 5 indicates moderate risk whereas a score of 6 or more is considered as high nutritional risk (Posner et al, 1993).

Seniors in the Community: Risk Evaluation Eating and Nutrition questionnaire(SCREEN)

Keller, Hedley & Brownlee (2000) created the screening tool known as "SCREEN" which is an acronym for: 'Seniors in the Community: Risk Evaluation Eating and Nutrition questionnaire'. This tool was designed upon critique of 3 tools: NSI, Payette's Tool and Nutritional Risk Index (NRI). This tool was made specifically to suit the needs of community-dwelling older adults (Keller et al, 2000). SCREEN has 15 questions covering issues of: appetite, frequency of eating, chewing and swallowing; digestion; weight changes; motivation to cook; ability to shop and to prepare food; isolation and loneliness; food restriction due to health conditions; and money to buy food (Keller, 2003, Spring). Each question is rated depending on the response and each has a potential score of 0 to 4. The lower the total score, the greater the nutrition risk and the resultant need for referral to a dietitian and/or a physician (Keller, 2003, Spring). Moreover, Keller et al (2000) validated SCREEN against dietitians' assessments of nutritional risk based on these: medical, weight and diet history as well as anthropometric measurement.

The Payette Tool

Payette et al (1995) have created a short 10-question evaluation to identify the risk of malnutrition of seniors living in the community. According to Keller, Hedley and Brownlee (2000), Payette's tool is validated by using three-24 hour food recalls with functionally limited community-dwelling seniors. The tool was found to have good sensitivity and specificity. The Payette's tool created for practitioners to be used with functionally dependent seniors at home. Dr. Payette defined these practitioners to be in the field of nursing, social work or rehabilitation professional, or a technician attached to one of these professions who are a members of the organization's multidisciplinary team (Payette, 2003, Spring). This tool has questions that concern seniors' food choice and intake at breakfast; health influences on daily living (including arthritis, pain and other stresses); sensory function (including eye sight) and appetite and weight change.

Reponses are weighed and scores of 0 – 2, 3 –5, 6 – 13 are interpreted as low, moderate or high-risk of malnutrition respectively. Payette et al (1995) have also included nutrition intervention recommendations for each risk-category.

Critiques of the screening tools

MNA and NSI:

MNA and NSI have been popular tools amongst the geriatric health community however they have been critiqued for their limited use. One of these critiques noted that some clinicians only use the tools if a problem is suspected (Kane & Kane, 2000). Moreover, these tools have limited value for assessing nutrition health of community-dwelling seniors (de Groot, Bech, Schroll, & Van Staveren, 1998). In addition, the validity of the exam is questionable as the creators of NSI noted that the test was not independently validated and their estimates of sensitivity and specificity of scores were likely overstated (Posner et al, 1993). Keller et al (2000) found that except for assessing readability, NSI did not indicate whether community-dwelling seniors were involved in the developing process.

SCREEN

Compared to other nutrition screening tools, SCREEN is considerably the most recent and comprehensive. It covers a number of eating issues with community-dwelling seniors. However, this tool has many questions and choice of answers and thus, it is rather long to use over the phone as recruitment and screening tool.

Payette's Tool

Keller et al (2000) noted that the Payette's tool was developed and validated only among functionally dependent seniors needing assistance for home-care support. Moreover, like NSI, Keller et al (200) did not find any indication to signify that community-living seniors were involved in the development of Payette's tool.

However, Payette's tool has been validated and has good sensitivity and specificity (Payette, Gray-Donald & Coulombe as cited by Keller et al, 2000). For this present pilot-study, Payette's tool is the shortest, simplest and easiest to understand as

compared to MNA, NSI and SCREEN. All of these characteristics are ideal for the recruitment process of this study.

Other Quantifying Tools

Nutritional intake could also be evaluated using tools such as: 24-hr recall, Food Record, Food Frequency Questionnaire (FFQ) and/or diet history. Generally, skilled dietitians or other well-trained professionals conduct these tools. Pirlich and Lochs (2001) reviewed each of these methods with the following comments:

a) 24-hour recalls have day-to-day fluctuations and may not usually represent nutritional habits.
b) 7-day food record is less affected by day-to-day fluctuations and less dependent on memory. However, the validity is questionable as food record may be invalid if patients' notes are unreliable, or if food intake is underestimated, or if the fact of recording influences intake.
c) FFQ is mainly used to explore long-term dietary intake (usually one year). It is time-consuming as it has a large number of questions. Also, its validity is uncertain as it depends on ones' memory of food eaten. It is a semi-quantitative measure
d) Diet history is not a practical screening tool since it is very detailed and time-consuming.

In summary, all dietary data are prone to inaccuracy depending on the interviewer's skills and the patient's (or interviewee's) memory (Pirlich and Lochs, 2001). The idea of measuring dietary risk is more reasonably attained through the use of screening tools.

Overall Comment

Various tools have been developed yet all have been critiqued for their limited use in one-way or another. Nevertheless, the appropriateness of the tool depends on the purpose of the study. For this research, the main focus is to learn from independent living seniors, at-risk of malnutrition, about their perspectives on health, food and nutrition while the nutrition screening is only a minor component. Therefore, the criteria for screening tool for this study are that it is designed for older adults' use and is non-

invasive. Also, the questionnaire must be short, simple to understand (with little or no technical jargon) and most importantly, applicable to seniors living in the community. Therefore, the Payette tool met all the criteria and it was chosen for use in this study.

Principal Interest of the Study

The principal focus of this study is to understand the factors affecting food intake from the perspectives of older women. The following is a brief yet broad overview of studies health professionals have identified thus far.

Factors affecting Nutritional Health in the Elderly

Some scientists have made acronyms to understand the complex phenomenon of factors influencing food intake in the elderly. These researchers focus primarily on the barriers affecting food intake or factors that lead to weight loss.

Morley (1994) created a mnemonic, MEALS ON WHEELS to describe reversible factors affecting seniors' food intake. A few years later, Morley updated the mnemonic to include other factors such as abuse of elders and anorexia tardive into the list (Morley, 1997). This is shown below in Table 1.

Table 1 also showed the description from Robbins (1989) on the major causes of weight loss in older persons known as the "Nine D's". In a more recent study, Wilson, Vaswani, Liu, Morley & Miller (1998) found similar causes of weight loss in community-dwelling medical outpatients ages 65 and over.

Recently, de Groot, van Staveren & de Graaf (2000) compared the mnemonics as shown in the table below. It seemed that the short forms from both Morley (1994) and Robbins (1989) described aging as a deterioration process and both seemed to have neglected the positive adaptations that the elderly can make.

Table 4: The Nine D's and MEALS ON WHEELS (de Groot, van Staveren, de Graaf, 2000)

The Nine D's (Robbins, 1989)	**Meals On Wheels** (Morley, 1997)
D rugs	**M** edication
D epression	**E** motion (depression)
	A lcohol, anorexia tardive , or abuse of elders
	L ate life paranoia
D ysphagia	**S** wallowing problems
D entition	**O** ral Problems
	N o money
D ementia	**W** andering and other dementia-related
D isease	behaviors
	H yperthyroidism, Hypercalcemia, Hypo-
	adrenalism
D iarrhea	**E** nteral Problems (malabsorption)
D ysgeusia	**E** ating problems
	L ow salt, low cholesterol, and other
	therapeutic diets
D ysfunction	**S** tones (cholecystitis) and shopping problems

Medical Causes

As Morley (1994) and Robbins (1989) have identified, certain health problems influence food intake and weight loss in the elderly. Study by Gazewood & Mehr (1998) has also identified more medical problems that lead to weight loss and anorexia in the elderly. These are shown in the table 2 below.

Table 5: Medical Illness Leading to Weight Loss and Anorexia in the Elderly (Gazewood and Mehr, 1998)

-Interleukin Factor (cause anorexia in cancer patient)
-Benign Gastrointestinal Disorder (i.e., Peptic ulcer Disease, Cholelithiasis)
-Hyperparathyroidism
-Thyroid Disorder
-Diabetes Mellitus
-Congestive Heart Failure
-Chronic Obstructive Pulmonary Disease
-Intestinal Angina
-Giant Cell Arthritis
-Malabsorption and diarrhea
-Structural Abnormalities, Motility Disorder of small intestine, achlordea, predispose to bacterial overgrowth of small bowel.
Other Medical Problems, Despite Adequate Intake:
-Oral Problem
-Function impairments
-Drugs causing xerostomia
-Visual impairment
-Metabolic disorders

Aside from the effect of health problems, medical treatment may have adverse side effects that may decrease the food intake of seniors. Ramsey (2003) listed some side effects of medications associated with weight loss in older adults, these include: xerostomia, taste disorder, anorexia, early satiety and increased metabolic rates. In addition, seniors may use different drug treatments at the same time and the interactions of these drugs reduce appetite and affect nutrient utilization (Krondl, Lau, Coleman &

Stocker (2004). Therefore, older adults' medical health problems and effects of medications influence their food intake.

Biochemical Causes: Anorexia of Aging

Morley (1997) termed 'Anorexia of Aging' to describe an age-related decrease in food-intake. This condition is mainly due to changes in gastric signals in older adults leading to early satiation (Clarkston, Pantano, Morley, Horowitz, Littlefield et al, 1997 as cited by Morley, 2003). Thus, older persons are less hungry and feel more satiated before as well as after a standard meal than younger persons (Chapman, MacKintosh, Morley & Horowitz, 2002). The changes in food intake is also influenced by a number of hormones and these are predominantly: Cholecystokinin (CCK), leptin, testosterone, cytokines (Interleukin factor-1 (IL-1) and interleukin factor-6 (IL-6), Tumour Neucrosis Factor alpha (TNF-alpha) (Morley, 2003).

Morley (2003) summarizes the effect of these hormones and these are briefly described in the following. CCK and leptin both decrease food intake. Also, cytokines (TNF-alpha, IL 1 and IL 6) can lead to anorexia and weight loss (Morley, 2001). CCK functions to decrease hunger and older persons have a higher level of circulating CCK than younger persons thus; this may explain the different satiety levels experienced between the older and younger individuals.

The hormone leptin decreases food intake and increases the rate of metabolism. Furthermore, circulating leptin is higher in older adults, especially in women (Morley, 2003). Increased concentrations of leptin results in body weight loss by decreasing hunger and food consumption as well as increasing energy expenditure. However, effect of leptin is not equal in older men and women, since leptin secretion is inhibited by testosterone while it is stimulated by estradiol (Isidori, Strollo, More, Caprio, Aversa, Moretti et al, 2000). Moreover, serum leptin concentration gradually decline during aging and this age-related reduction is higher in women than in men (Isidori et al, 2000). In older men, it has been found that testosterone level decreases with age and this decline is associated with an increase in leptin (Chapman et al, 2002). Altogether, these studies noted the age-related hormonal influence on food intake.

Another internal factor affecting food intake is ones' genetic disposition. De Castro (1998) found that eating and drinking maybe influenced by the interaction between gene and environment. Using same-sex and different-sex twins, de Castro (1998) identified that heredity and individual environment both affect ones' food intake, specifically ones' daily alcohol, coffee and milk intake. Therefore, ones' hormonal and genetic disposition adds to the complex phenomenon of food intake in seniors.

Perhaps what is even more important is that a vast amount of literature is on factors influencing total energy or food intake while far less is known about subject characteristics influencing the macronutrient composition of the diet (de Groot, van Staveren and de Graaf, 2000). The latter point may also imply that there is a need to learn more about the subjective, personal factors affecting food intake in the elderly.

Therefore, in order to have a basic understanding of the complex phenomenon of food intake, the following is a review on some recent research about influential factors of food intake at a more subjective level.

Psychological Factors

Self-perception of Body Weight & Image

Clarke (2002) found that the elderly women's perception and personal ideals of their bodies govern their desire to gain or lose weight. Some women revealed their desire to lose weight because they wanted to have "curved bodies" (Clarke, 2002). Allaz, Berstein, van Nes, Rouget & Morabia (1999) also studied the perception of body weight in elderly women. They found that normal weight in elderly women have what they called as a 'normative discontent' with their weight and that 40% of these women participants interviewed were trying to lose weight and that 37% of them were over 60 years old. Although the studies did not specify criteria of 'normal weight', it is interesting to note that the desire to be thin and fear of weight-gain suggested that weight-loss is not necessarily due to physical or medical reasons.

On the other hand, Miller, Morley, Rubenstein & Pietruszka (1991) has found that the elderly men in their study displayed abnormal eating attitudes and ideals about their body images. These men were veterans who exhibited anorexia-type symptoms and they developed malnutrition as a result (Miller et al, 1991).

Social (media) Influence

In the study by Gustafsson & Sidenvall (2002), the older female participants noted that they were more aware of the relationship between food and health however; some were frustrated with them because they had difficulty to understand the health messages from mass media and authorities while still others believed the messages about food were over-exaggerated. Therefore, it seemed the influence from media and authorities influence some older adults while others held their own perception about food and health thus, decided what they eat.

Emotional Influences

Food intake is also affected by ones' psyche. Several case studies have found that the older adults' overwhelming feeling of frailty and their perception of the resultant dependence caused them to refuse food (Duggal & Lawrence, 2001). Furthermore, Paquet, St. Arnaud-McKenzie, Kergoat, Ferland & Dube (2003) also found that everyday emotions might predict the quantity of protein and calories consumed by the elderly. The study found that positive emotions such as: feeling confident, proud, hopeful and reassured led the elderly to consume more protein and energy intake, than when they experienced negative emotions such as: anger and increased anxiety (Paquet et al, 2003).

Age-Related Eating Behavior

The elderly also have different eating behaviors compared to the younger population (de Castro, 2002). de Castro (2002) found that compared to the younger generation (age 64 and younger), the elderly eat significantly earlier, eat more on the weekend (compared to weekdays) and have significantly lower hunger levels or higher satiety than their younger counterparts. Moreover, 2 of the three psychological factors studied, namely palatability and cognitive restraint, seem to affect the intake in both the elderly and the young similarly while the third factor hunger, has a weak effect on food intake in the elderly. The study also found that the relationship between self-rated hunger and amount ingested in meals was weaker in the elderly compared to the younger people (de Castro, 2002).

Similarly, the elders' prior lived experiences also influence their food intake. In 2001, Brombach (2001) proposed that the food behavior of the elderly is associated with their prior experience in childhood but it changes during major life events such as: war, hunger and expulsion.

Other Factors

Arcury, Quandt, Bell, McDonald & Vitolins (1998) studied the barriers to the nutritional well-being of seniors from the perspective of service providers and community experts. In this study, 73 service providers and community experts from these disciplines of: health education; health care providers; social services; nutrition services and ministers participated in in-depth interviews. Arcury et al (1998) found that the perceived barriers affecting adequate nutrition in seniors were: characteristics of county and programs, transportation, kin-relationships, medical health, economic issues, seniors' food habits, knowledge and attitude. Interestingly, some of these results are also found in another large-scale study conducted by Weimer.

In 1998, Weimer produced a report based on the data from USDA's 1989-91 Continuing Survey of Food Intake by Individuals and found several factors affected seniors' food intake and several of these are relevant to the focus of this study. Weimer (1998) found that the seniors' formal education positively affected food consumption; the presence of two or more members in the household affected seniors' food intake; a significant lowering the intake of fat and energy was identified in seniors who were told by a physician of the specific disease(s), diabetes, heart disease and dietary fat. Herne (1995) also reported an economical influence on food intake such that compared to poorer people, those who are richer spend more money on food.

In addition, other factors that could influence food intake include: cultural, religious and regional factors; extrinsic factors (i.e., environment, advertising, time and seasonal variation; intrinsic factors (i.e., appearance, odour, texture, flavour, presentation) and personal factors (i.e., expectation of food, familiarity, personality, influence of and emotions, meanings attached to food) (Herne, 1995).

Evidently, most of the above studies were quantitative, using pre-dominantly quantitative data to explain the phenomenon of food intake in seniors. Much of the studies employed quantitative paradigm but until recently, qualitative research method

has been used to understand this phenomenon and qualitative paradigm has become increasingly popular.

Qualitative Research Methods

Qualitative research methods have gained increasing importance in studies of elderly health, including nutrition. (Quandt & Arcury, 1997). Moreover, studies about personal health perceptions generally used qualitative research methods.

Comparing Quantitative and Qualitative Methods:

Taylor (2000) compared the similarities and differences between the qualitative and quantitative research paradigm. Items shown in Table 3 were selected from Taylor (2000)'s table. Note that subheadings of the characteristics were added for easier understanding.

Specific Differences: Type of Data and Validity of Research

The meaning, importance and use of numerical values are very different in quantitative and qualitative research methods. Quantitative researchers use mainly numerical values to *prove* a certain finding based on its statistical significance. Qualitative researchers place less emphasis on numerical value as they focus on the *understanding* aspect of research and they question: *what is worth knowing*? *What data are most useful*? (Patton, 2002).

Validity of the research also differs between these two methods. The validity of qualitative research is addressed through honesty, depth, richness and scope of data from the participant and the extent of triangulation as well as the objectivity of the researcher (Cohen, 2001). On the other hand, quantitative data validity is concerned with the treatment of data through careful sampling, appropriate instrumentation and statistical treatment of data (Cohen, 2001).

Table 3: Selected List of Similarities and Differences Between Quantitative and Qualitative Research Methods (Taylor, 2000):

Characteristic	Quantitative	Qualitative
Sample size	Representative	Small ; not representative
Perspective	Objective	Subjective
Data collection	- Data collected through instruments based upon precisely defined variables	Emphasizes organizing, coordinating and synthesizing large quantities of data
Type of data	Numerical data	Narrative data, photograph, poetry etc
	Descriptions based upon numerical data	Rich narrative descriptions
	Descriptions of human behavior cannot always be expressed in numbers	Human behavior can be accurately described in words.
Analysis	Deductive in nature	Inductive in nature
	Known reliability and validity	Unknown reliability and validity
Setting	Controlled	Conducted in the natural environment
Analysis	Use various instruments	Use mainly observations and interviews
	Based upon facts	Based upon understanding
Length of study	Short Duration	Long duration
Literature	Reviewed at beginning of study	Reviewed at end of study.

Choice of Qualitative Research Methodologies

There are several types of qualitative research methodologies. This exploratory research has drawn on concepts from two different methodologies: phenomenology (Patton, 2002; Rogers 1983) and ethnomethodology (Patton 2002; Handel 1982).

Phenomenology

The main foci of phenomenology are: exploring how one senses, experiences, perceives and describes their lived experience (Patton, 2002). Phenomenologists study the meaning of something and are thus focused on clarification of knowledge (Rogers, 1983). They do not try to seek the truth (or reality), they treat reality as it is represented, intended and conceptually thought (Rogers, 1983). Moreover, phenomenologists do not produce new information. It considers the person as a 'whole being' who is complete with past experience attitude, beliefs, values and who lives in a world of experience replete with both cultural and social influence' (van Manen, 2000).

Ethnomethodology

Ethnomethodology shares some similarities with phenomenology, however it is unique because it is focused on 'how one makes sense of their daily activities in order to behave in socially acceptable ways' (Patton, 2002). The creator of this method, Garfinkel (1967) studied the social world as encountered in everyday experience as it appears to 'our common sense' through studying minute details of the everyday interactions that have been taken for granted (Handel, 1982).

The two working premises of ethnomethodology are: 1) All accounts are reflexive and 2) All accounts are indexical. Reflexivity considers perception; language, nonverbal communication and reasoning define and simultaneously represent reality (Handel, 1982). Ethnomethodologists use the concept of reflexivity to express their understanding of the continuous (re)construction of meaning interpreted from the data , thereafter, this 'objective reality' defined of the person or situation will be integrated as an indexical feature and used in the next interaction and interpretive process. (Keel, 1999). Indexical accounts are those that are based on the context in which the account occurs (Handel, 1982). The concept of indexicality is central to ethnomethodologists such that they study how one makes sense of a specific situation or how one experiences the situation in relation to other aspects of it (Keel, 1999).

Evaluating the suitability of Ethnomethodology and Phenomenology

The focus of phenomenology matches closely with my research interest. This is because through the seniors' recollections I can better understand their personal factors affecting food intake. Moreover, a phenomenological approach provides me with a rich

set of data, from which I can obtain a holistic perspective of the lives of participants that will help lead me to the answer of my research question. However, since my study is not to study or to discover the phenomenon of food intake of seniors (i.e., getting an in-depth understanding of the nature or meaning of everyday eating experience) but instead, to understand the factors affecting food intake (i.e., possible barriers hindering appropriate food intake) therefore, my study could not be a pure phenomenological study.

I assume that seniors living independently in the community with a certain degree of health ailments would need to have ways to manage their lives therefore, certain aspects of ethnomethodology will enhance the understanding of my data. For example, aspects such as questioning how do seniors, at-risk of malnutrition take care of their nutritional health everyday while living independently? And if present, how do seniors make sense of changes in their normal dietary patterns because of health.

However, similar to the issue with conducting a 'pure' phenomenological research, I found that using ethnomethodology alone would limit my research. One of the reasons is ethnomethodology may be too narrow for the purpose of my research. Ethnomethodologists discuss data that are picayune (Handel, 1982) and they are concerned with the day-to-day actions of these participants. This type of analysis is beyond my research interest. Moreover, I would like to have a more holistic view of the participants, thus I believe a mixture of ethnomethodology and phenomenological approach will be most suitable for the purpose of my research. (Note: More in-depth discussion of the particular method used for this study is located in the Methods chapter of this thesis).

Summary and Goals of the study

Through this literature review it is evident that the factors affecting food intake in the elderly is complex and Qualitative research methods will likely provide a better understanding of this phenomenon. Although researchers and health care professionals have identified some challenging factors affecting food intake in community-dwelling seniors, little is known about how they manage them and what they perceive of their health and nutrition status.

Health professionals need to know seniors' view about: their health issues; how they manage them; and how it may affect their everyday activities in order to help them maintain a sound quality of life.

Therefore, this exploratory-study will use a qualitative research method in order to listen to seniors' personal accounts. The main goals of this study are: 1) To understand the factors affecting food intake of community-dwelling seniors who are at-risk of malnutrition and living independently; 2) To share this information with the Yellow Door Elderly Project and Entraide Bénévole Métro such that they could use it to initiate nutrition-related programs and/or activities which they might organize in the future for their clients; and 3) To determine how results from this qualitative research help to understand the food consumption behavior of seniors living in the community.

CHAPTER 3: METHOD SECTION:

1. RECRUITMENT

Setting & Background

Senior participants were recruited from 2 volunteer organizations for seniors: the McGill Yellow Door Elderly Project (YD) and Entraide Bénévole Métro (EBM). Both organizations are located in Montreal, Canada. A brief description of the organizations' background and mission will be given in the following.

Yellow Door

The Yellow Door is a non-profit organization with a mission to promote personal, social and spiritual development through a multitude of programs within the McGill and neighbouring communities (The Yellow Door, n.d.)

In 1972, a special program especially designed for the seniors was created by students as a result of a door-to-door survey of the elderly living in the community. This is known as the Yellow Door Elderly Project. It attempts to examine and respond to elderly needs by providing volunteering services including: friendly visiting, accompaniments, friendly favours, social events and client referral (The Yellow Door, nd.)

The seniors eligible for the service need to have the following characteristics: at least 55 years of age; live in the territory of Montreal bordered by Mont-Royal Street to the North and René-Levesque to the South, Atwater to the West and Saint-Denis to the East.

According to the volunteer coordinator, their senior clients are mostly female, with an average age of 83 and with an equal distribution of English and French-speaking people at the time of the study's recruitment.

Entraide Bénévole Métro

Entraide Bénévole Métro known as EBM is a sister organization of the Yellow Door. Like YD, EBM is also a non-profit organization and offers similar services for the community-dwelling elderly clients.

EBM began serving the community in 1985 through the fusion of volunteer groups of CLSC Metro. Compared to the YD, EBM has a larger client pool and largest service area. It is partners with CLSC Metro, Contactivity Centre, Foyer Laurentien and Régie Regionale de la Santé et des Services Sociaux de Montréal-Centre and the Volunteer Bureau of Montréal.

EBM provide services for seniors and physically disabled persons who are socially isolated, living in the downtown-west and Westmount sectors of Montreal. EBM's mission statement is: 'To provide physical and emotional support to seniors and persons with temporary and permanent loss of autonomy'. Also, they strive to 'assist clients to break their social isolation, promote autonomy and helping them to know and defend their rights'(Entraide Bénévole Métro, nd.)

According to the EBM coordinator, their 2002-2003 data showed they had 500 clients with average age of 80; 50% are 75 years and older; 60% were English-speaking while 40% were French-speaking and 65% live alone.

Rationale for Choosing the Organizations:

These organizations were chosen because of two main reasons: 1) Their well-established history of community services for seniors and; 2) Their mission of enhancing the quality of life of community-dwelling seniors

Initially, the project was to be done entirely with YD participants. However, because of an insufficient number of willing-participants the recruitment process was completed at EBM.

First contact with Organizations

The Yellow Door coordinator was first contacted in early February 2004 when the study proposal was presented and discussed. The coordinator was very interested in the study topic and coincidentally; YD had planned to begin the preparation of a nutrition program for the seniors at the same time of my contact. Therefore, the coordinator decided to use the findings from this study to help assist the planning of possible nutrition-related program for their senior clients. Notably, she would receive the findings only after August 2005 upon thesis submission.

While recruiting at YD, I realized there were not enough participants and therefore the YD coordinator helped by introducing my project to EBM, a sister organization of

YD, and they were interested in this project as well. Therefore, EBM volunteer coordinators asked me to present my project to the EBM board members at their annual meeting. The project was well received by the board and they assigned the EBM volunteer coordinator to provide help whenever needed along the research process. The details of recruitment at EBM and YD will be provided in a later section.

Participant Criteria

This study recruited participants using purposive sampling. The sampling criteria are listed below:

The inclusion criteria are:

- Able to speak and understand English
- Able to converse for more than 45 minutes
- Men and/or women 70 years and older
- Living alone or with minimal assistance
- Residing in Montreal, Canada
- Having a score of $\geq$ 4 points on the Payette Tool (at time of telephone recruitment)

The following are the only exclusion criteria for health in this study:

1. Having recently diagnosed terminal illness (i.e., Cancer – inoperable, terminal or undetermined status)
2. Having had, or recovering from, a recent major accident or undergone surgical procedure (i.e., head injury, Fall, Hip Fracture) which may affect eating behaviour..
3. Having psychiatric illness (i.e., schizophrenia, impaired cognitive function, clinical-diagnosed depression). Note that data on disease status was obtained from (and determined by) the volunteer coordinators at both McGill Yellow Door Elderly Project (YD) and Entraide Bénévole Métro (EBM).

Each agency received a copy of the proposal. In brief, the key elements included: Purpose of research; participant criteria (i.e. inclusion and exclusion criteria); confidentiality terms and agreement towards data management (i.e., to ensure ethical research); and significance of my research and possible benefits for the organizations.

Preparing for the study: Pre-Phrase

The interview questions were carefully developed and edited through 2 significant stages: 1) Pre-phase and 2) Actual study phase. The pre-phase took place between February and March of 2004 with two additional participants from the Yellow Door. These interviews followed the same procedures of the study such that confidentiality forms were signed, interviews were conducted in an ethical manner, tapes were secured and interviews were fully transcribed. However, they were not included in the final results of this study as the purpose is to gain interviewing experience and to help evaluate the appropriateness of the questions for the final phase.

The actual interview phase began in May 2004 and completed in December 2004. During this time, some common themes were found and these were verified in the third interview.

Recruitment Phase

Following the pre-study, recruitment occurred between April 2004 and June 2004. Notably, there were 2 approaches used to prepare the recruitment process. At YD, the coordinator pre-selected clients according to participation criteria while at EBM, I was given the entire database where I independently selected eligible participants (based on the study criteria.) By the end of the 2-month recruitment process, 12 participants agreed to participate, comprised of 2 YD clients and 10 EBM clients.

2. THE PARTICIPANTS

Of the 12 participants recruited, 8 participants completed the entire set of 3 interviews. The four remaining recruited participants did not complete the interviews because of these reasons: 2 participants dropped out after the first interview (one said she was too busy and the other believed she was not a good candidate for the study thus discontinued); 1 did not meet the inclusion criteria as she revealed she just entered an institutionalized care center at the first interview and 1 refused to sign the confidentiality agreement even though she gave verbal agreement to participate in the study. Note, more details about these four non-respondents are in the conclusion section of the thesis. These 8 interviews were chosen for final analysis. The seniors ranged from 73 to 91 years old with an average age of 83. All participants were female, lived in the Montreal,

downtown area and had a moderate risk of malnutrition (according to Payette Nutrition Screening tool.)

The Screening Instrument

For details about the Payette Tool, please refer to the previous literature review section of the thesis. In brief, the Payette tool is a validated, short and simple 10-item questionnaire indicating the risk of malnutrition in community-dwelling seniors. (See Appendix for Payette's tool)

A score of 4 indicated a moderate risk of malnutrition, was chosen as the cut-off point for participant selection (Payette et al, 1995). For brief description of the clients, please refer to the Appendix. Note that for confidentiality reasons, all participants were given pseudo letter names.

3. INTERVIEW GUIDE

The interview guide was comprised of questions related to health and nutrition. The guide was created from three main resources:

1) *Literature review*: Especially the nutrition screening tools as these helped me to learn the aspects involved in geriatric health and nutrition)
2) *Expertise from my research team* whose members are: Dr. Katherine Gray-Donald (School of Dietetics and Human Nutrition, McGill University), Dr. Amanda Grenier (School of Social Work, McGill University) and Dr. Paul Saba (Medical Doctor specializing in community health and the geriatric population). They shared with me priceless information and expertise about the elderly. Also, their critique helped enhance the quality of my research.
3) *Study Pre-phase:* This phase helped me: to gain interviewing skills; to assess whether the length of the interview propose (close to 2 hours) was appropriate for the seniors and to evaluate the appropriateness of the semi-formal interview questions.

A list of questions was created and compiled in the document titled (see Appendix for details). The main topics of the questions were: Daily Habits/activities; Food habits; Meal Preparation (Method + preference); Appetite; Food Preferences; Loneliness; Transportation and mobility; Nutrition information and source.

4. ETHICS & SECURITY OF DATA

The protocol was approved by the ethics review board at Macdonald campus-McGill University. The required procedures were followed at YD and EBM. I signed their confidentiality forms and underwent the required police check procedure. The special attention was essential since qualitative interviews have the potential to be intrusive and my participants are considered as part of the vulnerable population (Patton, 2002).

During the recruitment telephone contact, each participant received a clear explanation on the purpose of the research and how he or she would be involved. These were repeated before starting the interview to ensure participants clearly understood the purpose of my study.

Moreover, I reassured each participant that all accounts revealed in the interview would remain confidential except in cases of current or on-going abuse. If abuse was reported, I had planned to first consult with the immediate coordinators and/or health care providers who may provide more information regarding this issue. I would also inform my supervisor to discuss possible actions that may have been needed.

All forms mentioned in this section are located in appendix. As stated in the confidentiality agreement, tapes of the interviews were kept locked in my possession and no one else had access to them. Transcripts were also secured and were accessible to my research committee members only when necessary.

5. THE INTERVIEW

Material & Setting

All interviews were tape-recorded using a micro-cassette tape player (Sony, M-200 MC). Interviews were recorded with 90-minute micro-cassette tapes.

All interviews were conducted at the seniors' homes. The mode of interview was flexible to the participants' such that they could: 1) Stop the interview at any time (e.g., tired or had other appointments); 2) Choose the date and time of the interview (if there was no conflict with other interviews) and; 3) Withdraw from the study at any point

without penalty. (For the records, all 8 participants completed the three interviews of the study).

Three-Phases of Interview

Each participants was interviewed 3 times with a specific purpose: 1) Introduction 2) Exploration and 3) Verification. The interviews varied from 0.5 hour to 3 hours with an average of 2 hours per interview.

The first interview mainly served as an introduction where the main purposes were to clearly explain the purpose of the study and to obtain background information about the participant.

During this session I established the interviewer-interviewee relationship by exchanging background information. I began the study by asking them to describe themselves; their daily activities, habits and preferred methods of meal preparation and/or preferred dish they enjoyed making. Then, I proceeded with the questions from the question pool.

The second interview served as an exploration phase where the purpose was two-fold: to *follow up* on the responses participants revealed in the first interview and to explore other un-asked questions from the question pool.

Follow-up questions are very important according to Rubin & Rubin (2005), because it is a way to get more depth and understanding about any theme, event and/or issue regarding my research that the participant revealed in the previous interview.

Moreover, since the first interview was more for introduction and getting to establish an interviewer-interviewee relationship, less time was spent on the core questions made for the study. Therefore, those were asked in the second interview.

Before the third interview

After the second interview, I reviewed the responses gathered from all participants and identified some common themes. I ensured objectivity and validity in my research by conducting triangulation with my participants at the beginning of the third interview. Triangulation is a method used in qualitative research as a practice to check the data collected using multiple resource of data, multiple investigators or multiple methods to

confirm the emerging findings (Merriam, 1998; Wolcott, 2001). For my study, I asked participants for their feedback about my preliminary results. The investigators were my committee members with whom I shared and discussed my findings throughout my research.

Therefore, during the third and last interview, I asked the participants to give me their feedback regarding my findings of preliminary common themes. Also, I clarified any other information discussed in previous interviews.

Note about the interviews

Interviewees received the questions in an individualized-fashion, meaning questions were not asked in the same chronological order as I had prepared in the question pool. That was mainly because each senior has a different lived experience; thus some topics may have been discussed more than others. Also, they became tired after about 2 hours of interview. Therefore, since I wanted to get a rich set of data, I never rushed the interviewees and I allowed the participants to talk freely about their experiences. Nevertheless, given all of these factors, I organized my questions according to the particular senior and follow up on those that were unanswered.

Experience at Interview

The most challenging part in my perspective was performing Seidman (1991)'s three levels of active listening as briefly described below. According to Seidman (1991), qualitative interviewers need to listen on at least three levels briefly described below:

1) *First level: What is said.* Interviewers must concentrate to assess whether the responds are answered as detailed and complete as could be.
2) *Second level: The 'inner' voice as opposed to the 'outer voice'.* Seidman (1991) described that inner voice has a deeper meaning and interviewers must search for it by asking participants to explain words and/or experiences whenever necessary.
3) *Third level: Be aware of the process and the substance.* Interviewers must be conscious of time during the interview; be aware of how much is covered; while also being sensitive to participants' energy level and any nonverbal cues he/she may be offering. (p.56-57)

Therefore, I was multi-tasking all throughout the interview. However, the experience was exciting at the same time because I was actively involved in the interview.

Problems encountered at interviewing:

1) Technical error

Data were lost for one of eight interviewees due to unexpected problem with the recording tape. As a result, half of the interview was lost. Unfortunately, it was the first interview with this participant and I could not repeat the interview because the participant expressed reluctance to do so. I therefore used my field notes and our two other interviews for analysis.

2) Reluctance to provide in-depth responses

All of my interviewees were willing to provide in-depth responses except for one. Interestingly, this woman agreed to participate in the study and showed great interest throughout my interviews however, her responses were always short and mostly consisted of yes/no answers. Coincidentally, this woman was the same person whose first interview was lost.

6. The Researcher as an Instrument

According to Taylor (2000), one of the differences between qualitative and quantitative research is that the researcher is involved with participants in the study as a co-researcher or an active participant. The qualitative researcher uses his/her lenses, understanding and lived experiences to analyze the data therefore; the researcher is seen as an *instrument* in the research (Bogdan & Biklen, 1992). This is important to be aware of and to understand because (qualitative) researchers are not naïve and the observer (or researcher) plays an influential role the interpretation of the data (Bogdan & Biklen, 1992).

Therefore, the qualitative researcher's goal is to purposefully take into account who they are, how they think, what actually went on in the course of the study and where their ideas came from (Bogdan & Biklen, 1992; Maykut & Morehouse, 1994). Moreover the identification of these will enhance internal validity of the study (Merriam, 1998).

Therefore, in the following paragraphs, I will describe: who I am, why I used the qualitative research method, my goals in the research, my beliefs and assumptions and; how these may influence my work. Details about how I analyzed and transcribed my data are discussed in later section of this chapter.

6. ABOUT THE RESEARCHER

Who am I?

I graduated from the University of Toronto where I specialized in nutritional sciences and minored in psychology. My honors Bachelor of Science degree nurtured my interest in nutrition and therefore, I continued my studies at McGill University's School of Dietetics and Human Nutrition.

Throughout my university years, I worked mostly in laboratory settings with quantitative researchers in the field of nutrition including: Dr. D. Jenkins (where I was a research assistant) and Dr. L. Wykes (where I took an independent study course). Also, most of my university courses were quantitative in nature such as: Chemical Food Analysis, Statistical Analysis, Organic Chemistry, Clinical Nutrition, etc. In short, my experiences as a student taught me that systematic procedure and statistics are very important in research and until I learned about qualitative research paradigms, I thought quantitative method were the only way to conduct studies.

I have always had a strong interest in the senior population and these were developed during my academic years and my familial duties. As a student, I had internships at Montreal's Maimonides Geriatric Hospital, volunteered in Meals-on-Wheels for seniors, and worked at old age homes (nursing home). All of these experiences harvested my interest in the aging population specifically towards seniors 70 years and older. At home, I was a caretaker for my maternal grandmother who had fallen ill for several years since my departure for Montreal. She used to be an active, independent woman but now she has become a dependent and frail woman suffering from symptoms of Alzheimer's disease. She is one of the key players who inspired me to be a nutritionist and to conduct this project. That was because I want to help other community-dwelling seniors like her and those at-risk of malnutrition who are in need of proper nutritional care.

My future career goal is to work with free-living seniors at community centers or other public health sectors involving geriatric health. I want to plan nutrition-related programs that are suitable for their individual needs. My personal goal is to help maintain and/or improve their quality of life through meeting their nutritional needs.

Why use the Qualitative Research Method?

From the literature research and my personal dietetic internship experiences, I have found that senior clients had not enough time to express their needs and/or concerns to their health-care providers. Most often, health-care plans are made through the health professional judgment and may not involve the senior's perspective in the care-plan. Therefore, my goal for this research is to discover seniors' perspective regarding nutrition and health through using a qualitative research paradigm.

Furthermore, few researchers use qualitative methods in the field of nutrition. I wanted to understand the seniors' food behavior or human experiences and these were better studied using qualitative research methods (Taylor, 2000). Therefore, I chose to conduct an exploratory study using qualitative research methods.

I preferred to conduct my research systematically. Therefore, I designed an interview guide yet had the participants select the length and type of topic (within the guide) such that I could retain both the systematic and flexible aspect unique to qualitative research methods (Arcury and Quandt, 1997).

My personal goals of this exploratory research are to:

1) Explore barriers (if any) that may hinder compliance to nutritional diets designed by dietitians and/or nutritionist, that maybe necessary for seniors with certain health conditions.
2) Explore strategies seniors use for self-care while living independently.
3) Understand the various aspects (such as psychological, behavioral and social) and factors affecting the food intake of independent living Canadian seniors.
4) Share my findings with dietitians; health professionals and nutrition scientists which may help them design appropriate care-plans for their older clients.

What beliefs/assumptions do I bring to the study and why?

Before starting this research project I held the following assumptions:

1) Many seniors living at home have some degree of malnutrition that would benefit from nutritional professionals' interventions.
2) Seniors' health is very delicate. It is vulnerable to multiple factors affecting nutritional status including: Social, psychological, physical, economical and environmental as found by research in the literature review section of this thesis. Therefore, it is important to listen to seniors' individual concerns.
3) Seniors don't have enough nutrition education to care for their health. They may lack food-safety tips and/or proper food choices, which may prevent them from obtaining adequate nutrition (Lecture material from Eating Assistance Program at St. Mary's Hospital.)
4) Seniors need to have some knowledge of nutrition, to carry on their independent lives. Otherwise, their health may decline and they may have to enter institutions prematurely.
5) This qualitative research may likely result in a very different, rather non-traditional approach to explore the health perceptions in seniors at risk of malnutrition.

How did these beliefs impact on the work?

My assumptions might negatively affect my research. I might become preoccupied to either 'prove' or 'clarify' my assumptions. Therefore, I had planned to minimize my subjectivity by conducting the following procedures suggested by Merriam (1998) throughout my research:

a) *Triangulation* This process refers to using multiple resources such as: various methods, data and/or investigators to confirm the emerging findings. For my study my resources were from a combination of: literature search; expertise from my research team and my participants.

b) *Member Checks* Refers to bringing the data and tentative interpretations back to respondents and asking for feedback. I did this with my participants as common themes arose in the interview.

c) *Peer Examination* This process refers to asking colleagues to comment on the findings as they emerge. I met with my supervisor frequently throughout the research for feedback and update of my progress.

d) *Researcher's Bias* This means to clarify the researcher's assumptions, worldview and theoretical orientation at the outset of the study. I planned to do this throughout my research by keeping journals to write about my interview experience and recording any thoughts regarding the research that could be used later on in analysis.

7. TRANSCRIPTION

Each interview was transcribed word for word directly after the interview. In the following, I will describe my experiences with transcription.

Experiencing transcription

Creating a typed transcript from a conversation is laborious and requires full attention (Rubin & Rubin, 2005). I personally experienced this while I was transcribing my interviews. Upon Rubin & Rubin (2005)'s suggestions for transcription, I produced what they called 'precise transcripts', transcribing not only what was said but also other information such as: abrupt changes of focus, profanity, exclamations and other indications of mood. I also used the technical details in transcription by noting specific changes in participants' tones, significant pauses and inserted my comments of the responses separately in the document (Morse and Field, 1995, chap 6)

I chose to produce precise transcripts because the qualitative data can become voluminous, since an audiotape 45-minute interview may result in 25 pages of text to be checked, coded, sorted and stored in a form that may be easily retrieved and analyzed (Morse and Field, 1995). Based on my experience, one interview transcript has a minimum of 32 pages in 11-point font with 1.5 line spacing and a maximum of 70 pages.

Therefore, with this amount of data I could not rely on my memory to account for the details in the interview. Also, I believed the details would enable me to immerse myself into their worlds better thus it would help me to identify any potential nuances or particular comments that I could explore further during later interviews.

Aside from typing out the interview verbatim, I was also writing down little notes about any feelings or insights about the issues discussed in the interview. Memos are important as they help suggest reformulations of research questions and later, they deal with concepts, themes and events (Rubin & Rubin, 2005)

From my personal experiences, I found that the one of the major difficulties with transcription was re-listening to the interview with the tapes. The interviews were much clearer than the recording. That was because while transcribing, I encountered the external environmental noises (i.e., background operating fans, heaters, ambulance sirens etc.; and the tone of the client (i.e., mumbling, slurring, stuttering etc). In addition, since the transcript is crucial for analysis, each interview was reviewed twice: first to transcribe and second, to verify.

8. ANALYSIS

Thematic analysis for this study is based on 2 major methods: 1) Maykut and Morehouse's Constant Comparison Method (1994) and Biklen and Bogdan (1992)'s Coding Method.

What is Constant Comparison?

Constant comparison (CC) is a method actually taken from Grounded Theory (GT) such that the key concept is to identify common, emergent themes by comparing the data obtained. (i.e., in this study, the data between participants). The CC method is a way to conduct an inductive analysis of data (Glaser and Strauss, 1967; Strauss, 1987). CC involves combining inductive category coding with simultaneous comparison of all units obtained. This process of comparison continues throughout the study. In brief, the comparison method is similar to a chain reaction where, each unit of the chain (unit of meaning) is compared to other units and then, grouped together. If the units don't have a 'shared' meaning, it will be placed in a new category/group.

In using this inductive approach, the research hypothesis is not made *a priori* thus, variables for data collection are not predetermined (Maykut & Morehouse,1994). The main procedure therefore, is to analyze emergent themes from the data itself through the process of deductive reasoning.

Why choose Constant Comparison?

Constant comparison provides a clear and systematic method to analyze the data, which is most suitable for a beginner qualitative researcher like myself.

I have adapted the procedures suggested by Maykut & Morehouse (1994) to suit the needs of my exploratory study. I have listed these below along with a brief rationale and/or description in the following:

a) *Systematic re-reading of transcript* Re-reading helped to review the content of the interview and to verify a concept. This was done frequently after transcription to prepare follow-up questions and for analysis.

b) *Highlighting.* Significant quotes, expressions and recurrent themes were recorded (or high-lighted) from each participant in their interviews. During the analysis phase of study, selecting specific quotes strengthened the theme identified.

c) *Analyze: Unitizing, categorizing & refining data.* Critically identify and analyze the underlying meaning of data. This step involved identifying the chunks or units of meaning in the data. Also, according to Lincoln and Guba (as cited by Maykut & Morehouse, 1994) 'each unit of meaning must be understandable without additional information except for knowledge of the researcher's focus of inquiry (p.129). After identifying the data, they are grouped into categories. The next step was to refine the units.

Once the data units are categorized, a short description of the category is needed. This is called writing the rules of inclusion. According to Maykut & Morehouse (1994), the goal of this is to write a rule that will serve as the basis for including (or excluding subsequent data cards in the category (p. 139).

d) *Coding data cards to the categories.* When the rule of inclusion was made for a category, the process of developing a code began. Coding is a process of extracting the main idea from the excerpt(s) with clarity. Once codes are made, they acted as 'reference points' to be used throughout the research for identifying relationships and/or experiences that may occur amongst other participants. For this pilot study, I have coded my data using the coding technique described by Bogdan & Biklen (1992).

According to Bogdan & Biklen (1992) coding is a systematic way of sorting the descriptive data collected. Bogdan & Biklen (1992) have developed families or kinds of codes that are used as tools to identify the codes and to sort qualitative data accordingly. I found these were very useful for my study and therefore, in the following paragraphs, I have listed the type of codes I have used to analyze the data, the description from the creators Bogdan & Biklen (1992) and some examples from my data:

Setting/Context Codes These are given to codes which the most general information on the setting, topic or subjects were sorted. For my study some of these codes were: grocery shopping, events occurred at medical appointments, reading flyers. [p.167]

Definition of Situation Codes The data that tell how participants define the setting or particular topics are placed under this code. The main purpose is to see their worldview, how they see themselves in relation to the setting or the topic [p.167]. For example, some seniors described challenges of shopping during winter (e.g., too slippery to walk, need to stock up food supplies.)

Subjects' Ways of Thinking about People and Objects This refers to the codes that illustrate subjects' understanding of each other, of outsiders and of the objects that make up their world. An example from my study is how seniors described their peers and aging.

Activity Codes These refer to regularly occurring kinds of behavior[p.170]. I emphasized these codes in my study because seniors provided more data about what they do. Examples of these include: Planning meals, cooking, keeping busy, going-out.

Event Codes These codes contain units of data that are related to specific activities that occur infrequently in the setting or in the lives of interviewees [p.170]. For example, period of appetite loss and adjusting to prescribed dietary regimens.

Strategy Codes Strategies refer the unique tactics; methods, techniques and other ways that people created and used to do things. For example: simplifying cooking, planning food supplies in advance, and eating vegetables.

Preassigned Coding Systems These refer to coding categories that may be more or less assigned to explore particular problems or aspects of a setting or a subject

[p.171]. This relates to my study because I developed a list of topics for the question guide as shown in the question pool.

The Process of Coding

Developing codes requires one to read through data and identifying certain words, phrases, patterns of behavior, subjects' way of thinking and events that repeat and stand out (Bogdan & Biklen, 1992). Therefore, following these recommendations, I began coding by reading the entire transcript once. Then I read it again, only this time, I omitted myself (by not reading my dialogues in the interview) in order to listen carefully to the interviewee's underlying message. Then, a short description (in a few words to a short sentence) was made to describe segments or units of data. This helped to put further focus onto the interviewee and to listen to the participant's perspective and underlying message.

In addition, there were various types of codes whose terminology resembles those used in quantitative research. These codes are known as 'In vivo codes', in which the code used the exact words given by the interviewee.

Provision for Trustworthiness

There are three steps, which I have taken to improve the trustworthiness of this research. The first step was to conduct a pre-study phase before the actual study, as described above in detail. Also, the pre-phase was successful at solidifying the appropriateness of the questions and the methods of the study.

The second step was that throughout this process, I discussed my findings and ideas with my supervisor and other qualitative researchers (namely, Dr. Grenier, Dr. S. Jordan, Dr. L. Davies and Dr. L. Butler-Kisber, with the following purposes: 1) to deepen my understanding of the research and to identify the true essence of the data obtained from interviewees: Also, 2) to determine whether I have gathered enough evidence to support my themes generated and, 3) To identify my subjectivity in the research and how it might have influenced my interpretation of the data. This discussion

phase was essential to my study as it helped to provide an objective view of my data and also it helped to deliver my research findings clearly to my audiences.

Lastly, I reviewed the information obtained from each of my interviewees at the beginning of each interview before exploring deeper. This was done to clarify any nuances and/or missing information that occurred at the previous interview(s) and thus, to ensure the accuracy of the data I have collected. Also, with each interviewee, I used part of my final interview to verify the common themes that emerged from previous interviews. Furthermore, I verified these common themes and sought their opinion about them to ensure I had captured their lived experiences accurately.

CHAPTER 4: RESULTS and DISCUSSION

This section contains both the result and discussion components of the thesis. The results are the common themes emerged from the eight participants and the discussion contains relevant literature related to the particular emergent themes. Please note that this section is carefully arranged for better understanding of the themes such that each common theme (presented in the result) is followed by the literature relevant to the theme (discussion).

Details about Excerpts

The responses from the participants are presented in short sections labeled as excerpts. These are quotations taken directly from the participants as recorded and transcribed verbatim in the interviews. Moreover, excerpts were selected to ease the understanding of the emergent themes.

The format of each quote was such that the '# X' presented the interview number (first, second or third) and 'L' represent the line number of the transcript. Moreover, to respect the confidentially agreement established with the participants, I omitted all names that could identify the participant (including their friends, relatives, health providers and other services except YD and EBM) and replaced them with fabricated letter names.

A short profile of the participants with their pseudo names is located in the appendix. This was made to give the audience some background information of the participants, which is intended to help understand the participants' situations better while reading the excerpts.

Please note that for ease of reading and understanding, I had condensed the dialogue by omitting: verbal utterances and expressions (i.e., stutters, repeats, pauses, laughs, signs); other environmental noises (i.e., ambulance sirens, construction noise, humming of an operating fan etc); and other material not relevant to the thesis. However, all these were documented in the transcript. Therefore at times I will insert in parentheses the context and/or any necessary information (required by omitted from the original transcript) for easier reading and comprehension. Finally, I have included subheadings, presented as italic font that highlights the subject of common themes.

Adapting to Own Capacities

Based on the seniors' descriptions, it seemed that they were all mindful of the limitations of their bodily capacities brought by their individual health ailments. The three most common limitations the women reported were (in random order): 1) Walking problems; 2) Fatigue or lack of energy; 3) Decreased eyesight. All of which the women reported had affected their daily activities to a certain degree, but they seemed to have a positive attitude about these limitations and seemed to have adapted to them. In this section, the women revealed how they created strategies to suit their bodily capacities while staying autonomous.

One of the most common issues raised was: lacking energy or having less energy to perform routine chores such as cooking for themselves and doing grocery shopping by themselves. Nevertheless, the women found ways to handle this challenge. For example, one of the women who had recently suffered a minor stroke (during the course of the study period) reported that it was more difficult to concentrate now than before the stroke. In the following, she described a method of keeping on track while cooking:

3 L: 404-416

J: Although I have trouble, concentrating, so, ... I make mistakes, even ... when I cook, I forget, 'Did I put the salt in?' , 'Did I put too much of this in?', you know, and I got another thing, when I COOK, I have to cook differently, from the way I cooked before...I had to do Step-by-step. And I had to gather ALL my ingredients. And then, do the mixing, and then I put in that, then, I had to put it away, on the side. And then, mark off, on my (list), that I put so much of this, yes, and then, the next thing, so I don't forget the sugar, the salt, put salt instead of the sugar. yes. You know, what I'm talking about (cooking), have to be slowly and Carefully, so THAT's why, just making a couple pies and a salad, and a pudding, this week, its just going to take me ten times longer, than it did, before.

Another woman shared her experience with grocery shopping. She explained that she could not do her grocery or choose the foods by herself because she could not walk well. She also mentioned that she once received help from an EBM volunteer who drove her to shop but later that service was not available. Therefore, she said she had to do her groceries by phone. In the two excerpts below, she revealed her strategy of trying to get the foods she wanted:

#1 L: 264 – 279

Fr: No, I cannot go and choose. No, because I cannot walk. ...Difficult. But ah, when I call, I don't get exactly what I need, but ah, I know the store (from past experience), so, in my ah, I know what to order.... So, I don't know, in the winter, ah, I might ah, ask EBM to send someone again, she told me the other day ah, they don't have someone with a car. So.... I, I better continue with what I'm doing now..... Since I've, been to ah, store, few times, I know, what they have. So that helps.

#3 L: 192-195

Fr: ... and ah, when I call (for groceries), I try to speak to the same person. And she comes to know me. So, I have a bit of (a better) choice.

W: When you call the PA , you speak to the same person.

Fr: I try... It's not, always possible.

Another woman who had increasingly more trouble with walking gave another example of a strategy she used to remain independent. She mentioned that she worried about doing her groceries in the wintertime because of her poor walking. In the following excerpt, she revealed her strategy that would 'save' her from walking too much:

 # 3b: L: 838-842

O: (grocery shop) At the health food store, but ah, I'll get it there anyways (at the Health food store) and because it's so near, it saves a lot of walking, so.

W: so, then, it becomes, how easy it is (to get there) and it overrides the cost.

O: Yes, yes, I get, quite a few things there, and all expensive. So, but I think it's worth it, because you know, walking, not so easy

Accepting Limitations

All older women in the study mentioned having certain physical limitations. The most troublesome was walking. Some women accepted using walking aids while others did not. The following excerpt came from a woman who contemplated about using a walker but finally got one. Notice her attitude towards getting a walker and how it was 'easier' on her than using the cane.

3L: 265-266 + 286-294

O : Well, they more or less insisted I get one, but the CLSC they forced me to! And, I liked it, when I got it...

She continued ...

O; Nnoo. I, I didn't really want it (the walker). I said I wouldn't like it !But I want something to sit down on, you know. Because I have to sit. I went to the Metro (name of grocery store), there's a lot of walking. And, now where, there's nowhere to sit down at all, and the whole way. And ah, that's partly why, I decided to get it, but, I like it much be-, much, much, much better than the cane! It's easier. So.

W: Can you tell me why, you didn't want to have it, in the 1st place?

O: I don't, I don't know. It's ah.... I suppose you'd , be, be, more crippled up, more, more ah.. you know... more, not on your own!

The expressions the woman gave about using the walking aids, such as being 'more crippled up' and 'not on your own', could be interpreted, as the woman's fear of losing independence and that could also be the reason why she refused to use them initially.

The Living Environment

In addition, one of the interesting observations found common amongst all these woman was that they all lived: relatively close to grocery stores; in a populated area of Montreal and; seemed to have good access to transportation (private or public).

When I asked the women for their opinion about their living environment, all responded it was convenient. Surprisingly, all admitted not being aware of the convenience until after my questioning. Perhaps one of the reasons why they were not aware of it was because they have lived in the same residence for a fairly long time. For many women, they have lived in their current apartment since they retired, at least 10 years ago.

One of the women described the convenience of her living environment in the following excerpt:

 # 3L: 1237-1239

Dt; I love it (her neighborhood)! It's ah, I've got, Old Montreal? I've got Chinatown? I've got SIX, bus stops? 6 buses that goes all over the place? 2 metros? Yep, um hm. So,

I'm very very convenient, and I have the um... Complex Desjardins (name of shopping center))?

Living in the same apartment building seemed to be advantageous for the women as they explained they have gotten used to the environment and they were all at ease to do their daily activities independently. As shown by this 88-year-old woman who lost her eyesight. She lived in the same apartment for a large part of her life and therefore responded calmly and proudly that she continued to use a gas-stove to cook for herself.

#1L: 491-497

B: ...I've been living in this building for 58 years! ... and we (her sister and her who has passed away a long time ago) have the same gas stove.

W: So you got used to it you mean?

B: Oh yeah. Um hm.

Another woman revealed that she moved to downtown (from a city near by) because she had trouble walking and felt that it would be better for her if she moved. She described how living in downtown now is now:

#2 L: 28-38

Gp: Well, I, find it's more closer down here. IF I could, much close, I can just walk out and get my groceries. Or, Go to... Alexis Nihon, to the shopping plaza there, and, everything is there. Or, the other way, ah.. just STORES all around here. Where in Westmount, I was kind of, confined in the corner there, and it was a WAYS to walk to ah, everything, Even to the grocery store, it was quite a way.

W: Ah!!!

Gp: It was quite a way when you're getting older. BUT, when you're YOUNGER... like, you'd figure, it's not, that, far. BUT, for an older person, it is far.

The convenience of living in downtown also included the ease of getting foods. As mentioned previously, some women frequently mentioned that because of the lack of energy or, having less energy compared to before, they would purchase prepared foods to help with food preparation. They also revealed that the local food-stores, markets and restaurants surrounding their residences provided convenience.

As one of the women explained, she lived in an apartment building connected to a depanneur with daily food service. She explained that she would purchase food from the depanneur on occasion when she did not want to cook. She mentioned previously that she disliked cooking and preferred if 'someone else does it'. In the paragraph below, she expressed her fondness for the depanneur and how it helped her with her meal.

3bL: 199- 207

Dt: ... ... downstairs, in this building, and they (the depanneur) have, ah, Monday to Friday, a wonderful meal, and usually it's either Chili Con Carne, or Stew, whether it's beef stew or, whatever, um.. Lamb stew, or, whatever, but ah, it's INCREDIBLY delicious, and it's not, worth making your dish at home, because you have to cut up ALL these vegetables. And it's, I don't even have to go outside! I just have to downstairs! Through the, through the um, ... well, it's actually a depanneur, but it's um.... but, they decided to do this, and they sell, also, wonderful, wonderful sandwiches, and soup, as well. You can take out soup. So, it's extremely, I'm SO fortunate!

In summary, the women created strategies to overcome their individual physical limitations that affected their daily lives. Although the particular strategies were tailored to their own individual needs the most common idea the women displayed was that they wanted to remain independent as long as possible.

Discussion on Adapting to Own Capacities

There is literature on how seniors designed strategies to help overcome their particular physical limitations in order to continue their daily activities. One of these is from the Gustafsson, Andersson, Andersson, Fjellström & Sidenvall (2003) study on older women's perceptions of independence and food-related work. This research team conducted a 2-part qualitative study with a total of 72 community-based participants including 18 non-disabled women and 54 disabled women. Within the group of disabled women, 18 had stroke, 18 had Parkinson's disease (PD) and 18 had rheumatoid arthritis (RA) . Note that women with diagnosed dementia and or severe speech impairment among stroke victims were excluded from the study. Amongst all participants, 50% of the participants lived alone (Gustafsson et al, 2003). The authors found that these women wanted to retain their functions of doing food-related duties and if they could not do

those, they were threatened because it was seen as a risk of losing their independence. Interestingly, Gustafsson et al (2003) reported that these beliefs about this risk were different in women with different types of disability. Women with RA strived to live their 'normal' lives, women with PD wanted to manage as long as possible, and women with stroke wanted to become their own masters again (Gustafsson et al, 2003).

Furthermore, seniors created strategies customized to their individual needs. Gustafsson et al (2003) found that women with RA reported they reorganized kitchen cupboards so they could reach things they need conveniently. Also, women with RA who had difficulty shopping would plan this trip such that they would avoid buying heavy items all in one trip. One strategy was to visit the store several times a week and buy small amounts of item each time. In addition, the seniors in Gustafsson et al (2003)'s study could be compared to my participants because they experienced similar activity-limiting health problem and also, they strived to continue living their lives independently.

Arcury, Quandt and Bell (2001) have also found similar self-protective behaviors and attitudes as shown by my participants. For example, some of my participants reported taking the taxi instead of the bus to prevent injury. Similarly, the seniors in the study by Arcury, Quandt and Bell (2001) expressed that they should not strain or over-exert themselves to prevent getting hurt. Also, the participants in that study described taking care of themselves means: 'not push beyond their physical limits, and getting enough sleep and rest' as a way to stay healthy. Therefore, seniors in this study seemed to be watchful of their health and tried to adapt to their own capabilities.

Asking For Help

The senior participants in my study were all living independently. However, they asked for help from time-to-time when needed. Moreover, they reported seeking help usually from friends, family and/or others (whom they selected) in order to fulfill tasks they could not do independently.

For example, a 91-year-old woman with a mobility problem said her niece would take her to shop by car whenever and to wherever she chose. As she described in the following excerpt, notice at the end how she described not asking for help very often:

 # 2L: 611-612 + 627 – 631

O: yes, that's (her niece) a great help. She's a teach-, she's off now, that's nice, but ah, she's nice, but she returns in the Winter and she's not free so much to, take me places, so... ... Well, she takes me anywhere I want to go. Yeah. ... ... I don't ask her very often because, you know, unless there's, something I need want especially.

Another 75-year-old woman also with some mobility issues recalled the winter-time when she needed help walking because of the icy streets. As she described below:

3L: 1914 – 1934

Di: Last year, where there, there, ah, the out, was awful last winter! Oh my God! Some days were very *icy! And ah, So, I just stood there! Outside! Outside the door. And if I saw, young men, I would say, 'Look! Help me out! Because I can't walk on that sidewalk. Because it's too icy. There's no sand.'... ... So, so, WELL, next time the young man comes around, the young man, or middle-age man, who's not walking with* a cane, *I'd say 'Sir! Please help me. To the corner of the Street! ... ... I must wait for a young one!*

When asked why chose younger-men, she answered:

#3 L: 1932-1934

Di: WELL... women, we, we're all the same! We all have packages, packages, packages. All sorts of packages all the time. So no use, no use asking them! Or... they have babies, you know?

Notice how the women above selected her helper carefully by choosing 'young man' as opposed to an older man or woman.

All the participants in the study used the grocery delivery service. Most explained they used it because the groceries were too heavy to carry. As this woman described in the following:

 # 2 L: 371-377

Dt: Yes I, DO shopping, once a week, normally. And I have delivery, and IF I have to, if I see something on special on another store, which I can carry, of course, I carry 1 or 2 or 3 items, if they're not heavy. But ah, for me, um, it's, it's very difficult to carry, to carry heavy bags.

Aside from not being able to carry the groceries, going to shop was also reported as physically demanding. The women said they had to choose from which store to shop that would alleviate the problem. The woman below gave an example of this:

2 L: 582-590

A: Mostly, I go to IGA (name of grocery store) Well, I would like to go to the Metro, when they have specials, they have real, good price on their things. But, Metro, is difficult, because you gotta take the bus, and it's been and they, re-route for so long, that you've gotta walk a MILE to get to store, after you get off, and walk A MILE back to get on to it ah... I'm not very good at walking. I'll try, so, I don't go to the Metro that often, it's mostly IGA, because, you can get off the bus right at the corner there. And get back on.

W: A mile... you have to walk that far...

An: No, no, it seems like a mile to an old girl!

Stocking up & Planning ahead food supplies

When using the delivery service, seniors said they planned ahead for obtaining their foods supplies. Grocery flyers was the most common source they reported they used to help them during this planning process. They would mark down foods, which were 'on sale' that week for purchase and also stocked up on those (if possible) for later use. This practice was clearly described by the following 91-year-old woman:

3 L: 137-138

O: yeah. I, like, I think, Provigo and Metro (names of grocery stores).... Um hm. I watch the... flyers every week, mark down the bargains.

And she continued her description:

3 L: 153-156

O: ... Well. They have, if they have ah... chicken breast? Um..ah, sale? Or, I wasn't going to get them? I'd get them anyways! And... ah.... salmon, canned salmon, it's on sale, I would stock up on them. The sockeye salmon, the expensive one. I always have 7 or 8 tins.

Most women said that every week they read the grocery flyers from several nearby grocery stores, which were available in their apartment buildings, to watch for on-

sale items. They also mentioned that they would compare the on-sale items from various grocery stores and make these purchases at the store with the most on-sale items that they wanted. The following woman gave an example of such behavior in the following excerpt:

 # 1 L: 218-222

Gp: And, fruits? I like ALL fruits. And I have a habit, to make, to give me variety, I look for what's on sale in these 2 stores out here. There's Provigo across and there's PA (name of grocery store) up the street. And, like this week, the PA has grapes on sale, so I got the grapes. And...then I don't have to think about it. Whatever that's on sale. Then, maybe next week, it's gonna be oranges and bananas...

Based on their attitudes about the grocery-delivery service, it seemed that the seniors used the service to the best of their advantage, of which the most commonly reported advantages were being cost efficient and laborsaving.

Seniors showed they were aware of the cost of the delivery service by the way they could quickly recall the amount per delivery and the difference of the cost between one grocery store to another. Also, they showed they were cautious about the price-discount on deliveries especially made for 'golden-agers'. The following woman described this awareness best when she compared between the senior-discount and non-senior discount. Notice at the end how she rationalized the use of the senior-discount in the following excerpt:

3b L: 470-472

Dt: Um hm, yes I guess, that because people who have Golden Ager card, they can have delivery at MUCH less price, than, if you have to, if you don't have, if you're not a senior. And why wouldn't you take advantage of that! You know?

Most seniors planned ahead to have deliveries every 7 to 10 days while others planned for every other week. The following excerpt is from a woman who used the service every month. Based on her description below, it seemed that she also took advantage of the service by the way she said she would 'fill her basket to the hill':

 # 1 L: 1085-1086

Di: ... ... I go 4 blocks to Prince Arthur and Parc (names of the streets), and I go downstairs in the shopping center. There's a big metro, so I buy $100 , $150 worth , I, I, fill that basket to the hill!

Seniors also revealed how and why they organized the grocery items to be delivered such that the heavier ones were left for deliveries while they would pick up the lighter-weight items by themselves or by other means. The following woman gave a clear example of how they organized and manage their grocery purchases:

 # 3 L: 946-950

J... when I'm out of something, and I haven't had it, in my last, delivery list. So, but ah.. I have ah, I have a sort of a tote, that I use, a TOTE bag, that I use, it's just need it for a few more things. But usually, I tried to, organize things, so, that I save up the heavy stuff, for my Wednesday delivery. You know, the big juice bottles...

Another woman revealed a different method to get groceries. As she described in the excerpt below, she mentioned that besides using the grocery deliver service, if she needed certain items that was not on the delivery list, she could ask her friends to help her. She described it in the following:

#1 L: 1090-1095

Di: (filled delivery-basket) With everything! Meat, eggs, milk, bread, whatever. So that's good for the whole month. So they deliver... seniors $1, so now, I don't have to worry. I don't have to worry about going to the corner store for bread, for milk or whatever. If I DO need, I have a couple of friends. I could tell them 'Please when you're finished with the car, please bring me a bread, or bring me a milk. So, so, it's not very difficult! Not very difficult getting groceries.

In general, all these women tried to remain autonomous. They described how they would ask for help when they really needed and how they used service that would help them complete their usual chores. Interestingly, they also revealed how they took advantage of the services for seniors for help (i.e., grocery delivery service) and that these seemed to help them maintain their independence.

Discussion of Asking For Help

My participants expressed strong desires to remain independent in the theme: *Asking For help.* According to the literature, this behavior is also common in other community-dwelling study participants.

Independence and integrity were found to be important personal values to the elderly (Wikby & Fägerskiöld, 2004). In their unique study of elderly residents who just moved into the retirement home, Wikby and Fägerskiöld (2004) found these participants did not want to trouble anyone and they said that it was important for them to walk and do things without assistance. Gustafsson et al (2003) also found the similar attitude of being independent in their research on elderly women. Their study had a mixture of elderly women with and without disabilities (of which the disabilities came from these three health ailments: stroke, rheumatoid arthritis and Parkinson's disease). Furthermore, all of these women had various degrees of physical limitations; nonetheless, they strived to remain independent just like the participants in Wikby and Fägerskiöld's study.

Moreover, another study on free-living seniors 80 years and over found that, despite reduced independence and physical limitations, the seniors focused on self-perceived aids than barriers they encountered (Callen & Wells, 2003).

Therefore, there seems to be a consistent pattern in my research and that of others indicating all of these studies showed that despite health complications, seniors' value and strives to remain independent when living alone.

During my interviews, seniors revealed the strategies they used to overcome the physical limitations. The participants in my study were most concerned about the weight of the grocery items because they could not carry them by themselves. This concern was also reported in a recent study.

Sidenvall, Nydahl & Fjellström (2001) found the female participants in their study planned their grocery items by weight, such that they had heavier-weight items delivered while they bought lighter-weight articles at very regular visits.

Interestingly, this study also found that some of the oldest women in the study preferred to ask their family members instead of other senior-service helpers, to help them only when they needed. (Sidenvall et al, 2001). Therefore, the seniors seemed to

have a particular preference to ask for help from those they were more familiar with and/or have a close connections with. Although this was not a common preferences reported by my participants, most revealed how their family members were involved with their grocery shopping and meal preparation from time to time.

Furthermore, it was interesting to note that none of the women in this pilot study reported using the grocery shopping help service offered by the volunteer organizations: YD and EBM (from where the seniors were recruited). When asked seniors why they did not use the service, the most common response was that they did not really need it since they could do it themselves and preferred to continue doing so. Nevertheless, some women stated that they might need the volunteer grocery-service in the wintertime when they said it would be harder for them to shop by themselves.

Frustrated with Health Care System

Seniors expressed frustration with their health care providers' lack of attention and/or care for their health problems. The women believed that this lack of attention was because of their age. As this woman, who described she suffered great pain from arthritis clearly remarked about her general physician (GP):

1 L: 115-121

Gp: . ... You have a few aches and pain in the beginning, but it's gotten worse and worse. But then, I find ah, like the doctor that I go to, the GP, ah, when I say something or complain, she'll say 'Well, you're know you're over 80!'. (tsk) I'm So... tired of hearing that. 'You know, you're over 80!' ...I only have one doctor that who won't say that..... They all ah, have that habit nowadays and you feel that, after you're 80, they're not looking after you. They don't care

The women also gave many examples where they took the initiative to ask their doctors to give them the health care they thought they needed. According to them, their doctors often did not perform the necessary examinations needed for their health. Therefore, they said they pushed their doctors to take action and to provide the care they felt they needed.

The following woman who suffered from lack of energy retold her encounter with her doctor. The emotional tensions she expressed are highlighted in bold font. At the

end of the following excerpt, this woman said she 'knew' when she needed to ask for her doctor's help, as if she had an internal signal that could indicate her needs. She described her experiences in the following:

 # 1 L: 362-372

Dt:... And just recently, I, I had to say (I) screamed at my doctor. Look at my test, because I, I was, I had, been lacking in energy, and I was, unhappy all the time, and ah angry and this and that. He said, 'Well, your thyroid is borderline. The test of the thyroid is borderline. So he put me on a pill for thyroid condition. Thyroid.

W: And, how long have you been on that pill?

Dt: I've been on that pill for over a year. And I just say that ah, it, did, exceptionally changed my life.

W: In a good way?

Dt: Yes.I have energy now, that I didn't have at that time. And I knew that there was something wrong. I think we know, when to, to ask our doctor to check again, ah, blood test, because we know there's something wrong

Another woman of 74 years old, commented on why and how she needed to pressure her doctor to make the necessary health test she felt she needed:

.# 1 L: 158-162 and, #1 L: 167-181

Di: ... I push the doctor you know? I practically tell them what to do.

W: What do you mean by tell them what to do?

Di: ... NO, they don't think of everything!.

She continued:

Di:.. I said that 'well, I read a lot of those magazines. I read everything that's medical you see. Then, one day, I found out that. That's true! I should go get the... the exam for the BONES.

W: the bones. Ok.

Di: You know. What they call, osteoporosis. So I did WELL. Because the doctor never mentioned that to ME!

W: When you say that you have to 'push the doctor', what do you mean?

Di: Well I mean..

W: How do you push?

Di:... if I say 'Doctor I feel this way, I feel that way.' So, he's going to say, hold on, I'll send you to the hospital, they do ah, they do ah, very good blood test, so on, so then, I said that ... then . I, I told him, I said 'well, at my age, I think I should go for a, --- an osteoporosis x-ray at the hospital.'

W: ok.

Di: ... well HE never mentioned it! I mentioned it!

Notice how the woman above said she 'read everything that is medical' as her way to educate herself about health. Her behavior was shared by other women in this study, which were described in another common theme titled 'Monitoring health'.

The women revealed they took matters into their own hands to solve their health problems and to get the health care they felt they needed. Although each woman described her different ways of problem solving, the common behavior seemed to be taking initiative. In the following excerpt, a 91-year-old woman recalled her experience of seeing her 'good doctor' at critical times of great bodily pain:

3L: 1171-1179

O: Oh, well, she's(her Doctor) busy busy. But, she, she doesn't, she never rushes me, when I'm there. She wants to know, what's going on, and ah... I, make an appointment. I have to wait 2 months to get there... need 2 months to get an appointment. I go up in the (clinic) , just appear up there. And if I have to,. And she doesn't like that, when I just drop-in. you know, she's so busy, you know. But I've done that, a few times!

Long wait times for health appointments were not uncommon for these women. Many recalled that their health ailments and/or concerns had to be put on-hold because their health care providers were busy and it took a long time to get an appointment. The following woman showed her frustration with this long wait-time in the excerpt below:

#1 L: 281-286

Di: ... It takes MONTHS, and MONTHS and MONTHS to get an appointment with the doctor. So anyway, so when we found out (I was) diabetic, the doctor said 'well, you better go see the endocrinologist. And ok, ... So, that's takes about, ... so ... I made an appointment, that takes about 6 months before seeing his 'royal highness.'

Perceived lack of attentiveness by health care providers was also a common issue raised by these older women. As one woman clearly expressed her dialogue below. She suffered from a dramatic unintentional 10 lb weight loss and poor appetite over the past year. At the time of interview she began to recuperate but she recalled her experience with the health treatment she received where it took a long time before having the tests done to find out the cause of the weight loss, as she described in the following:

#2 L: 82-86

> *Dt: Those tests in the hospitals were arranged because of my weight loss. Which the doctor noticed and wanted to know why, I lost so much weight. I, he had arranged them but, in hospitals, it takes many many weeks before, you can have the test. And they arranged them, but it was ah, probably, two and half months, before I had the tests.*

The same woman also described another experience she had in the excerpt below. During that interaction, she felt that the doctor was not caring for her and it also left her with a number of unanswered questions regarding her health. Notice in the excerpt how she tried to rationalize the causes of her problems based on her own opinion. Also note how it led her to be in a state of anxiety and a feeling of 'being forgotten':

 # 3bL: 1037-1050

> *Dt: I just, wish that, um... more questions would be asked by doctors.... I wish, ... there, there are many... ... ... experiences that you can have, that... that may trigger, ah... a,.. reason, for something that's happening, you know, in your health. And I DO think that more questions should be asked... ... ... for example, um, one time, I went to see my doctor, my feet, were blue. Now, obviously a circulation problem. Now, why didn't he look into that more thoroughly? ...(She continued on...) ... And why don't they say, 'well, we've checked into this, and everything is fine'. So, best thing to do, would be, to um... dress more warmly, or, this and that. At least, deal with the subject matter. And make the person feel that, make the person feel that they haven't been forgotten. ... .*

Knowing their own bodies best

They also held particular health beliefs that they thought were beneficial for their health. Most explained they knew their bodies much better than anybody; therefore they

made their own judgments to determine the usefulness of their health providers' advice. The following woman described how she interpreted the advice from doctors and dietitians, notice how she rationalized why she did not believe in everything that the health providers told her in the following excerpt:

3 L: 316-327

Fr: Not everything huh, you have to take what ah, is good for you, and ah... you, you don't take anything that's not suitable for you. Like ah, anything, like cooking, or, if you see a doctor, or you see, any kind of ah (dietitian)... ... eat, they tell you a lot of things. But that don't mean, you'll able to do everything that they said ...No! Because it doesn't suit you? They (health providers) don't (know) you, as much as you yourself, .. you know yourself much better than anyone. So, they try , like they do, like if I speak to the doctor, they try things, they don't know you! So, it's the same thing in the cooking... I don't believe that they can tell me, DO, (or) do not eat that food, not good for you? Because ah, generally, but it's not specially (made) for you.

Also notice how this woman feels the advice did not 'suit' her and how the health providers 'don't know' her. Her comments showed that she felt the advice was not tailored to her specific needs.

Another woman shared her experience with her eye doctor. The woman expressed frustration towards the care she received and in the following excerpt; she revealed how she felt she had to argue with her doctor just to express her concerns. She also pointed out that aging should not be a factor affecting health care.

 # 3 L: 1727-1738

J: Just take it, each person, as an individual, ah, human being! Not, as, ah, necessary as an OLD human being. Because I say to doctors, ah, like for instance a Doctor., said to me once, an ophthalmologist, um... he said 'Why won't you take these eye drops?' ... And I said, 'Because Doctor. 'It said , in the side effects, that it will take the color off my eyes!' ... Well, you know, I've learned, to be a little feisty, ... I said, 'Hey, Dr., I don't wanna change the color of my eyes! That's what!' ...(I said) ' I may be old but I'm still a woman! And I care about how I look!'

In addition, the women explained that they were under more than one doctor's care. Sometimes the advice given by different health providers became confusing thus,

they explained they felt that they had to use their own judgment to decipher which is best for their health.

3L: 346-350

Fr: you see, nowadays, you see different doctors. One is good for your heart, and another one, is good, for your feet, another one so, when they give, say, to you, no salt anymore. Another says, a bit of salt, another one says another thing so, you have to, make your own choice. Decide for you, what is good for you, what helps you the most.

Nutritional advice:

The older women also described how they selected the nutritional advice from the health care professionals. According to them, the selection was based on how well it suited with their food habits and food preferences.

Half of this study sample had consulted a dietitian mostly at the hospital setting where they were treated for nutrition-related health problems (i.e., Coronary by-pass, diabetes, kidney failure, high-blood cholesterol). One woman consulted the dietitian in a community clinic but only one woman continued to meet her dietitian periodically.

Some women reported that they continued to use the dietary advice they had received a long time ago, most exclaimed that they 'have gotten used to it' and that they have adapted it to 'a certain degree'. For example, one woman said she had not seen her dietitian for years. She described the difficulty she had at the beginning when she was first diagnosed with high blood-cholesterol. In the following excerpts, she recalled how challenging it was for her to adapt to the new diet:

#2 L: 708, 712-716

Gp: it's hard to change. Yeah....And, if you do change, it's not good. It doesn't taste good, you know. ...Like um... you know, supposing you're cookin', oh, say, is piece of salmon, in the oven. Like.... (according to dietitian) You supposed to put just water in, with it, well. Nothin' like a piece of butter eh? Or, something. Then it TASTE better! So, when you change you do these things, it's BETTER for your HEALTH but, it's not good, so you're not happy, with these changes.

This woman above was frustrated with the dietary restriction and with the changes she had to make. Interestingly, she interpreted food as not 'tasting good' as not 'good'.

She also seemed to acknowledge the fact that the change was good for better health but as she described, she did not feel happy about it.

Moreover, another woman who suffered from heart and kidney problem mentioned she had lost her appetite since then. Her comments clearly expressed how she struggled with the dietary restrictions and called it a 'God awful diet':

1 L: 311-328

A: Well. They gave me such, God awful diet. First with my heart condition, don't eat this and don't eat that. Don't give you much choice. Then, when my kidneys failed, then they gave me another list. And I said 'might as well just forget what's on the list! Nothing much else to eat! So, I just. I WATCH what I eat, to a certain degree. I don't FRY things... Except like bacon. Once in a GREAT long while, I might have that, But, I, try to bake everything. Because... well my cholesterol was very high when I had my heart attack. It's normal now, I still watch what I eat.

W: How challenging is it to always watch what you eat?

A: Oh I'm so used to it now.

W: You're used to it?

A: I don't eat like I used to before. I can tell you I enjoyed food before, now I only eat because I have to be ALIVE!

At the end of the excerpt, she showed anger towards her restricted diet and how it led her to lose her enjoyment for food. Apparently, the attitude from this woman was not uncommon, there were other women like her in this study who needed to adapt to particular dietary restrictions for health. Nevertheless, the women's attitudes with dietary advice and restraints suggested it had a negative impact on their appetite, enjoyment of food and hence food intake.

In summary, these excerpts were selected from a collection of experiences some women shared at the interviews about their health care systems. Through the women's expressions, attitudes and descriptions, it seemed they believed that their health care system did not meet their expectation and some felt frustrated as a result of the perceived lack of attention. Nevertheless, most of these women showed they took control to manage their health by reporting these: taking initiative to get the health care they felt

they needed; selecting the health advice from their health providers and; using their own collection of health-related resources to take care of their specific health problems.

Discussion of Frustration with Health Care System

There seem to be very little research that shares the same frustration my seniors' expressed towards their health care system. Nevertheless, some topics discussed within this theme have been found.

A recent study about perceptions of dietary advice from 152 older people ages 75 and older, was conducted by McKie, MacInnes, Hendry, Donald and Peace (2000). They found that seniors showed confidence in their own knowledge of their body and its needs. According to the seniors, they judged what was good or not for themselves based on their lifetimes' experience of looking self-care (McKie et al, 2000). Moreover, the analysis of the study's data found that the majority of the participants believed food and eating were topics that was to be experienced and not advice to be sought from any professional (McKie et al, 2000). Also some participants reported receiving dietary advice only in the context of specific disease and the most commonly reported general advice they received (often from their general physician) was to 'watch their weight' and to 'put away the frying pan' (McKie et al, 2000).

Similarly, seniors participants in the study by Gustafsson & Sidenvall (2002) reported that their food intake is influenced by messages from health authorities, scientists and the media however, these seniors could not understand the messages well enough such that they could not change but instead, kept on using the established food behaviors. Thus it is possible that seniors felt frustrated when trying to make the food choice that would be good for them.

Keeping Busy

None of the older women in this study could be classified as 'workers' according to our society's definition of work. The reason being they were not busying themselves to work for anyone and they were not busying themselves to work to earn for a living. Yet, the participants were working to achieve a common goal: to keep busy in their daily lives.

The women in the study described how they kept busy by: doing something, being alert, being active and spending time outside of their homes. As shown in later paragraphs, the act of keeping busy included doing activities for themselves, for others and/or with others.

Each of these women had their own schedules and their own specific ways of keeping busy. They planned their days with activities for themselves and they ensured they were keeping physically and mentally active, of which the latter was more emphasized.

These women have various ways of keeping mentally active. The activities they mentioned included: playing bridge, learning a second language (English or French), helping others, doing word puzzles and cooking.

For some women who enjoyed cooking, they described it as a 'creative' work that 'activates their minds'. The following woman illustrated this in the excerpt below:

#3 L: 394-398

J: Well, the senses, are, part of ah, your creative being. And also, creating, like if you're creating your own version of the recipe, that's a creative act! So, there's a lot of creativity, involved, AND ALSO, it affects many things, like for instance, you have to measure. So, you're practicing math, and ah... it, it does a lot for you. It, stimulates, you have to practice patience? And concentration? So, cooking does a lot.

W: Is this your way of keeping your mind active?

J: Absolutely! Absolutely! Because, um... if, if you follow a recipe, then you have to be SURE, that you've put in the right amount of each thing, and that, you have to keep track, of what's in it. And that you didn't put a tablespoon of salt, instead of sugar. You know. And it keeps you, it keeps you active. Yeah.

Moreover, some seniors associated being physically active as equal to being mentally active. As the woman described in the following:

3 L:37-39

Dt: Well, I think I'm more alert mentally, if I'm, busy physically, and um, so that I like to keep ah... walking, and exercising in the morning, and, doing many things in the routine of which I do.

Furthermore, the association between mind and body was also clearly illustrated in the following excerpt given by a woman of 88 years old. Notice how she described she would sacrifice her (bodily) physical function in order to keep her mental function:

#3 L: 394-398

J: ...Mind and body are one thing. One affects the other. And when I, when I, when I got this information, um... I PRAYED, I had prayed that, um... if I have to lose a faculty... Let it be my body and not my mind so, when I had the stroke, I thought to myself, 'Thank you God!' that's what I asked for. Because, I don't want to lose, the faculty of my mind [Note: (The woman above had suffered a minor stroke during the course of the study)

This sacrifice of other things for the mind was not uncommon amongst the participants as another woman also revealed how she could give up anything to keep her mental functions:

#3: L: 81-82

Fr: I don't want to lose ah, well, I can lose my mobility, or anything else, but I don't want to lose that (pointed to her head).

These women expressed strong desires to keep mentally active, despite having certain physical limitations. The following woman who had lost her eyesight displayed this attitude as she described why she played bridge:

#2 L: 594- 601

B : Well, bridge is very good for you.

W : Really?

B : Very good for your mind, very good for your brain.

W : How so, how so?

B : Cuz it makes you think.

W : Ok.

B : um hm. Any doctor, will tell, an older person, if they want to keep their memory, to learn, bridge

This woman said she plays at a bridge club twice a week. She said that she gave up other activities (such as Entraide Bénévole Métro's weekly activities for seniors), just to play bridge:

2 L 571-573 + L: 581 – 583

B : Yeah, and I used to go, down there (to Entraide Bénévole Métro) , alot. But, it's on Wednesday and on Wednesdays, I play bridge at the X (where she plays bridge). So, I don't go anymore... Yeah.... I, I wanna play bridge! I have to give up all my other activities. And everything happens on a Wednesday. Yea, all the trips (from EBM) and everything falls on a Wednesday.

Based on the seniors' experiences and descriptions it seemed that these women chose activities to challenge themselves. Another example of such behavior could be illustrated by this woman whose mother tongue was French, and was also more fluent in French, but she chose to attend weekly activities at an English-speaking senior-centre over a French-Speaking one) in order to 'work her mind', as she explained in the following:

#2 L: 480-487

Fr: ...I CHOOSE to go to English place, just to, keep my mind, ah... working all the time. And ah. that's quite an experience, it took me some time in the beginning, to ah... say to enjoy, what I was ah, doing, and it was, for me, it was a lot of concentration, to.. (laugh) to 1st of all, doing ah... to um... hear? .. to translate? Because all the time, I'm not ah , I'm translating all the time, and we do a lot of Brain Teasing (name of game). And ah, when they ask the question. My answer is in French, and, they (English-Speaking seniors) have a lot of time to answer before me? It was funny now, but it wasn't at the beginning.

The woman above was aware of the challenge, by saying at the end of the excerpt that 'it was funny now, but it wasn't at the beginning' and also near the beginning of the excerpt, ' for me, it was a lot of concentration'. These seemed to show how she challenged herself by trying to familiarize with a second-language. Interestingly, this woman described the experience as 'a pleasure' for her with the following excerpt:

#3: L: 72-79

Fr: It's a pleasure, it's ah, as I said before, it's a game? It's kind of ah, ... because it works in there (pointing to head) and I want to keep it working!
W: It works your mind?
Fr: yes... That's the reason I go to, ah, English, Centre de jour, Day care.

During the study, the women explained why they wanted to keep busy. Most of the explanations suggested that the activities made them feel good about themselves. For example, this 75-year-old woman stated below how keeping busy gave her 'a sense of accomplishment'.

#3 L: 92-97
Dt: OH Yes! The Day, goes quickly, if I'm active. And I feel, I ALWAYS feel a sense of accomplishment, everyday. Um....if I don't , if I'm not busy, I feel like I'm wasting my time. That's why, when I have ah... the opportunity, I try to,ah... sometimes read a book, But generally speaking, study something, or help someone else um... with their.. ah. practice in English, which I'm doing

Interestingly, just like the 88-year-old woman mentioned previously, this 75-year-old woman also used the English language as a way to keep herself busy. The difference was that this 75-year-old taught English to others while the 88 year-old learned English as a second language from others. In addition, most women revealed they helped others as another way to keep busy as well:

#2 L: 66-72
A: Maybe I'm selfish, in a sense...Because (helping others) it's helping ME, to exist....I don't know... I don't know. I like to be needed, so, this, fits my bills and requirements!

Interestingly, when asked to describe what it meant to be 'not busy' the women described it with a negative connotation. The following woman illustrated this in her excerpt below:

#3 L: 42-43
Dt: I, the only time that I, I think that I would not be busy, is if I were ill. And in bed most of the time, and I hope that never happens.

Notice how the woman above associated being 'ill' with not being 'busy'. Although her comment was unique, her attitude and strong desire to be busy was similar to the other women in this study.

In summary, the women in this study gave their reasons for keeping both physically and mentally active, with more emphasis on the latter activity. These women explained and described the various activities they did and how they benefit from them. Most of these activities were done in groups such that they would interact with other people while, some were activities they did on their own (i.e., cooking, reading, doing cross word puzzles etc.). Moreover, they chose these activities themselves and they felt good being able to do them.

Discussion of Keeping Busy

My seniors' behavior and attitude described in the theme keeping busy' are also found in other research in aging.

For example, in my study, the senior participants' habit of reading grocery flyers and planning grocery items before making purchases is also found in a study of community-dwelling women. Sidenvall et al (2001) found the older women selected to shop in grocery stores based on the price of food items advertised. Similar to my seniors' behavior, these women also stored on-sale food items. In addition, these women explained that stored items could make cooking easier for them and could also be used to entertain unexpected guests (Sidenvall et al, 2001).

Interestingly, the women studied by Sidenvall et al (2001) reported a feeling of shame when they talked about cutting coupons from direct advertising. However, my participants did not share this feeling as they recalled the benefits of using the grocery flyers. For example, some said grocery flyers helped them to economize; be a better buyer as they could get the good deals while still getting quality foods; and also even helped to create ideas for their meal.

In the literature of the definitions of health as perceived by seniors, activity is a commonly described component of health. For example, the meaning of activity has been researched and Kaufman (1996) found that seniors perceived being active as related to being healthy. In her study of personal definitions of health among elderly people, her

sample of 67 community-dwellers, 65 year and older, reported that they were healthy because they did activities. Kaufman (1996) grouped these into 4 subcategories including: 'getting up and about', 'exercising' in the form of walking', 'volunteering' and 'actively being active'. Interestingly, those activities were very similar to those that my senior participants reported doing. My participants said they valued their ability of *volunteering* (such as teaching English at community center, making monthly luncheon meals for residents, shopping for other seniors whenever possible) and *exercising* (such as doing 15 minutes of stretching every morning, going grocery shopping everyday and walking indoors). Although my study focus was not the same as Kaufman's, my seniors perceived their health positively as those senior participants in Kaufman's study.

Another study on 25 elderly women age ranged 55 to 104 years old from various backgrounds discussed how they valued helping others. This study involved interviewing three groups of women with these living arrangements: nuns living in personal care home, community-living seniors and seniors living in retirement-center. This behavior seemed to have an emotional attachment such that these women felt 'sharing themselves or thinking of someone as a significant part of self-care behavior' (Maddox, 1999). Therefore, the seniors' attitude of keeping busy with some activities may not only be for the benefit of oneself but for others as well.

Most of my seniors stressed the importance of being both physically and mentally active and these have also been reported in the study by Arcury et al (2001) regarding community-dwelling seniors 70 years and older. They found the common themes of 'staying busy' and 'taking exercise' as 2 of the 7 highly salient health maintenance domains in their qualitative study.

Moreover, 'staying busy' referred to being physically active, mentally active and maintaining independence while 'Taking exercise' includes doing formal exercise, walking and/or moving around. (Arcury et al, 2001). All of these behaviours and attitudes are similar to those expressed by my participants and in addition, participants in my study explained in-detail how they keep active. Also, they gave examples of food-related work that they would use to activate their minds and physical health (i.e., planning what and how much ingredients to put in a recipe, what to cook, what to buy and/or how to modify a particular recipe they are accustomed to and etc.)

Similarly, keeping active was also considered important for seniors who were newly admitted to retirement homes. These seniors reported it was important to keep pursuing their interests and maintaining their usual life styles (Wikby & Fagerskiold, 2004). These fifteen seniors age ranged 79 to 95 years old reported that visits, letters, telephone calls, outings and walking outside were important. (Wikby & Fagerskiold, 2004). Although my participants are all independent living, it is still important to note that these behaviors of keep doing activities is common between seniors despite different living environments especially because these seniors all have certain physical limitations that affect their daily living. Acknowledging this factor may possibly have implications on providing effective elderly health promotions in the future.

Simplify Cooking

Based on my participants' descriptions, managing one's daily life independently in terms of food was challenging. Many things were involved. However, they described they had adapted their food preparation to their lifestyles and capacities. One of the clearest and most important tasks for self-care was feeding oneself. Remarkably, these seniors had found various ways to simplify their cooking according to their personal standards.

As my participants revealed, not all enjoyed cooking. The minority enjoyed it (3 of 8) and the others either did not mind or disliked cooking. However, despite this difference, they all simplified their cooking.

According to these women, simplifying cooking meant: using less time, less effort and requiring less energy. This meant something that was: fast, quick and easy to make. One of the most common attitudes or comments about cooking for themselves now was, they 'don't want to fuss for one person' or 'can't be bothered with cooking' (for oneself). As the woman explained in the following excerpt the changes she had since living by herself:

#3 270-272

B: Well, I think it's true, because when you live by yourself, you don't go fuss, if you would, you know, if you were living with other people, eh? So, you settle for, things that are most convenient to get.

One woman who revealed she used to be a homemaker for her seven-member family and now, she catered for at least twenty elderly residents in her retirement building every month, described her attitude for cooking for herself as 'the line of least resistance', she explained in the following:

#2 146- 148

A: Oh I guess I'd do ...anything...once in a while I prepare...proper meals,... but, I think it's the line of least resistance, less effort...I don't know...there's not much point in FUSSING around for one person...if you're not, extremely hungry. And anticipating food, there's no desire to feel to make things special. And, take what will suffice you.

She gave further definition of what she meant as 'the line of least resistance' in the following:

 # 2 L: 846-847

A: well, you don't take a lot of effort? To do something? So,... takes a little bit of time, so, you're resisting a lot of work there.

Notably, all of these women revealed they were used to cooking in the past. Most often, they cooked for more than one person and it was either for family and/or for friends. Now they explained they cooked less and that they usually ate and cook alone at home. In the following, the woman described how she felt cooking was too much work for her and that her pain also influenced her ability to cook for herself:

 # 3L: 797-801

Gp: ... ... Like I, I don't have anybody, in, to eat, I do have my son, once in a while, but, other than that, nobody. Because, ... it's just too much work! I guess, that, goes back to my arthritis, I'm, too full of aches and pain to bother working in the kitchen!

Most of the participants reported having difficulties with mobility. According to them, the act of cooking and preparing food for themselves was effortful and require 'energy' and 'a lot of work'. The explanation by a 75-year-old woman clearly illustrated this attitude in her excerpt below. This woman first mentioned needing the 'courage' to cook for herself and she defined courage with the following two excerpts below:

 # 2 L: 624-626 + #2 L: 671-672

Dt: (Why) takes courage to cook? Oh, I dunno, I think the older you get, the, the less energy you have the cook. I'm not sure. But I think, ... but I, I think most people are 75, don't have as much energy to cook as, as, they did, when they were younger.

And she continued with the following:

Dt: I just think I'm, saying it in a sense that, I know it's going to take a long time. And it's going to be a lot of work. So that's what I mean by it takes courage.

Notice how the woman above included the factor of old age, energy, time and workload to describe the process of cooking.

Moreover, they reported that their health ailments affected their cooking habit and food intake. The following excerpt, from a woman who is an author of several cookbooks, exemplified the affect of her health problem. She said now she suffered from symptoms of low-blood sugar and lack of energy and these affected how she cooked, as she described in the following:

 # 3 L: 723 – 725

J: WHEN I, feel that... that I'd like to do it (to cook) , and I have enough energy to do it. But NOT at night, I don't, I used to(do) it (to cook) at night, and write , in the daytime when I was doing the cookbook, but, at night, I'm just, ah.. wasted! so, ..

Aside from lacking energy, effort and patience to cook for themselves, the particular diet regimen and/or diet restrictions also influenced the women's appetite, as the following women described in the following excerpt:

3 L: 138-146

A: I dunno, I am not hungry, never get hungry. Maybe because ah, I, tend to,, have a , cup of tea, with a cookie, at the middle of the afternoon...it maybe that, puts me off, being hungry? I dunno. .. and even drinking water, takes away my hunger, so, ... I guess over the years, your stomach gets smaller, I dunno. but, some people, eat a lot, I, I just don't feel like eating it,WELL, I've had bad sickness at times, so, the diets, were very limited and you lose interest in the food after, ...get tired of eating the same thing

. Despite the challenge, they continued to monitor their nutritional health. They revealed the strategies they used to overcome the limitations imposed by their health ailments. One such strategy from a woman with a mobility problem and experienced fatigue, said she would take short-breaks during cooking to manage her tiredness, as she described in the following excerpt:

 # 1 L: 1007- 1009

Fr: Well, when I'm tired. Because I'm, up and up. And I, I go and sit, and after... 3, 4 minutes,(and then) try again.

This woman also explained how she simplified the cooking process by steaming her vegetables with a steamer while cooking her meat in the same pot together at the same time.

Diet Variety

The women revealed their strategies to add variety into their diets. One of these strategies was to use smaller portions or smaller packages of food when preparing the meal for themselves. Some women revealed that the fresh vegetables they found in their market were too large for them to eat all by themselves and often, it turned bad before finishing it. The women revealed they would use canned vegetable as one of the substitute sources of vegetables. The following excerpt from a 86-year-old woman exemplified this strategy and explained her reason below:

 # 1 L: 206- 214.

Gp: if it's (vegetables) fresh, it's just too many!. Supposing I get carrots. We'd say. Then I'd eat carrots forever! But if I get the small tins of carrots, then, 1 or 2 days, it's gone. Like I got some ah, asparagus last week, and I cooked half of it, and ah, I ate that, then the other ½ I cooked, but they went bad! You see, fresh stuff is in too big a quantity. And like to think of gettin' a lettuce! Ah, it's just too much! I have to throw half of it away! And I don't like throwing food away! Sometimes, those bags of lettuce, if there are on sale, I buy 1 of those. And then I can afford to throw ½ of them away, because, you know, it (vegetables- if unfinished) goes on and on and on

She also described how she gave herself food-variety by comparing the produce on-sale that week from the grocery stores she could get to and made her purchases that way, as she described in the following:

 # 1 L: 218-222

Gp: And, fruits? I like ALL fruits. And I have a habit, to make, to give me variety, I look for what's on sale in these 2 stores out here. There's Provigo across and there's PA up the street. And, like this week, the PA has grapes on sale, so I got the grapes. And...then I don't have to think about it. Whatever that's on sale. Then, maybe next week, it's gonna be oranges and bananas...

All women in the study reported they made use of foods that took less time to prepare compared to conventional (fresh foods). Examples of these quick-cooking foods the women mentioned included: frozen vegetables, frozen meals (from groceries stores or caterers), powdered soup mixes, tinned vegetables, ready-to-eat foods from grocery stores or take-out restaurants. Most of the women said they also added some other foods in addition to the quick-cooking foods listed above. One of the woman stated that she added foods onto the frozen dinner in the following excerpt:

#2 L: 112-114

Fr: And there is some vegetable with it (the frozen meal). And then I cook some other vegetable, to put, to add to it, sometimes a rice, or, ... noodle. All kinds of things.

Two of the most common reasons the women gave for using quick-cooking foods were that they were too tired and too busy to make the entire meal.

As the following woman described below, she attends senior-day centers twice a week and would occasionally use the frozen meals on days when she were too tired to cook:

 # 3 L: 117-126

Fr: Oh, not regular(meaning not using frozen foods regularly)...just, once in a while, when I'm not ah, sometimes I'm tired or, I've been out in the afternoon, but I have to bring it out, before I go out. Because it's, frozen, so I have to, have them.....

W: Thawed?

Fr: yeah.

W: So, you'll use them, if you, don't have time to prepare?

Fr: yes, time or, if I go to the day center, when I come home, very pleased to have this ready. Not all the time. Sometimes I cook, a few things on Sunday? So that's ah, I can use that.

Also note that the woman above revealed that she would not always use the frozen meal and would also prepare her meals in advance during the weekend. Another woman who lost her eyesight also mentioned that she would use the frozen meals on occasion and would prefer to cook her foods from scratch as she described in the following:

#3 L: 276-277

B: I usually cook from scratch. I mean, occasionally, I'll take a Stouffer, but very rarely.

Need Ambition to Cook

Interestingly, seniors reported that they would cook a proper meal from time-to-time, when they were 'ambitious' enough to do so. Proper meals had almost the opposite definition of a simplified meal such that these proper meals would likely require more preparation time; involve more steps; and even more ingredients.

Moreover, these ambitious moments usually arrived at 2 unique conditions: 1) Sporadically, when cooking for themselves and; 2) Deliberately, when cooking for others. The descriptions from the following women clearly described these two conditions. For the first condition, this woman explained she used to have 'proper meals' before but not anymore. Notice the difference in attitude this woman gave between cooking for others and cooking for her in the following excerpt:

 # 2 L: 240-249

A: Well, I had proper... big meals. I cooked for, whoever was at home then and... I had...Oh, you know, stews and, spaghettis and all that jazz. Now I have the stuff to make it, and I don't even bother to make it

W: How come?

A: How come!? Well, why make all that up for me?

W: Why not?

A: Well! I can eat just anything!.

W: But it'd be tasty, just like you made before

A: I know it'd be tasty but..oh, 1 of these days, I'll get ambitious and make it up I guess.

Cooking deliberately meant they would spend more time, and more effort to cook for others. An example of deliberate cooking came from a woman who used catering services and other ready-to-eat products more often than cooking a meal for herself. She explained that she would cook for her son, whom she said was her only home-visitor, once a month. For her son, she would spend the time to prepare the food and cook it though she exclaimed that she disliked cooking. Notice how she would spend the time and effort to cook shown in the following excerpts:

2b L: 1713-1720

Gp:... ... I don't like to cook, you see... ... ... Like as I mentioned, my son come, the last time, we had the sausage, BUT, he comes, oh he just comes about once a month, he's a principal in the school, and once a month they have ah.. meeting after, school .that he has to go back to. So, he comes and, here for a couple of hours, and ah, there. The time before, I made a stew, and THAT's a big job! ...Cuz I put lots of veggies in and, BUT THEN , I have enough stew for a month after!

She described how it was 'big job' for her in the following excerpt:

#2b L: 1734- 1737

Gp: And like to make a stew, like ah, it's a BIG job, fix all these vegetables. But I usually do that, over 2 days. I... you know, peel a lot in one day, and, and wrap them up in something, and... and they're already cooked, the next day

Whether one liked cooking or not, the participants' method of food preparation was also influenced by their experiences at different stages of life: prior (at childhood) and recent (at marriage and/or after retirement). As this woman explained the evolution of her cooking-style where it began at childhood with her food-aversion of eggs at the farm and how it changed when she was an adult and how it changed again when she married:

1 L: 306-312.

Dt: I suppose when I, when X (name disclosed), my ex-, was ah, was a chef, I think I learned a few things from him. Perhaps I taught him a few things too. But I don't think so. Ah. but ah, when I think back, I have to, learn, good, cooking. I had to learn good cooking because I was born in a farm, and there we ate eggs 3 times a day. So, that wasn't incentive for me, to learn, to learn from my mother and father, and.. so I decided much later in life, that I'd have to learn to cook well, and I got, I bought a lot of recipe books. And ah, just work from that... And I took a X (name disclosed) course in Chinese cooking. So that helps me too.

Similarly, another woman described how she also had limited food choice as a child and how it changed with her children as she revealed in the following:

#2 L: 1162- 1168

A: Well, if you grew up in my house when I was young, I had to eat everything... If I didn't like it, I had to sit there at the table until I ate it. Sometimes I would sit for 2 hours. Looking at it. Cabbage. In those days, they cook cabbage in a big clump...not, nice, at all. That big BLOP on your plate. I look at that, and look at it, and look at it. I wasn't allowed to get away from the table until I ate it. So, when I had a house of my own, I didn't cook anything that I didn't like. And my children could choose what they like, I had a restaurant

This woman described earlier that she liked to have variety in her foods but said she would not 'fuss' for herself at her meals as she lived and cooked alone. Therefore, she said she made her meals simple. However, she described that she would prepare a variety of dishes for her residents at the monthly luncheons. (Note that her excerpts have been displayed previously in this common theme)

Seniors' also revealed that they received meal ideas from foods they tasted outside of home (i.e., at restaurants, at someone's home etc). Some said they would mimic these recent experiences at their own home. As one of the women recalled that she would get the recipe from the restaurant the she dined in and tried to do it at home in the following:

#3 L: 38-40

Fr: like we go, to the restaurant very often. And ah, I get some recipes, I find-, I try to find what there is, in that food? Or, so, that's pleasant, and can do it here (home) too. So... I have a good variety of food.

A similar mimicking-behavior was also found in another woman's excerpt, when she explained how she liked the salad from a restaurant so much that she tried to replicate it at home and shared it amongst her friends in the following excerpt:

#1 B: 179+

J: I served him (her friend) ah, Spinach salad that my daughter and I had, in a wonderful restaurant in Miami Beach over the last Christmas holiday. And so, I tried to ah, reconstruct it at home. It was very simple. It was: Spinach, just spinach, and raw tomatoes, in little strips, they took all the inside out, so made into little strips. And little strips of onions, or, um,. Mixed up, tossed, and topped with little bunches of creamy goat cheeses

One senior even mentioned she got a new recipe idea from the hospital where she was a short stay patient. Altogether, their descriptions suggested that the women were learning from their different experiences and some of these motivated them to repeat the recipes at their own homes.

Even though the women simplified the meal preparations, they all replied that they were conscious of what they ate. The most common food group seniors mentioned they had was vegetables and fruits. As some women mentioned before, preparing the vegetable was 'a lot of work' and it maybe this that lead some women to find short cuts to alleviate the 'work' they needed to put forth. One of the women revealed her method in the excerpt below. Note how she explained she ate her vegetables in a 'smart way' and focus at the end when she reasoned why she had to be 'smart' to eat her vegetables in the following excerpt:

#2L: 880 - 906

Di: ... , I bought containers of ah, veg, salad... POTATO SALAD, and macaroni salad, and coleslaw, and ...things like that. ... ... I like to come home, and just... eat, eat vegetables... ... right away! Sometimes I go out, I come home and I want to eat my

vegetables right away! ... ... You don't, you have, you have vegetables, you have to be smart! You know? You don't want to make so much work for yourself!

In this common theme 'simplifying cooking', the seniors gave their definitions of simplifying their meals and their reasons for doing so. From their responses, it seemed the most common reasons were: fatigue, not wanting to 'fuss' for one person and needing 'ambition' to cook a proper meal for themselves. Ambitious moment to cook a 'proper meal' for self comes occasionally and they also recalled being motivated to replicate the recipes that they learned from eating at places outside of their residences and recreate them at home. Furthermore, the women described themselves as health conscious and emphasized eating vegetables and fruits. Some women also described how their cooking skills and eating habits have changed at various periods of their lives: at childhood, adulthood and at older-adulthood.

Discussion of Simplifying Meal

Research found that community-dwelling seniors simplified their methods of cooking and interestingly, each seemed to have a unique definition of simplifying and reasons for doing so.

In a recent qualitative research study by van Dillen, Hiddink, Koelen, de Graaf & van Woerkum (2003), 30 free-living adults ages 18 to 80 were asked to reveal their thoughts about these issues: food, nutrition and health, information sources, food topics, nutrition knowledge and nutrition education (including the role of the family doctor). From this study, 10 food associations were found, these were (in decreasing order) 1) Safe food, 2) Preparing meals, 3) Healthy food, 4) Tasty food, 5) eating less fat, 6) unhealthy food 7) price of products, 8) vegetables, 9) balancing food, and 10) shopping (van Dillen et al, 2003). Note that preparing meal was the second most important association.

It seemed these participants preferred 'very quick and easy' as well as 'quick cooking' meals. Also, the thoughts about these: saving meals, actual cooking time, warming up meals, danger of salmonella, cooking for groups and recipes are found within the discussion of meal preparation. Interestingly, compared to the adults 31 years

and older, the youngsters (ages 18 to 30 years) were most concerned about preparing meals (van Dillen et al, 2003).

Similar to the participants in van Dillen et al (2003)'s study, the seniors in my study made similar association and preference when they described preparing their meals. Seniors in my study preferred making simplified meals that meant 'fast' or 'quick'. Also, they described they cooked less of the dishes that seemed to have complicated procedures (such as roasts, creamed onions, Sheppard's pie etc).

The study by Callen and Well (2003) also found seniors preferred shortening time of cooking. In their study, 68 free-living seniors age ranged 80 to 102 commonly discussed having labor and time saving solutions for making their meals (Callen & Wells, 2003). According to these seniors, the solutions helped to maintain their nutritional health without making them tired. Callen &Wells (2003) identified some of these solutions to include: the microwave oven (which was the most frequently reported labour-saving device), packages frozen meals and nutrition supplements (such as Ensure, Carnation packets, Boost bars, ready-to-serve soups etc.) From Callen & Well (2003)'s study (2003), it seemed that tiredness was one of the possible reasons for seniors to simplify meals and this is not unique.

Sidenvall et al (2001) reported that some of the independent-living women age ranged 64 to 84 years old simplified their meal preparation because of certain physical limitations such as having defective vision, lack dexterity or being tired. Interestingly, the seniors in my study mentioned these limitations as well and they also revealed strategies that they used to help overcome the problems they faced and still able to continue cooking.

Another study with elderly men age between 62 and 94 years living alone found that men's cooking skills affect their diet quality, especially intake of fruits and vegetables. Hughes,Bennett & Hetherington (2004) found that men with self-rated good cooking skills reported better health and consumed less total energy from their diet but consumed more vegetable (as vegetables has low energy density) than men with poor or adequate skills

Another recent study found that elderly women revealed they simplify meals because they had a fear of dietary fat and gaining weight or they desire to lose weight

(Gustafsson & Sidenvall, 2002). The ideal for these women was to prepare tasty food without too much fat and some of these women gave examples of simplified meals as those that require no cooking (such as eating sandwiches at meals instead of cooked meal) and making meals that have fewer dishes to wash (Gustafsson & Sidenvall, 2002). My seniors have also reported using some ready prepared or easy to prepare food items for their meals (ie, canned vegetables or ready-to-eat prepared salad purchased at grocery stores) but unlike those participants in Gustafsson & Sidenvall (2002)'s study, my participants all seemed to value cooked meals, especially at dinner time.

Simplifying meals also has other social causes. From the same study, the majority of the women used to cook for their family but now they only do so for themselves, therefore they simplify the cooking time and procedure as they have lost the main motive to cook (Gustafsson & Sidenvall, 2002).

Another study shared similar finding in that social and environmental barriers that affect nutritional health in community-dwelling older adults. Callen and Wells (2003) found that widowhood often means eating alone for their study participants who have had years of companionship at mealtime. For these participants, their cooking methods have changed such that they cooked less and that, seemed to be a challenge. The study found that having the opportunity to socialize at meals such as: sharing a meal or going out to eat with family or friends or going to community meal sites, all helped to maintain their nutritional health (Callen & Wells, 2003).

Within the theme of simplifying cooking, seniors also mentioned cooking a proper meal when 'ambitious enough to do so'. Having motivation to cook has been found in elderly men an important contributory factor to healthy eating when cooking and shopping for one and eating alone (Hughes et al, 2004).

Stereotyping Older Adults

All participants seemed to have certain attitudes and perceptions about the aged. This section revealed several common attitudes the senior women held which they used to distinguish themselves from their peers. Also, they shared their experiences about how others see them as an older person and how these made them feel in the following paragraphs.

Being Different from Peers

The women identified themselves as different from their peers, in other words, women in their own age category. One of differences they used was in terms of their nutritive behavior and food intake. They usually described how they ate better than their peers. One of these examples was from a 91-year-old woman. She described how her appetite differed from her friend's and thus would avoid eating with this friend:

 # 1 L: 869-881

O: No, I have, I had a friend, she used to ask me to come to lunch. And she has the craziest lunch I used to tell her, I had lunch before so I couldn't have. But She'd have toast and tea and maybe a little sliver of cheese and that'd be lunch. And I thought, God!... She's just , it's just that she couldn't eat. She said 'I couldn't eat a lot'. You know. ... ... She died years ago. A stroke. ..., most of these (elderly) have awfully bad ideas about meals. A lot of old people... ... They eat, little bits of things. I, I could eat a horse! ... That's why I'm, 91 and ...counting!

Another woman with limited mobility described how she was not like her peers who disliked cooking. She was different because she enjoyed cooking and she felt it was important for her to continue to cook, as she described in the following:

#2 L: 53-59

Fr: People that I meet at the day care center? They say, they're tired too much, they make too much meal, during the live, now they want to rest... And ah.. so they eat, something all prepared. They don't want to cook anymore. ... I meet ah, very few person, that take their time, to make their meal. Very few.. But ah, I feel that I'm important enough, to make meal, for myself.

Other seniors also commented about how they ate better than their friends (of the same age group). One of these women used her diabetic condition as a healthy eating guide to compare how she ate differently than others. She recalled her advice to her friend who indulged in a dessert:

#1 L: 504-529

Di: Yeah, I feel I eat the right things! Other people don't! I tell other people what to eat!

W: What do you.. can you give me an example?

Di: People eat junk! Terrible! ... Well, you know, you have ah, like ah, like some friends of mine or anybody, family or any acquaintance of mine. Sometimes I don't tell them

because I figure, what's the use? I know a friend of mine there who, who used to live upstairs, she's moving but anyways, she'll say 'Well, yesterday, I went to Provigo, and I got this,... lovely pie! with Pecans and Caramel, and ah, and ah, whipped cream.' And I am thinking, 'OH! How delicious!' But I couldn't eat it! Me, if you gave it to me, I couldn't eat it. No, because it's too much sugar!

Enjoy Being with Younger People

The participants had certain functional (mobility) issues that affected their daily lives however; instead of dwelling into these problems, they found unique ways of dismissing these troubles to continue on with their normal day.

The following excerpt was from an 86-year-old woman with arthritic pain that affected her daily activities. She described that she lived alone in a condominium where there was a mixture of young and old residents. In the following excerpt, she emphasized that she preferred to talk to the younger tenants more than the older ones. Also, pay attention to how she expressed her uniqueness when she talked about how others (her peers, friends) thought she was 'cookoo' for going to the Grand Prix ceremony:

1 L: 478-485

Gp: No, no., no. Because, to be with a bunch of old people. Well, I can complain about all my ailments, but all you hear from them is about all their ailments. You know, they got this, and they got that and... I don't wanna hear about that. I'd rather hear about somebody's night out on a town! Like, ah, the Grand Prix this weekend? Every. Time. Usually on Friday. I go on Crescent Street. Just by myself! Nobody wants to go with me! They think I'm, sorta cookoo! But I like that! So all the people the young people there's excitement and, you know, I watch them changing their tires and all of that? I enjoy it!

The behavior and attitude from the respondents above was not unique. Another woman, also of age 86, explained how she benefited from being with younger people in the following excerpt:

 # 3L: 830-841

Fr: ... I wanted to tell you that, ah we learn from other people too. I learn.

W: what did you learn?

Fr: Their way of thinking is interesting, its' ah, new... ... and, I learn a lot, I have grandchildren, who are 30 and 28, and um, their way of thinking is different. They

always ah bring me something that is ah new? Like , x music, they take me ah, modern music. So, that's interesting. And, I learn from their conversation. And ah. I guess we have to learn a lot from younger people. ... ...They, they're, they're ac-, active. And they have new, way of seeing life, which we have, it's not we establish from that, but ah, it's good to communicate now with younger people

Both of these women emphasized the enjoyment they had when being with 'younger' people as opposed to with 'older people'. Also, of interest to note the learning aspect the woman mentioned above. These seemed to suggest that the older women were willing to learn something new and that the younger people was one of their resources of knowledge.

Resisting Aging

The women's resistance towards aging could also be found in some of the adjectives they used to describe themselves. For example, the woman described how the distance from the grocery store to the near by bus stop was very far for her. The following excerpt is used to point out how this woman described herself as a 'girl':

 # 3 L: 585-590

A: ...that you've gotta walk a MILE to get to store, after you get off, and walk A MILE back to get on to it ah... I'm not very good at walking. I'll try, so, I don't go to the Metro that often, it's mostly IGA, because, you can get off the buss right at the corner there. And get back on.

W: A mile... you have to walk that far...

An: No, no, it seems like a mile to an old girl!

Similarly, another participant of age 85 talked about her experience with her younger volunteer and her mother. She acknowledged her biological age and how she chose to use the word 'girls' to describe her encounter with her volunteer and her mother both of whom were younger than her.

 # 3 L: 1682-1690

J: ... My volunteer (name disclosed) , who was with me for 2 and a half years, her mother came to visit, one weekend, and we went out for lunch. Her mother is still in her mid-forties, and (the volunteer) is 22 now, I think, and I'm you know, 85 now, and we

went to lunch, and we were like 3 girls!, having a chat and talking about this and that, and the World and guys and this and that and everything, I, I think no, no generation gap at all! And with none of the girls, that came, that comes to help me. I mean, I'm talking to you like I would be talking to a contemporary.

In addition, all participants stated that they were different now compared to the times when they were younger. Throughout the interviews, they all made comments about the changes they experienced as a result of aging. The topic they most often mentioned was that they could accomplish much more when they were younger. Through analysis, this comparison was found to describe 2 distinct tasks: 1) Tasks they did now that would need more energy, effort and time to complete and; 2) Tasks that they would need help on (as a result of their health ailments).

As an example, this woman, who had limited mobility because of her 'bad leg', described how her leg prevented her from doing activity she liked and how the leg also changed her life-style in the following excerpt:

#3 L: 32-46

Di: SO , well, things change, especially, this year, 2004, things change because, I like to go to the movies, and I like to go downtown! I like to go to St. Catherine street... ... because I, used to ah, to be around there, when I was working, so for now, I hardly go out! Because, I hardly go anywhere! Like I don't go the movies, because I'm afraid that if I seat down, my leg will go numb, I won't be able to get out of the cinema.. .... Because when I go downtown now, it's ah, it's ah, complicated. I have to take the taxi, because I can't get onto the bus you know! ..... So, how do you expect me to get off the bus, with a half numb leg, the last time I did that, I nearly break a leg! How, ...I, I can't do that anymore. Jumping off the bus like a 20 year old!

Most of the women in the study required some sort of walking assistance. Some used walking aids while others refused them. For those who used them, they recalled how they were viewed when seen with the aid. For example, one woman recalled how a younger man treated her when he tried to help her enter the mall with her walker:

3 L: 1896-1912

Di: ... if I (go out with), my walker, at , at the mall ... Yes. They think I'm an old lady! They open doors for me! They let me go first with my walker! ... And I say, thank you .. they must, they must think that I'm infirm, or something, invalid or something. Because, they see me with my, with my walker, before I go through the door! I have to fold it! Bon! And carry it! And Bon, Or else, I'm going up the stairs with my (walker) .... sometimes it makes me laugh, because, sometimes, I feel like saying, 'No, it's not, not like that' you know? ...

In this excerpt, the woman used the words 'infirmed' and 'invalid' to express how she believed the young man might have felt because of her walker and that near the end of the excerpt, she seemed to be justifying that was neither.

Another woman recalled an unpleasant experience with some storekeepers when she went grocery shopping with her cane and walker (interestingly, she called her walker a 'cart'). It seemed as though she thought the walking aids were the culprit of the storekeepers' ridicules. She shared this experience and how she felt in the following excerpt:

3 L: 192-204

O: The last time I went in (the grocery store), they were kinda nasty about it! I don't know what. They weren't the same people (that helped her store her walker while she shopped). I figured, were they laughing at me? For getting in to the Metro (supermarket)..

W: they were laughing about?

O: They seem to think that having a cart, ah, I was... impaired!

This woman continued on this topic in the following excerpt. In her response, she seemed to be searching for a solution, as an alternative way to enter the shop without asking for help. Notice she found a strategy to overcome the problem and that she was not discouraged from the store despite the unpleasant experience she had.

#3 L: 208-216

O:... THERE MUST be somewhere to get into that, basement. There must be an elevator somewhere that I can take. But ah... there's an elevator from the hotel, behind the.. but, they don't like people going through there, to get to , the Metro. Metro, grocery store, Oh.

W; Will this stop you from going?

O: Noooo. I'm going to find somewhere else, to leave it... I am to hope some.. I like to. I like it (Metro grocery store) better than Provigo, really,, for, most things Big orders

To summarize, these women shared their personal experiences and attitudes about aging. They distinguished themselves using their words, comments and attitudes about aging. Moreover, their experiences also exposed how the society see them, based on their outward appearance, and their descriptions revealed how it made them feel uncomfortable.

Discussion of Stereotyping Older Adults

Stereotypes of the Aged

Stereotype is considered as universally applicable, regardless of interpersonal differences (Hazan, 1994). In other words, if stereotype is applied to a group, it views that group as homogeneous.

According to the literature, stereotyping the aged is not uncommon. Also, most of the stereotypes gave a negative presentation of the elderly. Dr. Palmore described a rather extreme negative attitude about aging as he introduced his article 'the Future of Ageism'. This article highlighted the society's fearful and negative attitude about aging. Palmore noted that 'Ageism has been called the ultimate prejudice, the last discrimination, the cruelest rejection. Like racism and sexism, ageism is prejudice and discrimination against members of a group, in this case, older people' (International Longevity Center-USA, 2004, p. 2).

Similarly, Hazan (1994) provided some stereotypes about the aged as well. He listed and described some common stereotypes of the aged as shown below (Hazan, 1994):

Inflexible: Seniors are described as being conservative, inflexible, and resistant to change. They are incapable of creativity, of making progress, of starting afresh. Also, ordinary old people are seen to have entered a state of intellectual sterility and emotional impotence.

Senile: Senility was described to have two important distinctions. These are medical definition and image evoked by popular use (Gubrium 1986 as cited in Gubrium & Holstein, 2000). In the medical field, senile dementia is a condition of poor blood circulation to the brain due to vessels clotting and resulting in certain loss in emotional and cognitive capacities. (Gubrium, 1986 as cited in Gubrium & Holstein, 2000)

On the other hand, the popular image of senile individual is one that focuses on certain behaviour as evidence of senility, disregarding alternative explanations for that behavior. Senility seen as an illness, which is included in a very wide definition that 'few people can escape its range' (Gubrium, 1986 as cited in Gubrium & Holstein, 2000)

Dwelling on the past: The aged has been described to dwell on and draw their life meaning from the past. The present is deemed to hold no real interest for them

Seek peer help: Seniors are described to seek company of their peers for reasons of pure sociability rather than for any desire for practical, instrumental gain, or part of a quest for meaning, identify and knowledge.

(Most extreme stereotype): Depressed, unhappy, pervaded with sense of failure, disintegration, and pointlessness.

Based on my observation on the senior participant's experience, attitude and behavior as it was described in the interviews, my participants seemed to differ from most of the stereotypes as listed above. The differences were exemplified in the excerpts used throughout the study. Nevertheless, for discussion purposes, I have chosen the following themes to highlight the differences: 'adapting to own capabilities', 'keeping busy', 'stereotyping older women' and 'asking for help'.

For example, my participants showed they were flexible as they adapted to their physical limitations by creating strategies to help themselves continue on their daily lives independently. Also, unlike the stereotype 'dwelling on the past', my participants talked most about their daily activities at present as shown in the theme 'keeping busy'. Moreover, the older women in my study said they asked for help mostly for tasks that they could not do by themselves.

Notably, it is not my contention to say that my participants were especially unique. I have used Hazan (1994)'s discussion on the stereotypes of the aged simply to

point out that stereotypes of the aged exist and that my participants' experiences showed these 'labels' for the aged does not apply to every older persons.

Sidenvall et al (2001) states that the socially constructed stereotype of the aged as dependent individuals by recommending that 'older women should be stimulated to do as much cooking as possible, such that the woman will be seen as a person, not as the socially constructed stereotype of dependent old age.' (p.165)

Also, through speculation of the interviews, the seniors in my study seemed to focus on the positives rather than the negative factors (or barrier) affecting food intake, an attitude much like the community-dwelling elderly in the study by Callen & Wells (2003). In my study, the seniors recalled they had troubles with walking, had less energy and experienced more fatigue than before and all of these affected how they carry out their daily affairs. Similarly, in Callen & Wells (2003) study, the leading barrier for these seniors were the restrictions imposed by health conditions. Nevertheless, the authors noted that those seniors were remarkably positive about the barriers and they commonly shared their labor and timesaving tips at cooking (Callen & Wells, 2003).

Cognitive Functions of the Aged

An age-related topic my seniors often mentioned was cognitive disease in the elderly (especially dementia and Alzheimers' disease). Most of them gave examples of their peers who had those diseases and they expressed a concern for having those mental problems as well. Through the excerpts of the common theme 'keeping busy'; they shared with me a number of activities, which they used to keep their 'minds active'. Within this theme, several women said they were willing to sacrifice their physical abilities to preserve their mental functions. Therefore, these women highly valued their mental capacities. Nevertheless, based on their discussions, it seemed that the women associated aging with risk of mental dysfunctions. Interestingly, Goodwin (1991) discussed about this association as well. Therefore, to have a better understanding of this concern of cognitive function and aging, I have made a brief literature search and the findings are presented in the following paragraphs,

Goodwin (1991) argued that there exists an ideology about the elderly known as 'geriatric ideology'. According to Goodwin (1991), this ideology includes the concept of dementia as a disease instead of a natural consequence of aging. Therefore, as a result of

the ideology, normal aging held the same regard as diseases, which were to be rigorously evaluated and treated (Goodwin, 1991). This particular view about aging and disease has also been discussed by Kontos (1998).

Perspectives of Old Age by Social Scientists

Although it is beyond the scoop of my research, it is of interest to learn the perspectives from social scientists' such as gerontologists and critical gerontologists, on old age because it is quite different from those of medical-health professionals.

In Konto (1998)'s article on 'Resisting Institutionalization: Constructing Old Age and Negotiating Home', the author pointed out that geriatrics and gerontologists all assumed the biomedical model of old age such that 'the body, with its physiological changes and organic functions, became the central focus of an understanding of old age' (Kontos, 1998). Moreover, 'medicine positioned the aged body in pathology thereby investing it with meanings linked only to disease and decline' (p. 256, Kontos, 1998).

On the other hand, medical health professionals such as Dr. Morley (1997) pointed out the association between ageing and the decline in energy intake of the aged which could lead to malnutrition in the long term. Moreover, well-known short-forms about elderly health including Dr. Morley (1994) 's famous MEALS ON WHEELS mnemonic and Robbins' (1998) the 'Nine D's' (as shown in Introduction chapter of this thesis) both provided a list of problematic issues seniors may have that would lead to poor health via weight loss. Although the list seemed comprehensive by listing both medical and non-medically related factors affecting food intake, these lists seemed to have a disease-oriented focus and they also seemed to have omitted the influence of seniors' experience which could affect ones' health (as shown in my research findings and other qualitative research described throughout the discussion chapter of this thesis).

Gerontologists and geriatrics have different perspective about the aged. The latter exclusively focus on physiological changes thus as Katz notes, 'creating a limited social construction of the aged' (Katz, 1996 as cited by Kontos, 1998). Katz also notes that gerontologists differed from geriatrics in that they sought ways to broaden their discourse about the aged by including studies of sociology, psychology and demography (Katz, 1996 as cited by Kontos, 1998).

Nevertheless, Konto (1998) notes that despite gerontologists' attempt to move beyond the biological perspective of old age, they still "retained many reductionistic tendencies characteristic of geriatrics and biomedical model" (p. 257). In other words, gerontologists' perspective of the age was still too limited. The emergence of another field known as 'critical gerontology' seemed to further broaden the knowledge about the aged.

Katz (1996, as cited by Kontos, 1998) described critical gerontology differed from gerontologists such that it 'admonish gerontology for its narrow scientificity, advocate stronger ties to the humanities, endorse reflexive methodologies, historicize ideological attributes of old age, promote radical political engagement and resignify the aging process as heterogeneous and indeterminate. (1996, p. 4, as cited in Kontos, 1998). Altogether, the social scientists' perspective all helped to broaden the understanding of the aged.

Weight Concern from the Older Women

Although weight concern was not a common theme that emerged from my study, 3 of 8 of the women in my study have talked about their body weight and their concern about losing weight. Interestingly, the study by Clarke (2002) found their participants also shared similar attitudes about body weight as some of my participants.

Clarke (2002) has conducted a study on older women's perception of ideal body weights in 2002 and their participants shared some of my seniors' concerns about body weights. The interviewees from Clarke's (2002) study included a group of 22 community-dwelling women aged 61 to 92 years and she found that one of these women expressed dissatisfaction with their weight gain in terms of their physical appearance. Moreover, Clarke (2002) reported that they tended to describe the need to lose weight in terms of health risks and benefits rather than in terms of approximating the beauty ideal or achieving a desired body size and shape. Similar to Clarke's (2002) participants, my participants shared the same attitude that they wanted to lose weight for better health however, the difference was that my seniors did not express profound dissatisfaction about their weight and also, they revealed how they watched their weight through carefully monitoring their food intake.

CHAPTER 5: CONCLUSION

In this exploratory study, I have used a qualitative research method to understand some of the factors affecting food-intake in community-dwelling, independent-living seniors. In retrospect, I found that the participants reported to me a wealth of health-related information, which was much more than what I had first expected. Throughout the results and discussion sections, I have reported what seniors have revealed through their lived experiences and the findings from other research that have corroborated and differed from those in my study.

In this final section of the thesis, I will discuss my reflections on what I have learned from doing this research and my interpretation of the results. I will also discuss the possible limitations and suggest possible future research questions to better enhance our understanding of issues related to food and aging.

What I have learned from this research?

By using this qualitative research method, I have gained a number of insights from this study. First of all, I have learned from the older participants' accounts that many health-related issues were involved in their daily lives and although food intake was considered important, it was not their highest concern. From the seniors' interviews, they seemed to suggest that they were more concerned with these: their daily activities; their ability to continue living independently and feeling accomplished with the activities they selected for themselves.

I have also learned that each older adult was unique and they emphasized that they wanted to be regarded as such. They each had different lived experiences, led different roles in their lives, and had different health ailments that troubled their daily living yet, they did not dwell on the negatives but instead, they created personal ways to solve those troubles.

Nevertheless, I have also found that they shared some similar characteristics. The most important of which seemed to be that they strove to remain independent even in the presence of troubling health ailments. Other commonalities included: their desires to keep busy (physically and mentally active); their frustration towards their health care system; their ability and motivation towards monitoring their own health; their ability to

adapt to their individual health limitations; the stereotypes of older adults they had experienced from some of their everyday interactions with others and/or the stereotypes they perceived about older adults and; simplifying their cooking and the reasons for doing so.

Moreover, seniors reported that they liked to learn more about their health and especially on what more they could do to care for themselves. From their interviews, they expressed that they preferred using their own health-knowledge that they have learned in the past and gained through personal experiences, to determine the treatment that would be suitable to their needs, tolerances and preferences. Notably these preferences were mainly in reference to food intake.

The older women were unhappy about being viewed by others as the elderly, a term they related to as meaning being 'infirmed', 'impaired', 'and/or crippled'. Their statements suggested that our society has been making inaccurate judgments about the older adults based on their outward appearances (i.e., with a cane or walker). Moreover, the lived experiences from the participants showed that stereotypes about the aged (as identified by Hazan, 1994) certainly existed yet, these could not be used to describe them because their behaviors and attitudes seemed to have opposed those stereotypes. Therefore, I have learned that one must listen to the seniors carefully in order to hear about their concerns, to know what they are capable of doing and to learn what they know about their health and importantly, how they have been managing it.

In addition, it is important to reiterate the point from editors Gubrium & Holstein (2001) about the chosen research method for this study:

> *"The distinction between quantitative and qualitative approaches should not be invidious. In general, we should not compare them for whether one is better or worse than the other. They do different things as methods of procedure. A qualitative approach is better at portraying a world of social processes and emergent meanings. A quantitative approach is more suitable when the subject matter is fixed in meaning and straightforward in variation"* (Gubrium & Holstein, 2001, p. 9).

This study attempted to explore the phenomenon of food intake. Given the complexity of this aspect of life, it was felt that it would be better-captured using qualitative research methodology.

My Interpretation: Factors Affecting Food Intake

Using the data and the common themes that emerged from the data, I have made several findings on the possible factors affecting the food intake in seniors from this study.

1) *Perceptions about Dietary Regimen*(s) This referred to: how seniors felt about the dietary regimens given from health professionals (i.e., usefulness and importance) ; how it affected their food intake.

2) *Personal definition of 'being healthy' and 'healthy foods'* In addition to the perceptions of the diets, seniors' food choices were also guided by their personal definitions of 'health' and what they considered as 'healthy' and 'non-healthy' foods. These definitions guided the quality and quantity of food eaten.

3) *Accessibility of food stores* This referred to the physical distances between seniors' residences and the food stores (including grocery stores, food markets and food courts at shopping malls), the convenience and the accessibility of going to the stores. Seniors revealed they shopped at stores that were most convenient for them.

4) *Availability and Perceived Credibility of Nutrition Resources* This referred to the source and seniors' perceived credibility of nutrition and health information they obtained from: their health care providers, books and other health-related literature, friends, family and media. It also included how seniors deciphered the information to suit their perceived needs and personal preferences.

5) *Motivation towards meal-making* Senior's motivation towards meal-making also affected what they ate. Based on seniors' descriptions, motivation included: being ambitious enough to cook for self, having the desire to cook for others and having the desire to replicate certain dishes learned from dining experiences outside of home.

6) Individual Physical Condition Physical conditions included factors such as: degree of fatigue, ability to stand and ability to walk. These affected the quantity and quality of

seniors' diet because these influenced whether they were capable of doing their own groceries and the challenges of preparing their meals by themselves.

7) *Social network* Social networks included seniors': friends, family and neighbors. Seniors gave many examples of how their appetite and enjoyment of meals changed when they ate outside of their homes. However, these also depended on the company with whom they ate. It seemed that sharing meals with the company they enjoyed enhanced food intake. Also, seniors mentioned they had occasional help from their family and friends with food-related work (i.e., receiving frozen meals, cooked meals and/or leftover food after a family dinner.) These also influence the food consumed. Therefore, seniors' social support their food intake.

My Interpretation: 3 Key Points from the Common Themes

The common themes identified in the Results section could be further categorized into three groups: learning, struggling and taking control. These groups therefore became the essences of this thesis such that they provided a further understanding of seniors' health behavior. Each of the three groups will be described below.

Learning: Anthropologist Haim Hazan (1994) has pointed out a number of stereotypes the aged have been labeled with. Some of these included: '(the aged) are conservative, inflexible and resistant to change; (elderly are) perceived as incapable of creativity, of making progress, of starting afresh.' and 'the imputation to the aged of inability to learn-to store and process information" (Hazan, 1994 in Gubrium and Holstein, 2000, p. 15).

The older participants in my study all seemed to deviate from these stereotypes that Hazan (1994) has pointed out many people have about older adults. The older women provided many examples that they were adaptive to change. The following were the common themes that supported how they were learning continuously there were: Adapting to own capacities, stereotyping women and monitoring nutritional health.

The operational definition of learning included the following characteristics: having a keen desire for knowledge, searching for (health) information and applying these findings to better their own health.

The older women showed the above characteristics by the way they: learned about the limitations on bodily functions resulted from health complications and then, created strategies to overcome them; learned about the negative stereotypical views of the elderly and then, use them as comparative tools to generate positive attitudes about their living conditions. Moreover they searched for various health resources to learn about their individual health ailments and then, use them to monitor their nutritional- and overall-health.

Moreover, the seniors' behaviors and attitudes all seemed to show the opposite of the stereotypes put forward such that: they were flexible (by adapting and strategizing), they were changing (they change their diet and lifestyles for better health) and they were creative (by creating recipes and planning their menus to give variety.)

Examples of seniors' learning behavior have been shown throughout the results section. A few of them will be re-emphasized here in the following paragraphs. From the common theme, *Adapting to Capacities*, one of the most problematic health complications seniors recalled was fatigue, lack of energy and strength. Instead of dwelling on the problem or feeling helpless. For example, they stated how they simplified their cooking (as they reasoned: to give self with less work to do) and how they took advantage of the grocery delivery service.

Struggling: The senior participants showed they were struggling in these common themes: monitoring nutritional health; frustration with health care system; stereotyping of elderly and simplifying cooking.

The operational definition of struggling was defined as exerting negative emotions (anger, frustration) and needing more energy, effort and/or time than usual to carryout health care tasks independently. In this study, the older women reported they were frustrated and discontented with the dietary regimen that they were first given. Although they said they 'have gotten used to it now', their discontentment on the dietary restrictions seemed to remain to a certain degree.

In the theme 'monitoring nutritional health' and partially in the theme 'frustration with health care', seniors described their prescribed diet as 'limited', 'uninteresting' and 'God awful diet'.

Furthermore, the older women expressed they were struggling to obtain what they perceived as the proper service from their health care providers. Some examples from the theme 'Frustration with Health Care System' showed how they were unhappy with the patient-physician interaction.

These older women also emphasized they wanted to be regarded as unique individuals. They gave numerous examples of how they were different and more capable than their peers in the theme 'stereotyping older adults'. Moreover, in the theme 'Keeping Busy', they gave examples of how they kept up with their lives despite their health problems, while they stated that they did not want to end up like their peers who had mental problems and/or physical problems that would result in being homebound.

In the theme 'simplifying cooking', seniors have mentioned that cooking for them now was full of effort and required more energy and time compared to the past. Also, the women reported that they would still cook a 'proper' meal occasionally when they were 'ambitious enough' to do so. Therefore, they were struggling to continue their habitual cooking behavior in spite of their health problems.

Taking Control: In addition to the essence of learning as described above, the women in my study all showed a common behavior of taking control of their overall health. This was evident in the following common themes: planning own meal & planning food supplies in advance; monitoring nutritional health; and keeping busy & mentally active.

In this study, taking control was operationalized as a purposeful act involving careful planning and organizing of activities of daily living and self-care. One example of this was when they planned for their grocery order and what to have for the upcoming week's meals. They organized the grocery items carefully while taking in consideration the cost (of food and delivery services); the weight (i.e., whether they could carry them by themselves) and the accessibility of the food stores (i.e., how convenient the stores were to them by public transport, by foot and/or through help from others (i.e., family, friends)). Moreover, the women also organized their day with physically and/or mentally stimulating activities to keep themselves busy in order to feel accomplished and to avoid having cognitive problems in the future.

In summary, the emergent themes found common across the older women suggested that they were: learning, struggling and taking control when living alone and independently in the community.

Limitations:

Like other research studies, there are limitations. The two main limitations of this exploratory were: 1) Not generalizable to the entire elderly population and 2) Only on older women.

Generalizability of the Findings:

The findings in this exploratory research is not representative of the elderly population at large because this study: had a small sample size (8 participants in total); used purposeful sampling at recruitment (as listed in the method section) and shad influential participant characteristics (to be described below).

There were several characteristics from participants that influenced the generalizability of the study. One of these was that the participants selected themselves to decide whether they were appropriate for the study. At the recruitment phase, a large number of seniors refused. Some of the reasons for non-responses were: 'I'm too old to be doing something like this and this long' (said by a 100 y.o. senior, who, was recommended by the volunteer coordinator). 'I'm healthy',' I'm sick now, don't want to participate' and some sounded confused then hung up quickly.

Moreover, there were a few seniors who accepted the first interview but excused themselves from the other interviews. A few examples of these were described in the following. One 91-year-old woman who lived independently agreed to participate in the study and was interviewed once. However, she explained she was 'too busy' to continue.

Another 82-year-old woman agreed to participate in the study and had the first interview, in a shopping-mall food court (instead of her apartment) as her choice of location. However, she discontinued the study and reasoned that she 'may not be a good candidate because she doesn't follow any rules, eats whenever she wants, and what she wants.'

Still, another 89-year-old woman expressed interest in the study over the phone and invited me to her apartment for the interview. She refused to sign the confidentiality form and said she did not like the word 'research'. She said she needed someone she

knew from CLSC Metro to read the confidentiality first before signing it. She asked me to return to her apartment twice to wait with her for the CLSC member but the member never presented him/herself because of this, the woman never took part in the study.

Therefore, the comments from non-respondents who initially refused and those who refused after an initial meeting suggested that seniors seemed to hold certain perceptions of the 'suitable' participant, even though they were never told of (nor asked about) the participant criteria.

Other characteristics that limited the results of the study included the participants' economical status; previous education and gender. With the seniors' permission to report their economical status, all seniors stated their annual income to be above 15,000 dollars Canadian. Moreover, 6 of the 8 participants had followed careers. Since economical status and education level have been found to influence food choice and food consumption of seniors (Herne, 1995), This sample is not fully representative of the population.

Gender

Only women showed interest and participated in this study. There were few older men on the list of potential interviewees from both YD and EBM and those contacted responded they were not interested in participating and/or they were not living alone. Therefore, the results of this study might have a gender effect, such that the results might not be similar the male counterparts. This gender difference was important to note as several studies point out more ageing studies are focused on women than men (Fleming, 1999; Hughes et al, 2004).

Fleming (1999) stated that ageing as been 'feminized' such that there is little report on the experiences of older men. Also, he noted that one of the antecedents of such 'imbalance' were contributable by the gender difference in longevity (Fleming, 1999).

According to Statistics Canada (1999), death rates have fallen among seniors in all age group and senior women have a longer remaining life expectancy than senior men. Moreover, Musil (1998) found there is gender difference in body awareness and emotions (including depression and anxiety) among community-dwelling elders. Musil (1998)'s study consisted of 491 participants of which 60.9% were female. Participants were 65 years and older with a mean age of 75 years. Musil (1998) reported that women seem to

take a more active approach to manage health concerns; whereas men reported greater body awareness and were somewhat more likely to make physician visits. Nevertheless, the study found no gender differences in self-assessed health, or in the number of health problems or symptoms reported.

In relation to the topic of this present study, this gender issue might also be influenced by the fact that this study focused on food-intake and food preparation which, the latter was considered by Gustafsson et al (2003) as 'women's work. According to Gustafsson et al (2003) women in traditional Western countries were responsible for food-related duties in the family. In summary, the study participants were only female despite the fact that it was not the intention to select only female participants.

Lastly, in addition to the limitations mentioned above, it remains unclear whether the results of this pilot study could be replicated because of the unique nature of the qualitative analysis. Moreover, this is a successful pilot study in that the goals have been met. The researcher took into account the participants' perception, life-roles and lived experiences using rigorous research methodologies. Therefore, this research has achieved a high-level of validity and will be very helpful for future related studies on community-dwelling seniors.

Summary

The main research focus of this exploratory study was to understand some of the factors affecting food intake in senior women at-risk of malnutrition. Eight community-dwelling, independent-living women have shared their lived experiences during three semi-formal, guided interviews. Based on these accounts, several themes were found common amongst these women. Furthermore, the essence of these was identified and they suggested that seniors were: struggling, learning and taking control as they lived independently.

As seniors revealed their own lived experiences, their rich descriptions suggested that taking care of oneself in the presence of limited health while living alone was not an easy task. Nevertheless, seniors continued to manage their lives independently through creating strategies for themselves.

Furthermore, the older women in this study showed that the barriers affecting food intake were more complex than those identified in the Introduction section of this thesis.

Also, it seems that the aging literature has focused to date on biomedical aspects of health, so that aging is portrayed as process of decline and deterioration. On the contrary, the seniors in this study revealed a more holistic and positive view about aging and despite being at nutritional risk, they found resourceful ways of meeting their nutritional needs.

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Ethics Certificate

Sample Informed Consent Form

Informed Consent Form

Title of Research: **Understanding the Factors Affecting Food Intake of Elderly Persons in the Community**

Who is conducting this research?

My name is Winnie Cheung, I am a graduate student from the Department of Dietetics and Human Nutrition at McGill University and I am the principal investigator for this research.

What is this form?

The purpose of this form is to describe to you the nature of this research and your involvement in this research. Please sign this form only after you have read it and understood what this research is about. You can ask me any questions about this form (or research) at any time.

What is this research about?

This research is about exploring the factors that influence food intake in seniors at risk of malnutrition. Through individual interviews, we will explore together, your experiences with issues on food, health and nutrition.

The two main purposes of this research are: 1) To help the Yellow Door and Entraide Bénévole Métro to develop a suitable nutrition program for seniors and 2) To teach dietitians and nutritionist to become aware of the influence of personal factors on food intake and incorporate these when designing nutrition recommendations for seniors.

What if I cannot continue with the research?

You can withdraw from this research at any time if you feel that you do not wish to continue any further. Please do not hesitate to tell me your concerns during any part of the study.

What about confidentiality?

This research is <u>not</u> directly associated with the services provided by the Yellow Door or Entraide Bénévole Métro, therefore, I will keep your opinions about their services confidential. This means that I will not share your information to the Yellow Door (or Entraide Bénévole Métro) unless you have agreed that I can. If you have any concerns about the Yellow Door (or Entraide Bénévole Métro), I can bring these back to the Coordinator if you wish.

Also, the tapes and transcripts of the interview will be secured and accessible only to my research group (my supervisor and committee members) and I will not identify you in the written report.

How will I benefit from this research?

After the study, you can receive a summary report about the findings from this research. Your participation and contributions to this research will greatly help the Yellow Door and Entraide Bénévole Métro to develop a nutrition program in the future for seniors and yourself.

Other concerns?

Your participation will not change your relationship with the Yellow Door or Entraide Bénévole Métro and it will not affect any services you are receiving from them.

Contact info

Name	Phone	Email:
Winnie Cheung (Principal Researcher)	514-398-6243 or 514-939-9575	Winnie.cheung@mail.mcgill.ca
Katherine Gray-Donald (Supervisor)	514-398-7842	katherine.gray-donald@mcgill.ca
Channing Rodman (Yellow Door Coordinator)	514-398-6243	elderlyproject@yellowdoor.org
Elisabeth Chewey Entraide Bénévole Métro Coordinator	514-939-9575	ebmmetro@vif.com

Signature

I, _____ (your first and last name), agree to participate in this study on food and nutrition. I understand that the interviews will be tape-recorded. I understand that the information gathered will be kept confidential and that this information will be used for academic purposes only.

I understand that I can stop the interview and even withdraw from the study at any point. In that case, I can ask that any information I have given thus far in the study be destroyed and this will be done. I also understand that my participation will not change my relationship with, nor affect my services from, the Yellow Door or Entraide Bénévole Métro

I understand that I am free to discuss my concerns with Winnie Cheung or others involved with the study at any point during the study period.

Your Signature:_____ Investigator's Signature:_____

Date: _____ Date: _____

Copy of Proposal to Yellow Door and Entraide Bénévole Métro

McGill

School of Dietetics and Human Nutrition

Faculty of Agricultural and Environmental Sciences

McGill University
Macdonald Campus

École de diététique et nutrition humaine

Faculté des sciences de l'agriculture et de l'environnement

Université McGill
Campus Macdonald

Tel.: (514) 398-7842
Fax: (514) 398-7739

21,111 Lakeshore
Ste-Anne-de-Bellevue
Québec, Canada H9X 3V9

To: Entraide Bénévole Métro

Project Proposal:

Background My name is Winnie Cheung, first-year M.Sc. student from the department of Human Nutrition and Dietetics. I plan to conduct this study for my M.Sc. thesis project, under the supervision of Dr. Gray-Donald (Director of Dietetics and Human Nutrition).

Purpose To explore the perspectives of the elderly who are identified as at risk of malnutrition, using the Payette Nutrition Screening Tool. I would like to explore how these seniors perceive their health and to find what possible factors are preventing them from adequate food intake from their perspective. The significances of this study are: 1) to prevent pre-mature institutionalization; 2) prevent further nutritive health decline, 3) to increase quality of live and, 4) to promote autonomy over the elderly own health status.

Method A qualitative research will be conducted with a sample of 10 seniors with the following characteristics:

-Ages 70 or older
-Male or female
-Living alone
-Speaks English fluently
-Score 4 points or more in the Payette Nutrition screen tool (score of 4 or more identifies those who are at moderate risk of malnutrition according to the Payette nutrition scale; living independently (alone or with spouse)
-Able to conduct daily duties of self-care
-Determined by Yellow Door Coordinator (*and/or Entraide Bénévole Métro Coordinator)* as able to sustain a 1 – 2 hour interview
-Does not have diagnostic psychiatric or behavioral problem (i.e., schizophrenia, aggressive behavior etc).

Each participant must sign a consent form before beginning the interview.

Time frame The entire study period will be approximately 40 to 50 weeks in length. However, there is a chance that the study will be longer than expected, since the ability to conduct interview is dependent on the seniors' health, which, is unpredictable.

Depending on the availability of the participant, each person will be interviewed 2 to 4 times. Each visit will range from 1.5 to 2 hours in length. Participants will be interviewed at their home. Moreover, the interviews will be tape recorded and later, transcribed into text format for analysis.

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21,111 Lakeshore
Ste-Anne-de-Bellevue
Québec, Canada H9X 3V9

To: Yellow Door Elderly Project

Project Proposal:

Background My name is Winnie Cheung, first-year M.Sc. student from the department of Human Nutrition and Dietetics. I plan to conduct this study for my M.Sc. thesis project, under the supervision of Dr. Gray-Donald (Director of Dietetics and Human Nutrition).

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Payette's Tool

Centre de recherche sur le vieillissement

Institut universitaire de gériatrie de Sherbrooke
Sherbrooke Geriatric University Institute

ENS
Elderly Nutrition Screening

Reported weight : _____ kg or lbs
Adult height : _____ m or ft., in

CIRCLE THE NUMBER CORRESPONDING TO THE STATEMENT THAT APPLIES TO THE CLIENT

The person is very thin	No	0
Have you lost weight in the past year?	No	0
Do you suffer from arthritis to the point where it interferes with your daily activities?	No	0
Is your vision, even with glasses, ...?	Medium	1
	Poor	2
Do you have a good appetite?	Sometimes	1
	Never	2
Have you recently suffered a stressful life event (e.g., personal illness / death of a loved one)?	No	0

WHAT DO YOU USUALLY EAT FOR BREAKFAST?

Fruit or fruit juice	No	1
Eggs or cheese or peanut butter	No	1
Bread or cereal	No	1
Milk (1 cup or more than ¼ cup in coffee)	No	1

TOTAL : _____

TOTAL SCORE	Nutritional Risk	RECOMMENDATIONS
6-13	High	Help with meal and snack preparation **AND** Referral to a dietitian
3-5	Moderate	Regular monitoring of diet (checking food intake, providing advice and encouragement)
0-2	Low	Regular monitoring for appearance of risk factors (e.g., change in situation or weight loss)

E N S
ELDERLY NUTRITION SCREENING

This questionnaire has been developed to identify elderly persons needing assistance to improve their food intake and meet their nutritional needs.

It was designed to be used by home care personnel. Answers are obtained by interview. The numbers circled reflect the **elderly person's answer** and **not** the interviewer's assessment except for the statement : THE PERSON IS VERY THIN.

NOTE THAT THE EFFECTIVENESS OF THIS QUESTIONNAIRE HAS BEEN DEMONSTRATED *ONLY* AMONG A FUNCTIONALLY DEPENDENT FREE-LIVING ELDERLY POPULATION.

Weight : Adult height :	Weight and height are not measured. The person is asked his/her current weight and adult height.

THE QUESTIONNAIRE : PRACTICAL APPLICATIONS

THE PERSON :

Is very thin	This is a **subjective** assessment by the interviewer.
Have you lost weight ?	**Any** weight loss is indicated as a **YES**.
What do you usually eat for breakfast ?	**USUAL** food intake is evaluated here, not on a specific day.

RECOMMENDATIONS

A person at **high nutritional risk** needs to increase energy and nutrient intake. In addition to professional advice and encouragement he / she needs help to increase food intake. The services offered can include food preparation at home, home-delivered meals or transportation to a congregate meal service.

A person at **moderate nutritional risk** needs regular advice and encouragement to improve his / her food intake and to prevent deterioration in his / her nutritional status.

A person at **low nutritional risk** also needs monitoring. In the frail elderly, nutritional status is precarious and can be easily altered by any change in situation or instability (death of loved one, personal illness or hospitalization).

Client Profile

Participant Profile

Issues	A	B	Fr	Dt	J	O	Di	Gp
Past health issues	-Coronary By Pass surgery -Kidney failure	-Hyper-blood anemia -Spinal surgery (lost sight as result)	-Fell down many times before -Cataract surgery failed (lost eye sight on 1 eye)	-Kidney problem (1 kidney left) -cirrhosis -Allergies (environmental + food)	-Cataract surgery (successful)	-Fell down many times	-Goiter	-Hiatus Hernia
Activities	-Organizer + the cook for monthly lunch meal (20 person) -Care-taker for other residents when needed. -Takes care of gardening around building -Shops -Reads -goes out	-Plays bridge (2x/week) -Walks dog daily -Listens to books + musical records -Dines out with family occasionally	-Attends Senior-day center (1 to 2x/week) -Likes to read, listen to music, radio, to watch TV.	-Exercises daily 15 mins -teaches English at community center + at home -Learns French -Likes to paint; to read; -Dines out with friends. -Take walks -Attends congregate dining monthly.	-Surfs Internet to learn -Cook to share with friends (occasionally) -Likes to write, to cook, to read, -dines out with friends and daughter.	-Attends senior-day care twice a week -Attends Yellow Door activity once a week -Read health magazines, news paper, -Listens and watches T.V. -Does cross-word puzzle daily.	-Take daily walks -Shops and meets with friends at local mall -Likes to read news paper, magazines, books. -watches T.V.	-Take walks -Listens to news radio daily. -Write letters to family -Does crossword puzzles -Talk on phone -Attend congregate dining monthly.
Weight change?	N/a	Yes -dress size chg.	Not sure.	Yes -10 lbs weight loss	Yes 9 lbs. Weight loss	Yes -Intentional weight loss (Dr. recommended)	Unsure. Weight gain or loss.	Yes Medical treatment related weight loss.
On diet?Y/N (Type)	Yes -Lo-fat -Lo-salt	N/a *Not mentioned	Yes Low iodine diet.	Not mentioned -Had food + environment allergies.	Yes -Hypo-glycemia	Yes. -South Beach (self-selected to lose weight)	Yes -Diabetes -Low-fat diet	Yes -Hi-chol.

Participant Profile

Issues	A	B	Fr	Dt	J	O	Di	Gp
Age:	**84**	**88**	**83**	**75**	**84**	**91**	**73**	**86**
Issues								
Payette Score (point)	8	6	6	8	4	4	4	6
Gender	F	F	F	F	F	F	F	F
Marital Status	Widow Mother of 7	Widow	Widow Mother of 1	Widow Mother of 2	Widow Mother of 2	Single	Single	Widow Mother of 3 (2 past away)
Education/ Occupation	House-wife	Social Worker	-Medical-clinic Secretary -Translator	-Accounting manager -Volunteer (English-tutor)	-Family therapist -Costume designer -Recipe-cookbook writer	-Hospital nurse	-Secretary for lawyer	-Housewife
Language	English	English	Bilingual (Francophone)	English	English	English	Bilingual (Francophone)	English
Current Health Issues	-Limited diet regiment due to: coronary heart disease; kidney failure) -Arthritis affects hand dexterity	-Thyroid treatment -Lost eye-sight -Lost weight (thyroid treatment)	-Thyroid problem (radiation treatment) -Arthritis hurts everyday -Back pain -High-Blood pressure	-Thyroid treatment -Recent unintentional weight loss	-Frequent fatigue -Thyroid problem -self-reported hypoglycemia -complained of having medicinal side-effect	-Spinal stenosis (contemplates surgery) -Osteoporosis -Thyroid treatment	-Diabetes Mellitus -Hyper-thyroid (on treatment)	-Severe arthritis -has pacemaker -cataract (contemplates surgery) -frequent constipation -painful all over body.
Economical status(Income above or below 20,000$)	Above	Above	Above	Above	Above	Above	Above	Above

M.Sc. Thesis Project:

Question Pool for Interview

(REVISED after Committee Meeting in Apr 28, 2004)

By: Winnie Cheung

April 2004

Winnie Cheung – M.Sc. Project: Question Pool & Rationale

Note: The following are the question and my rationale for the questions. They are arranged in the order which I'd like to ask. If you do not agree with the order, please write on the 1st column your 'preferred order'. We'll discuss this for the meeting.

Preferred Order	Topic	Question	Rationale
1	Daily Habits	1.Can you tell me a little bit about yourself? 2.Can you walk me through your typical day? → (i.e., what do you do?)	-An Ice breaker. 1. Suggested by Prof. Gray-Donald. From her previous experience with focus group. This question is expected to open the conversation in a friendly manner. 2. To see what client does in a day, may reveal some important information of things that are affecting their health at this particular time.
	Food Habit/Food choice	1.What is your typical meal like? What did you have when you first wake up? Anything after that?	Source: Cindy Fogel (P.dt) *Cindy has suggested changing stating the specifics (breakfast, lunch, dinner) to 1st meal after wake up etc. based on her professional experience as P.dt, and with seniors.* -this question is like a 'Usual Food Intake' -Avoids assuming seniors have Breakfast, Lunch and Dinner. Since seniors may have different definition of these. Thus use instead 1st meal after wake up in morning.
	Meal Preparation	1.How do you prepare your (1st meal), 2nd, 3rd? 2.Is there anything you find difficult in preparing any of these meals?	Source: Lawton's IADL[1] *-Item C: Food Preparation (concepts: plans, prepares & serves adequate meals independently)*
	(for Yellow Door)	3. Who do you usually eat with? 4. Have you always eaten alone? 5. Do you think you eat differently when you are by yourself compared to eating with others?	Purpose: For YD -these are questions YD would like to know to enhance and/or improve their services for seniors. -These questions will also help get ideas for the nutrition program.

[1] Lawton, M.P. & Brody, E.M. (1979). Assessment of Older People: Self-Maintaining and Instrumental Activities of Daily Living. *Gerontologist* (6), p. 179 – 186.

		3, I have a question that seems to be different for every senior asked, so I'd like to hear your response as well to this. 'What does eating right mean to you? 4, For you, is it difficult to 'eat right'?	Source: Arcury, Quandt, & Bell[2]: *Concept: as a health concept, 'eating right' is one of the 8 found, however, the definition was different amongst seniors and they cannot give specific information about it.* -Therefore, I want to see whether seniors' concept of eating well, and whether they believe they are eating well. -I also hope to see if seniors will reveal what a 'good' meal consist of.
	Loneliness	1. Are there activities that you do when you're not with volunteers and/or family? 2. How enjoyable are these (the suggested) activities? 3. How important is it to cook with other people? 4. How enjoyable is it to share meals with other people? (i.e., volunteers & friend)?	For YD Also get to see how seniors live through loneliness.
	Transportation	1, How do you go out nowadays? (i.e., use transport? Use other services? Help from friends?) --- the ( ) probes, will be used only if no response is given. 2, How often do you use (the suggested) modes of transportation	Source: Lawton's IADL *Item F: Mode of Transportation (concept: Transports independently, arrange transportation, mode of transportation)* -I want to see whether there are issues involving transportation that affects their social activities (which may influence food-related activities as well). -Q #2: to see how useful the buses, metro and tax

[2] Arcury, T.A., Quandt, S.A., and Bell, A. (2001) Staying Healthy: The Salience & Meaning of Health Maintenance behavior Among Rural Older Adult in North Carolina. *Social Science & medicine*. 53 : 1541-1556.

		3, Are you limited by the lack of transport to shop for food? If yes, in what way? (if no, how do you feel about transporting?)	etc. are helpful for her to get to places.

Winnie Cheung – M.Sc. Project: Question Pool & Rationale

Preferred Order	Topic	Question	Rationale
	Appetite	1, In your opinion, what makes food appetitizing? (AND, Are these characteristics shown in your daily meals?	Source: Loss of Appetite is a common aging problem (common geriatric nutrition issue) -Therefore, I want to see how appetite is viewed and how it has changed through time.
		2, Do you think you are a 'good eater'?	-'good-eater' – could be someone who eats slowly, fast or being picky etc. This question gets to food habits of the seniors. It may get into seniors' *past* experience
		3, How has your appetite change since your (weight loss/stressful event/health problem*)?	-This is a follow-up question from the Payette Nutrition Screening tool.
	Chg senses (taste acuity etc)	1, Has your taste/smell for food changed? If yes, How has it changed? AND 2, Has this change(s) affected your food choice? Food preference? and Cooking practices?	Source: Sensory decline is common in Aged persons.(common age-related nutrition issue) -I want to see whether they modify their foods to accommodate the chg in taste sensation. (The dietitians (dt) can learn what the seniors' food preferences/habits are, and to make appropriate suggestions.
	Food preferences & food choice	1, Do you have any favourite foods that you enjoy but cannot have anymore? 2, If so, what is preventing you from having it?	Using 'Favourite foods' will increase their interest in the topic. -I may also find out what 'type' (i.e., texture, tastes etc) of their favourite foods to know their food preferences as well. -This question may bring about these factors: (i.e., social, physical difficulty, self-restriction, transportation, past experiences)

Winnie Cheung – M.Sc. Project: Question Pool & Rationale

	Health (Medication).	1. How does your health affect your food intake? 2. Do you have any health problems that affect what you eat? OR, ---Has your health change the way you eat compared to when you were healthy? If so, how?	<u>Assumption:</u> -I am assuming the interviewee has some type of health problem that influence some aspect of their life, including nutritional health status.
		2. Have you made any changes to your usual diet to adjust to your health condition?	-I want to see if the seniors are actively doing something to help themselves overcome the problem & what they're doing to help. -I want to see if 'motivation' can be a theme here.
	Energy	1. Can you tell me what gives you energy to fulfill your day? AND/OR, 2. what DON'T you have energy for?	<u>Source: Pilot project – BJ</u> -BJ mentioned she has lack of Energy. She needs energy to 'do' things. -Coffee 'brought' her energy. -I want to see whether seniors see 'FOOD' as an Energy source. -Note: From Cindy F. the question 1 or 2, may be asked to different people depending on the interviewer's response. More alert clients will do #2., less alert clients will do #1.

Winnie Cheung – M.Sc. Project: Question Pool & Rationale

	Body Image	1, What is an ideal weight? 2, Why is this 'ideal' for you? 3, How much weight has you lost in the past 3 months? Past year? 4. Do you feel your clothes are looser (or tighter)?	Source: Clarke[3] (concept of article: *body weight & body image was a concern for the elderly women interviewd.)* -Prof Grenier & Prof. Dr. Gray-donald both agreed that the self-perception of ideal body weight is an idea weight is better than asking for the weight senior used to be comfortable with.... -I assume senior at-risk of malnutrition, experience weight loss. I want to see what the senior thinks of their weight, and the reasons behind the ideal weight. (The response may reveal issues about food restriction and food choices). -Maybe a follow-up question to Payette screening tool. Q3: suggested by Dr. Saba.
	Nutrition info.	1, Are you worried about eating certain foods? (or certain places)	-This is to see if there are external (i.e, environmental or other issues) affect the senior's intake.

[3] Clarke, L.D. (2002). Older women's perceptions of ideal body weight: the tensions between health and appearance motivation for weight loss. *Ageing & society*. 22; 751-773.

Winnie Cheung – M.Sc. Project: Question Pool & Rationale

	Intentional Kcaloric restriction (of seniors)	1, Do you feel you need to eat more? (why or why not?) 2, Is there anything that's preventing you from eating more/less (than you'd prefer)?	Source: Morley (2003) cites ref: 44 – 48 *Concept: When known about studies on kcaloric restriction, & longevity in animals, excessively restrain their food intake & develop malnutrition.* -The basis of this question is to see what the senior thinks of their current health situation. Health-care professionals[4] would 'push' for food for malnourished seniors, but without really knowing what the senior thinks of that idea, I want to use this question, to explore their perspective.
	Thought of Aging/Frailty	This concept maybe revealed via Question #1 (tell me about yourself...)	Source: Duggal & Lawrence[5] *This article has 2 case studies about 2 women, their anxiety towards aging cause them to refuse food (and experience unintentional weight loss).* -I am trying to see whether there is an impact on the 'thought' of aging from seniors. -Through this question, I want to get to know more about their experiences as an aging senior. I am expecting answers like (aging means limitations, burden) -I also expect pt's desire to be independent will surface here in this response.
	Emotional State affecting intake **(volunteer)**	1, How do you spend your time with your YD volunteer? 2, Can you suggest what volunteers can do now, to enhance the nutrition program for seniors of the Yellow Door? 3, Does volunteers influence your food intake in any way? (if YES: How? If NO: How can they help? What do you think?)	Source: Paquet et al[6] *Concept of article: Emotions affect ones' intake. (happy, confident, secure) lead to higher protein & kcal intake compared to those who are frustrated or sad (study was done on institutionalized patients)* 'Emotion' in this case will be those evoked from the interactions with YD volunteer, family, friends. - I am asking specifically about YD volunteers because of my goal to help YD make a nutrition

[4] Lipschitz, D.A. (1995) Approaches to the Nutritional Support of the Older Patient. *Nutrition, Aging, and Age-Dependent Diseases* 11(4): p715-724.

[5] Duggal, A. & Lawrence, R.M. (2001) Aspects of food refusal in the elderly: the hunger strike. *Int J Eat Disord* 30; 213-216.

[6] Paquet et al (2003). Direct and indirect effects of everyday emotions on food intake of elderly patients in institutions. *J of Gerontology: medical sciences.* 58A (2); 153-158

			program, thus, I am evaluating the possibility of having volunteers to be involved in 'meal/food-related' activities with the seniors. - But I also feel pt may reveal their emotions they have a out their friends and/or family during the interview. So, I'll collect these information via transcription & at analysis.
	Volunteer Help	1,YD is trying to organize a Nutrition program, What do you suggest will be interesting for YD volunteers and seniors to do together?	-This Q. is for the Yellow Door.
	For interest	**Can you share with me 1 dish that you usually make which you'd like to share with other seniors in the YD?** **-- I have an idea of putting the recipe together. And standardize it for easier reading.**	-This is my interest question, I want to make a recipe book (from the 10 clients, and maybe add my own as well). But I want to see the complexity of their food preparation. I have a feeling that their input will be a good contribution for the Nutrition program. It'd also make them feel happier for participating in this study. :o)

- Morley J.M. (2003) recommended clinicians to use these regularly: 1) MNA ; 2) SCREEN 3) Appetite Questionnaire.

Topics of 3rd Interview

Note:

For the third interview, several topics that were found common from previous two interviews were brought back to the participants to obtain further details. The following is a list of these topics:

1. Ethnic foods
2. Diet variety and influence of grocery flyers/bargains
3. Taste changes (re: changing recipes)
4. Priority of meal-preparation
5. Living environment and choice
6. Adapting to changes
7. Simplifying meals
8. Age difference and its effect.