A Grounded Theory of Eating Behaviours
Among Older Widowed Women

By

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ABSTRACT

A GROUNDED THEORY OF EATING BEHAVIOURS AMONG OLDER WIDOWED WOMEN

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Widowhood is a common and expected life event for married older women. Prior research has found disruptions in diet and eating behaviours to be common among widows. Little, however, is known about the process underlying these disruptions. Aiming to fill this gap, this study explored the eating behaviours of older widowed women for the purpose of generating a substantive theory to explain the changing eating behaviours of older women living in the community during the transition of widowhood.

Qualitative methods based on constructivist grounded theory guided by a critical realist worldview were used. Individual active interviews were conducted with 15 women living alone in the community that were mostly independent with respect to eating behaviours. Participants were aged 71 to 86 years (mean age: 77) and had been widowed six months to 15 years at the time of the interview. Participants described a variety of educational backgrounds and levels of health, were mainly white and of Canadian or European descent, and had sufficient income to meet their needs.

A substantive theory of why and how older women’s eating behaviours shift in widowhood was developed. The shifts in eating behaviours described by participants were interpreted as a process in which they were aligning their eating behaviours with their food-related self. It was found that the primary catalyst of change in behaviour as
part of the widowhood experience was the loss of commensality with their spouse, that is, the loss of regular shared meals. Two sub-processes were conceptualized whereby women first fall into new patterns and then re-establish the personal food system. These sub-processes enabled women to redirect their food system from one that satisfied the couple to one that satisfied their personal food needs. A number of factors influenced the trajectory of the aligning process including the couple’s food system that women brought into the process, their experiences with nutritional care, their food-related values, the food-related resources they had access to, and the social integration they experienced. Further research is needed to include the voices of more vulnerable widowed women in the theory. Implications for research and practice are discussed.
DEDICATION

This dissertation is dedicated to the women who participated in this research, the many others that share the experience of widowhood, and those that support and love them. I am deeply grateful for the personal narratives that have taught and inspired me.
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CHAPTER 1: INTRODUCTION

A Note on Structure

This dissertation has been structured following a new model that allows for the creation and inclusion of journal-ready manuscripts in the dissertation. A single research study provides the basis of this dissertation, the detailed rationale and methodology of which are presented in part 1 in separate chapters. Two manuscripts have been developed focusing on different aspects of the results and are presented in part 2. The articles are situated within broader theoretical discussions in the literature review and discussion. The broader discussion is presented in part 3.

Introduction

Canada, like many industrialized countries, has a rapidly growing aged population. It is projected that the proportion of the population over the age of 65 will increase from 14.8% in 2011 to 23% in 2030 (Statistics Canada, 2012; Statistics Canada, 2014). Many seniors live independently and report generally good health. However, some seniors carry heavy burdens of disability and disease, which often result in institutional care (Bates, Benton, Biesalski, Staehelin, van Staveren, Stehle et al., 2002). It is well known that inadequate nutrition contributes to the development and progression of loss of function and disease (Bates et al., 2002). The food intake of older adults living in the community is often poor and consequently many are at nutritional risk (Keller, 2007; Payette & Shatenstein, 2005). Nutrition is a modifiable risk factor and has the potential to improve the function and quality of life of older adults (Drenowski, & Evans 2001). Therefore, there is a clear need to better understand the determinants of eating behaviours among older adults to help this growing segment of the population lead healthier lives.
Food intake is extremely complex as there are multiple individual, social and environmental determinants, which may interact or change over time. For instance, older individuals may experience changes in their oral health and digestion, physical ability needed to prepare meals, and social relationships, all of which may impact food intake (Payette & Shatenstein, 2005). A fixed income such as a government pension combined with variable health expenses (e.g., prescribed drugs or services not provided by the health care system) may result in less money available at the end of the month for food (Keller, Dwyer, Senson, Edwards & Edward, 2006). Age-related events such as widowhood can have negative consequences on food intake. Studies have found poor diet quality, increased nutrition risk, loss of appetite, and loss of interest in all food-related activities among widowed older adults compared to their married peers. However, it is unclear if these behaviours are a temporary component of grief or if they are longer term effects of the loss of a spouse. Nor is it clear how and why eating behaviours shift in widowhood.

Widowhood is largely an older woman’s concern as widows outnumber widowers four to one and almost half of Canadian older women are widowed (Statistics Canada, 2011). A need to generate explanations of how and why marital loss affects physical and emotional health has been underlined (Waite, 2009). Developing an understanding of the process of eating behaviour change in late-life widowhood is essential to be able to support women in their nutrition needs throughout the life cycle.

Widowhood is one of life’s most stressful events (Carr & Bodnar-Deren, 2009) as it is marked by the loss of a key social and emotional relationship. Dietary practices are inextricably linked to this relationship through a lifetime of shared meals, a shared food environment, and ongoing negotiated food choice (Sobal & Bisogni, 2009). In addition, the companionship,
support and social control received from this relationship may have further supported or constrained eating behaviours. Food choice is also deeply embedded in one’s identity (Fischler, 1988). The link between food and identity may be even more salient for older women who have likely fulfilled the role of preparing the family meals (Slocum & Nye, 1976) and may have used this role to affirm their very femininity (Fürst, 1997). A spouse or a marriage does not have a uniform effect on behaviour but one that is contingent upon the nature of the couple’s relationship, their individual personalities, their shared history and the greater social context. In order to understand why older women’s experience of the loss of the conjugal relationship is implicated in eating behaviour, an exploratory and flexible method that can not only consider these factors but remain open to others as the research evolves is required. We know that recently bereaved women have poorer diet quality (Rosenbloom & Whittington, 1983), poorer intake (Heuberger & Wong, 2014), and are at greater nutritional risk (Johnson, 2002) than their married peers. Through qualitative work, we have learned that cooking, food, and mealtimes are no longer enjoyable and appetite is poor, all of which directly explains poor food intake (Johnson, 2002; Sidenvall, Nydahl & Fjellström, 2000). What we do not understand is why widowed women lose interest in food. If over time they regain interest, we need to learn how and why.

A qualitative explanatory approach provides the nuanced and flexible methods required to explore the subjective experiences of older women’s eating behaviours during the loss of the conjugal relationship and to develop a rich understanding of the process by which the transition of widowhood may influence diet. The purpose of the research is to develop a substantive theory to explain the changing eating behaviours of older women living in the community during the transition of widowhood.
CHAPTER 2: LITERATURE REVIEW

The following sections will position the project in the literature by reviewing the importance of nutrition among older adults, widowhood in Canada, presenting my assumptions around the inherent social nature of eating and dietary practices, and exploring the potential links between widowhood and eating behaviours. Finally, I will discuss the theoretical perspectives that have helped me to design the research study and which provided the initial theoretical sensitivity for my data analysis.

Community-living older adults and diet

People over the age of 65 are a growing population group in Canada due to the first baby-boomers entering this demographic in 2011 (Schellenberg & Turcotte, 2006). In 2011, 14.8% of Canadians was an older adult and this proportion is expected to grow to 22-24% by 2030 (Statistics Canada, 2012; Statistics Canada, 2014). With increasing life expectancies, older adulthood is no longer a short period of life. In 2006, men and women who were 65 years of age were expected to live another 18 and 21 years respectively (Milan & Vézina, 2011). Although 73% of older adults living in the community rate their health as good to excellent (Schellenberg & Turcotte, 2006), 43.4% are limited in their everyday activities due to disability (Statistics Canada, 2008). Minimizing the risk of disability among older adults will be important to help this growing segment of the population live independently.

Nutrition is integral to overall health, independence and quality of life in older adults (Drenowski & Evans, 2001; Wellman, 2007). Low food intake can lead to malnutrition and low body mass index which has been associated with morbidity, institutionalization, and mortality (Keller, 2007; Payette, 2005). Even sub-clinical nutritional deficiencies can have a negative effect on health (Drenowski & Evans, 2001). Improving dietary practices in older adults can
reduce risk of chronic disease and disability even when past nutrition has not been optimal (Rivlin, 2007).

Food intake is commonly poor among older adults. Age-related physiological changes such as hormonal imbalance, reduced metabolic rate, dysregulation of energy balance, changes in sensory abilities, dysphagia and tooth loss, and digestive difficulties all impact food intake (Krinke, 2008). National and provincial population household surveys have consistently found older adults to be consuming an inadequate number of food group servings (Keller, 2007; Statistics Canada, 2013). Accordingly, 34% of older Canadians living in the community were found to be nutritionally at risk in a national population survey (Ramage-Morin & Garriguet, 2013).

Understanding food choice is extremely complex as there are multiple individual, interpersonal and environmental factors that interact to produce a personal system of food choice that includes conscious, habitual and even unconscious considerations (Furst, Connors, Bisogni, Sobal & Falk, 1996). Furst and colleagues (1996) proposed that food selection results from a personal system of negotiations between sensory perceptions, monetary considerations, health, convenience, quality and interpersonal relationships. The personal system is mediated by one’s values, personal preferences, resources, social framework and food context, all of which evolve over time due to societal trends and culture, personal experiences and anticipation of future events.

Investigations of food choice systems among older adults are further complicated by the heterogeneity of this group. Older adults differ greatly in terms of health status, physical and cognitive abilities, literacy levels, years of formal education, financial resources, social support, emotional health, and personal living skills (Higgins & Clarke Barkley, 2003). When chronic
disease is layered on top of normal aging changes, the result is that individuals differ more from one another in old age than at any other period in their lives (Higgins & Clarke Barkley, 2003). For instance, 33% of Canadian older adults in the community report mobility limitations impacting their everyday activities (Statistics Canada, 2008). Limitations in mobility may make food-related activities such as grocery shopping and food preparation difficult. While inadequate nutrition contributes to the loss of function and progression of disease (Bates et al., 2002); the loss of function and disease also results in barriers to adequate food intake (Keller, 2007). Disentangling the effects of chronic disease and normal aging changes from nutrition and food intake is very difficult. Qualitative inquiry into the underlying mechanisms of diet among older adults may help to shed light on these factors.

**Widowhood in Canada**

Widowhood is said to be one of the most stressful life events (Carr & Bodnar-Deren, 2009). It is marked by the loss of a key social and emotional relationship for many and generally has a negative impact on the surviving spouse’s mental and physical health (Waite, 2009; Stroebe, Schut & Stroebe, 2007; Stroebe & Stroebe, 1987). Loss of this relationship results in a profound disturbance to the structure of day-to-day life. Widows lose not only their partner, but also the relationship they had with that partner and the life they shared together (Silverman, 2004).

Widowhood is generally regarded as a women’s issue due to sex differences in life expectancy, age differences with spouse, and the likelihood of remarriage of men (Carr & Bodnar-Deren, 2009). Older women of today often married men that were older than them due to cultural norms, further increasing the likelihood of outliving their spouse (Carr & Bodnar-Deren, 2009). In 2011, 51% of senior Canadian couples had a difference in age between spouses of at
least three years whereby the man was four to seven years older than his spouse in 23% of couples and at least seven years older in 22% of couples (Milan, Wong, & Vézina, 2014). Although separation and divorce are becoming more common causes of uncoupling, in 2011, the majority of uncoupling for senior women (65%) was still due to the death of their spouse (Milan, Wong, & Vézina, 2014). Consequently, widows accounted for over 45% of Canadian women aged 65 years and older and they outnumbered older widowers four to one (Statistics Canada, 2011). Older women were also approximately twice more likely to live alone than men of the same age (Milan, Wong, & Vézina, 2014). This may be a result of the age differences and life expectancies amongst couples but also due to the greater likelihood of remarriage amongst widowers. There are more potential partners for widowers to choose from and widows seem to have a reduced desire to remarry (Carr & Bodnar-Deren, 2009). Understanding the contributing factors of well-being among older widowed women will help this growing segment of the population to live independently longer.

**Eating behaviours as social phenomena and widowhood**

It has been argued that eating is a social activity that embodies culture, history, and lifestyle (Casalanti & Hendricks, 1986). Dietary practices are socially determined because they are learned according to shared cultural values and norms and thus food preferences and behaviours become part of one’s social and personal identity (Hendricks, Casalanti & Turner, 1988). Adhering to certain dietary practices may provide a sense of belonging to a particular religious, ethnic, or even geographic group (Fischler, 1988; Shatenstein & Ghadirian, 1997). Cultural norms may not only prescribe the food that is eaten, but when, how much, and with whom (Hendricks, Casalanti & Turner, 1988). Some may rely upon others for the preparation of food. For example, the elderly women of today were socialized to be responsible for preparing
all meals for their families (DeVault, 1991). Men anticipated this role and thus remained largely unfamiliar with food preparation (Hendricks, Casalanti & Turner, 1988). Consequently, for a man of this cohort, receiving meals that were satisfactory and aligned with his personal preferences depended on the relationship that he had with his wife. Similarly, the way that the woman felt about her role as meal preparer may have depended on the relationship she had with her husband. The social context of food intake and its social symbolism must be considered in any nutritional inquiry (Douglas, 1984; Sobal & Bisogni, 2009).

**Marriage, Health, & Eating Behaviours**

The social context for older women changes with the death of their spouse as the marital relationship is an important component of the social context for many adults. The association between marriage and health outcomes is widely known (Waite, 2009); married adults are healthier both physically and mentally (Shoenborn, 2004). One hypothesis for these phenomena is the selection theory, suggesting that healthier people are more likely to get married and stay married (Besculides, Koball, Moiduddin, Henderson, & Goesling, 2010; Hanson, Sobal, & Vermeylen, 2014; Schone & Weinick, 1998). A more accepted hypothesis is the protection theory which suggests that it is the nature of marriage that is beneficial to health. Marriage can provide economic and social support advantages, which may lead to better health. Married people accumulate more wealth possibly due to the economies of scale of sharing a household, insurance benefits, and savings (Joyce, 2007; Waite, 2009). The economic advantages of marriage are certainly a key factor in marriage’s benefit to women (Lillard & Waite, 1995). Financial stress may be linked to poorer appetite among older adults (McIntosh, Shifflett, & Picou, 1989) thus the greater financial security of marriage may be linked to appetite. Marriage is also an important source of social support that is distinct from other sources of support (Coyne
& DeLongis, 1986). Being married may discourage unhealthy behaviours and spouses (wives in particular) may play a role in encouraging healthy behaviours (Umberson, 1987). Further, the support and intimacy of marriage improves emotional and physical well-being (House et al. 1988). However, these benefits are largely contingent upon the quality of the marriage (Waite, 2009). Individuals in low satisfaction marriages are worse off than individuals who remained single or who are in happy marriages (Williams, 2003). This may be of particular concern among older adults because marital quality decreases with declining health (Booth & Johnson, 1994; Umberson, 2006).

With respect to eating behaviours, research in middle-aged adults tells us that couples who live together usually eat together (Sobal & Nelson, 2003). Each individual brings to the table their own personal food choice system including but not limited to a set of food ideals, resources such as knowledge and skills, and personal preferences (Sobal & Bisogni, 2009). Thus eating together involves a complex negotiation on food choice (Ristovski-Slijepcevic & Chapman, 2005). Schafer, Schafer, Dunbar and Keith (1999) found that frequency of eating together and discussions concerning food choices and behaviours were positively related to spousal diet quality, suggesting the direct influence of commensality and negotiating food choices within the couple on individual diet.

In the following sections, I provide an overview of the literature involving marriage and diet; I review the literature examining marital status and diet and the social mechanisms of marriage that may be linked to diet. Some of the following review has been published in the Journal of Nutrition of Gerontology and Geriatrics (please see Vesnaver & Keller, 2011 for full reference).
Marital status and diet. Marital status is the most common social factor measured in quantitative nutritional studies and is used to measure the effect of marriage on nutrition and health. It is operationalized in most nutrition research as the legal marital status, dichotomized into ‘married yes/no’, such that divorced, never married, and widowed individuals are collapsed into one group. This variable is easily assessed and can be included in studies examining many other psychosocial factors (Pierce, 2000). In fact, many studies have documented an independent association of marital status with diet of older adults (Davis, Murphy, Neuhaus, & Lein, 1990; Donkin, et al., 1998; Horwath, 1989; Locher, Ritchie et al., 2005; McInstosh & Shifflett, 1984; Yap, Niti, & Ng, 2007; Zazpe et al., 2010). However others have not found this association (Dewolfe & Millan, 2003; Hsiao et al., 2013; Keller, Østbye & Bright-See, 1997; Locher, Ritchie et al., 2005; Locher et al., 2008; Locher et al., 2009; McInstosh et al., 1989; Roberts, Wolfson & Payette, 2007; Shahar, Shai, Vardi & Fraser, 2005). Some researchers believe it is not marital status that affects diet but living alone. Similarly, the empirical research shows mixed results with only a few studies finding an association between living alone and poorer diet or greater nutritional risk (Brunt, Schafer, Oakland, 1999; Larrieur et al., 2004; Yap, Niti, & Ng, 2007) and many more not finding an association (Izaka, Tadaka, & Sanada, 2008; Locher, Robinson et al., 2005; Locher et al., 2008; Locher et al., 2009; Pearson, Schlettwein-Gsell, Van Staveren & de Groot, 1998; Shatenstein, Nadon & Ferland, 2004).

Studies measuring both variables may help to disentangle the reality of this association. For example, Davis et al. (2000) examined NHANES III data and found that Caucasians living with only a spouse as opposed to living alone, living with others, or living with a spouse and others had better diet quality. Also using NHANES III data, Sahyoun and Zhang (2005) examined marital status, living arrangements and diet quality, and included a measure of
frequency of social contact with members outside the household. They did not find living arrangements to be associated with diet quality or with frequency of social contacts. Instead, they found that higher frequency of social contacts was related to better diet quality. The only finding related to living arrangement was that women who were living with spouses and others were at greater risk for low frequency of social contact outside the home and thus lower diet quality. The authors speculated that a woman living with a spouse and others may be involved in household caring activities, leaving little energy or time to seek additional social contacts (Sahyoun & Zhang, 2005). These proxy measures assume that being married or living with others has a single unidirectional effect on diet regardless of the nature of the relationships or the social context. This methodology also assumes that the lack of marriage, whether it be due to divorce, widowhood, or never having entered a marriage, all presents a similar effect on diet. Social support, social control, and opportunities to eat with another person may be mechanisms of marriage that influence diet. These likely vary greatly between marriages. The following sections will review the literature of these mechanisms among older adults.

**Social support.** Social support is a much-popularized term, which is often used to refer to any process or aspect of social relationships that is thought to promote health (Cohen, Gottlieb & Underwood, 2001). There exist many definitions of social support in the literature that include various aspects of social relationships. I take the position of Cohen (2004) whereby social support refers to the social resources that are available or are perceived to be available to them in response to stress. A commonly used categorization of social support put forward by House and Kahn (1985) divides these resources into emotional (empathy), instrumental (goods and services), and informational (advice). Multiple definitions of social support have accordingly spurred multiple theoretical models. One that is congruent with the chosen definition is the *stress-coping*
perspective, which has also been the most influential (Lakey & Cohen, 2000). The hypothesis of this perspective is that social support influences health by reducing or moderating the deleterious effects of stress through the supportive acts of others or their perceived availability (Lakey & Cohen, 2000). Received support is thought to increase the individual’s coping ability and perceived support helps the individual to judge the event as less stressful.

The stress-support-matching hypothesis suggests that support will only be effective in increasing coping if the individual evaluates the help available and considers it to meet the demands of the stressor (Lakey & Cohen, 2000). For example, a married elderly woman breaks her hip and can no longer prepare meals. In order for her to have cooked meals, her husband may take over food preparation, or ask for help from their children despite her refusal to ask for help. These would be supports matched to the stressor. However, if he goes to rent a nice movie to cheer her up, this may increase her mood and feelings of self-worth, but it does not directly alleviate the stress of lack of cooked food. The stress-support-matching hypothesis is particularly important to the social support research in vulnerable populations such as older adults that have limited mobility. Thoits (1985) suggests that when an intentionally supportive act results in a mismatch, the individual may feel uncared for, frustrated and humiliated, possibly affecting their identity and feelings of self-worth.

In the nutrition literature, measures of social support are extremely diverse, often including any social factor thought to promote health under its umbrella. When it is used in this broad fashion, it is tapping more accurately the Durkheimian construct of social integration whereby social relationships provide health benefits without being explicitly supportive (1897/1951), see theoretical perspectives for further discussion). The distinction between social support and social integration is that social support focuses specifically on the aid that can be
obtained from others rather than the more holistic and indirect benefits social integration provides. I have limited the following review to studies that have measured clearly **supportive aspects** of social relationships in line with the chosen definition of social support indicated above. Furthermore, studies that have explored social integration operationalize the construct by measuring the social network such as the number of social contacts and different types of social relationships (e.g. Sayhoun, Xhang & Serdula, 2005). This is outside the scope of this work as it is focused on relationships outside the conjugal bond.

Social support within the marital relationship has been associated with increased health benefits and lack of support within the marriage cannot be compensated for by support from external sources (Coyne & DeLongis, 1986). The following section reviews the empirical literature on the construct of support and diet among older adults. It is not limited to spousal support as the source of support is rarely identified in nutrition research. However, since the construct of support is deeply implicated in the health mechanism of marriage (Coyne & DeLongis, 1986), a discussion of its effect on diet among older adults is relevant here.

McIntosh and colleagues (1989) investigated a main effect and the buffering effects of social support on appetite and diet quality of older adults. Their conceptualization of the buffering effects of social support is similar to the stress-coping perspective in that social support helps individuals to maintain healthy habits under situations of stress. However unlike this perspective, McIntosh and colleagues (1989) hypothesized that social support would only have an effect under conditions of stress. McIntosh et al. (1989) conducted secondary analyses on data that included social factors, stressors, appetite and nutrient intake. Social support was conceptualized as marriage and a host of other social support variables. In order to facilitate analysis, the social support items were collapsed into two variables using factor analysis,
yielding two social support variables: friendship network (number of close friends, friendship density, frequency of getting together, and advice sharing between friends), and companionship (meal time companionship and help with cooking). They hypothesized that these variables would have both main effects on appetite and nutrient intake and buffer them from stressors. The stressors included in the model were the effects of subjective financial stress on appetite and of poor appetite on nutrient intake. In the main effects model, friendship network was an independent predictor of appetite, appetite was related to diet, and marital status and companionship were not associated. In the buffering models, both marital status and friendship network lessened the negative effects of financial stress and poor appetite on appetite and nutrient intake respectively. Companionship lessened the negative effects of poor appetite on nutrient intake but increased the negative effects of financial stress on appetite. This conflicting finding regarding companionship may be related to its conceptualization. The companionship factor was derived through factor analysis and included help with cooking from friends and relatives and commensality. Marital status was not included in the factor analysis and correlations with the two factors (i.e., friendship network and commensality) were not reported. Marital status may have been highly related to commensality as many married individual eat together, thus potentially removing some of the variance attributed to commensality. Due to the conceptualization of the support variables, it is not possible to isolate the effects of social support on food intake from this study. Aside from help with cooking included in the companionship factor, the social variables in this study do not capture the instrumental support that may have been present. The investigators reported (although did not include in their analyses) that the most frequent form of aid received was transportation. Research into the role of instrumental aid in diet was recommended (McIntosh et al., 1989). Although limited, this study provided evidence
that a cohesive friendship network is related to diet quality and that the network and a spouse may buffer the effects of stress. The buffering effect may indicate that a spouse and friendship network provided a supportive function in the presence of stress. The measures of supportive acts were not significant; however the qualitative reporting of the importance of instrumental aid provided a foundation for future research.

To further delineate these associations, Locher, Ritchie et al. (2005) examined social isolation and support and nutritional risk across gender and ethnicity in older adults. Nutritional risk was measured using the Nutrition Screening Initiative DETERMINE checklist. Support was operationalized using two measures: marital status and perceived social support. Perceived social support was captured with four items including the confidence in the assistance of family and friends if required, others’ sensitivity to personal needs, others’ interest in helping the individual solve problems, and others’ understanding of their personal experience of aging. Social isolation was operationalized using a composite measure of geographic location (rural vs. urban), an adequate transportation system, and mobility (ability to leave dwelling, neighbourhood, town or unlimited without assistance from another person). The findings revealed nutritional risk factors specific to ethnic-gender groups with important implications in the southern United States. I will only report the findings related to social support here (see Locher, Ritchie and colleagues, 2005).

Across all groups, reduced mobility predicted nutritional risk. Black women and white men without an adequate transportation system were at increased nutritional risk. However, perceived social support was only related to nutritional risk among white women (Locher, Ritchie et al., 2005). The measure of perceived support used appears to capture emotional support, some informational support (solving problems), and perceived availability of instrumental support, but it does not measure the instrumental support received. In light of these
findings, those without adequate transportation would have required transportation assistance. While emotional support is extremely important to the wellbeing and quality of life of older adults and may be indirectly related to diet, transportation to the grocery store or meal preparation when mobility is limited directly relates to food intake. Information regarding the instrumental supports received in this study may have helped clarify the roles of these different constructs.

Locher et al. (2008) more recently examined a greater number of social factors alongside medical, functional, economic, oral health, and psychological factors to better understand their relationships with under-eating in homebound older adults. The social factors included marital status, living arrangements, social network size, perceived social support (4 subscales: tangible, affectionate, positive interactions, and emotional support), religiosity (private and congregation activities), religious support (support from congregation), and caregiver support (frequency). Independent predictors were gender, frequency of caregiver support and prior hospitalization. The social support measures were not independently related to under-eating and in fact, in bivariate analysis, only tangible support provided a significant association, highlighting the importance of instrumental support in older adults. Unexpectedly, support provided once a day (rather than several times a day or a few times a week) reduced the risk of under-eating. Locher et al. (2008) speculated that the protection of once per day care was due to the type of the support provided. They had observed (but did not analyse) that care that was provided once a day was in the form of a daughter caregiver that frequently brought or prepared a meal that they then shared with the older adult, highlighting the importance of commensality. Care that was provided several times a day was thought to be provided by a spouse who may have been just as ill as the
participant. This finding highlights the complicated nature of eating behaviours and support among couples in late-life.

Instrumental support is directly related to the food security of older adults. Food security is defined as “all people at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life” (Agriculture Canada, 2002, p.1). Although food security is often thought of as an economic problem, in older adults, the ability to carry out food-related activities such as food acquisition, preparation and consumption must be equally considered (Payette, 2005) and assistance with acquisition and preparation has been reported by seniors qualitatively as an important form of support (Callen & Wells, 2003; Keller et al., 2006; Pierce, 2000; Tyler et al., 2014). Keller (2005) reported that 29.5% of a convenience sample of 193 community-living seniors relied on others for help with meal preparation and/or grocery shopping. These individuals were highly dependent upon their support relationships for their food intake. The participant’s relationship to the support was not reported but many of these individuals would likely have relied upon their spouse (57% of those that depended on others lived with others, which was their spouse in most cases). In the event of the death of their spouse, these individuals would have to find new supports to carry out these tasks. Limited and fixed income may heighten the importance of these relationships. Although paid services may exist, low-income older adults may not be able to utilize them and rely on informal supports instead. Helping relationships have been expressed by low-income older adults as critical to food security (Keller et al., 2006; Wolfe, Olsen, Kendall & Frongillo, 1996).

Many women who rely on their husbands for support in their food-related activities would have to adapt to their circumstances if their husbands were no longer able to perform them
in the case of illness or death. Research to date, suggests that reliance on others for food intake represents a highly complex set of value negotiations and social interactions that cannot be captured using a dichotomous variable of ‘yes/no’ to the query on whether or not they receive support. Some older adults who rely on friends or relatives for food-related activities express anxiety about imposing on others or frustration with the food that is purchased for them, resulting in a lower frequency of soliciting these supports (Keller et al., 2006). A limited budget may further complicate these interactions, possibly creating anxiety about reciprocation or if helping supports are not as sensitive to the costs of food when providing shopping assistance (Keller et al., 2006).

In the McIntosh et al. (1989) study discussed above, their variable of companionship (measured by help with cooking and commensality) showed an unexpected relationship. Under financial stress, those with high companionship were likely to have higher diet quality but lower appetite. It was speculated that if individuals were receiving help with cooking as measured by companionship, this may have resulted in meals that were not in line with the older adults’ preferences, thus reducing appetite. Although the meals were possibly distasteful, they were sufficiently consumed to maintain adequacy. Considering the complexity of the dependent/caregiver relationship, another interpretation of the relationships between help with cooking, appetite and food intake may be plausible. The help with cooking may have been provided in response to a need due to increased disability or disease both of which may reduce appetite (Lenni, Moser, Heo, Chung & Zambroski, 2006; Wikby & Fägerskiöld, 2004). Despite lower appetite, the dependent older adult may have eaten meals prepared by the caregiver to show appreciation, thus maintaining diet quality.
Hopkinson (2007) explored the experience of changing eating habits in advanced cancer patients living at home. Patients described that their changing eating habits created tensions with primary caregivers. Caregivers became very frustrated when prepared food was not eaten and some patients ate without appetite only to resolve relationships or to avert disagreements. Findings from this unique population may not be generalizable to all dependent/caregiver relationships but it may shed light on some of the motivations for eating in older adults that are reliant upon others for food-related activities. A similar observation was made by Locher, Robinson et al. (2005), where some participants expressed that they did not always like or want the food brought by others, but that they were more likely to eat it if the deliverer sat down and ate with them. As many widowed women may in part rely on others for food-related activities, further exploration into the subjective experience of receiving food-related support may help to elucidate the mechanisms by which this factor is related to appetite and diet.

Instrumental support is clearly implicated in the food security of older adult. However the role of other forms of support and specifically emotional support have been relatively unstudied with respect to food intake in older adults. Perceived emotional support has been found to have a stronger influence on mental health than other forms of support (Thoits, 1985). Mental health may be an important influence on the diet of older adults as self-reported depression may increase nutritional risk over time (Keller, 2006). Emotional support may improve mood, and consequently, appetite (Wikby & Fägerskiöld, 2004). Emotional support may also be key to the grief work required of widowed older adults (Rosenbloom & Whittington, 1993). Grief resolution has been associated with better appetite and diet quality among widowed older adults (Rosenbloom & Whittington, 1993). Both food security and appetite are concerns for recently widowed older women. Further exploration into the role of social support in general and
emotional and instrumental support specifically may clarify the role of these constructs in diet among older adults.

**Social control.** Another social construct that may relate to eating behaviours among couples in late life is social control. Social control theory rooted in Durkheim’s suicide studies (1897/1951) suggests that relationships can regulate health behaviour by deterring the individual from engaging in risky or socially deviant behaviours (see theoretical perspectives for further discussion). Umberson (1992) proposed a model of social control whereby relationships deter deviant behaviour through indirect and direct means. By the indirect path, individuals are constrained in their behaviours by their sense of obligation, meaning and, purpose of their relationships. In regards to eating behaviours in the spousal relationship, this might entail self-care so that the individual remains healthy and can continue to grow old with their partner. This may also mean eating three times a day because it is an activity that they share. The direct path involves the other person directly intervening in health behaviours such as controlling the foods available in the house or providing reminders of a health-promoting diet change (e.g. “you know all that salt isn’t good for your blood pressure”).

The investigation of the social control of eating behaviours among older adults is limited. Stephens, Rook, Franks, Khan, and Iida (2010) examined the effect of social control in 109 older couples, among which one of the partners was diagnosed with diabetes. Self-reported spousal attempts at control and patients’ receipt of control over the previous month was collected and categorized as warning (e.g. emphasizing diabetes complications) or encouragement (e.g. suggesting healthy foods). Both warning and encouragement attempts but not patient receipt of control were independently associated with self-reported dietary adherence after controlling for patients’ diabetes symptom severity and both partners’ individually perceived marital quality.
Gender differences were not examined in this study. Although patient and spousal control experiences were significantly associated, it is not clear why spousal but not patient experience was related to patient dietary adherence. The authors speculate that time since diagnosis (and correspondingly evolving relationship dynamics) may have altered how patients receive the social control.

Most of the social control literature relates to health behaviour without being specific to diet. Franks, Wendorf, Gonzalez and Ketterer (2004) examined the initiation and receipt of health promoting exchanges in 61 marital dyads (aged 44-80) for which the husband had recently been treated for or diagnosed with a cardiovascular condition. The wives’ perceived receipt of control is of most relevance to this discussion. Their measure included questions regarding the frequency of behaviours in the past month such as "your husband encouraged you to make choices favourable to healthy living" and "your husband prompted or reminded you to do things to take care of your health". The sampling in this study was based on a recent diagnosis for the husband, yet the vast majority of wives reported receiving some form of health promoting social control from their spouses. This suggests that health-related social control is common among married couples and is not unidirectional.

Social control may also come from relationships in the larger social network; however, Tucker (2002) found that married older adults receive the most social control from their spouse. The more social control individuals received the more attempts they made to make healthier lifestyle choice. However, the effect was contingent upon marital satisfaction (Tucker, 2002). Those in low-satisfaction relationships perceived the social control negatively and subsequently tried to hide their behaviours from their spouses. Widowed individuals however were not without social control influences. They received social control from their friends (Tucker, 2002).
Although social control is theorized to be a health promoting mechanism in marriage, its relationship may not be straightforward. Grzywacz and colleagues (2012) found that receipt of greater amounts social control related to diabetes recommendations (e.g. exercise, weight loss, diet) among older adults with diabetes (46% married) was related to poorer glycemic control and greater depressive symptoms. This research supports other findings that social control can have negative psychological consequences (Lewis & Rook, 1999). However, the nutritional implications of these findings are less clear. All participants had a diabetes diagnosis for at least two years, but history of glycemic control or symptom severity was not measured in the study. It is possible that individuals who struggle more with adherence are more subject to social control from their network. For married individuals, this places considerable burden on the spouse to provide this health behaviour regulation (August, Rook, Stephens, & Franks, 2011).

Some of the changes in health behaviour in widowhood may be related to the change or loss in health-directed social control. In a prospective cohort study, Williams (2004) found older individuals who became widowed experienced a substantial decline in health-directed social control. This was followed by an increase in unhealthy practices among widowed individuals, but only among those that had in fact experienced a decline in social control. Some had not declined because they had either not received meaningful social control from their spouse, or had friends and family members who increased social control upon the death of the spouse. This suggests that health-directed social control is a key mechanism of the health benefits of marriage. The forgoing studies have examined the direct path of social control. Further research is required to understand the indirect path of social control. Understanding how social control, both direct and indirect, affects eating behaviours may help to identify a diet-regulating influence that may
decline in widowhood. Sharing meals in marriage may be one aspect of the indirect path. This is discussed in the next section.

**Commensality.** Marriage does not necessarily imply eating with your spouse. Eating alone has been consistently associated with increased nutritional risk (Lenni et al., 2006; Shahar et al., 2005; Sharkey, 2002). Several studies have reported that older adults eating alone may experience less enjoyment of meals (Callen & Wells, 2003; Keller et al., 2006; Moss, Moss, Kilbride & Rubenstein, 2007; Sidenvall et al., 2000; Sheahan & Fields, 2008; Tomstad, Söderhamn, Espnes, & Söderhamn, 2012; Wikby & Fägerskiöld, 2004). De Castro and Brewer (1992) have examined the social facilitation of eating among older adults by collecting food diaries. Participants, who ate with someone, consumed more than those that were alone. If a Meals-on-Wheels delivery volunteer simply stays with the meal recipient over the mealtime, dietary intake is improved (Suda, Marske, Flaherty, Zdrodowski, & Morley, 2001). Similarly, Locher, Robinson et al. (2005) examined food intake in homebound older adults and found that eating with others was related to intake and living arrangement (living alone or with others) was not. They explained that living with others may increase the natural opportunities for commensality, but several participants who lived with others ate alone and many who lived alone, ate some meals with others. Furthermore, De Castro (1994) found that caloric intake increased with the number of others present at the meal. The effect was larger for family and friends than for other companions (De Castro, 1994). Consistent with this finding, a qualitative study reported that older women described a dislike of eating with people they did not know and eating alone in public (Sidenvall et al., 2000).

Commensality may provide social cues for when and what to eat. In a sample of older adults living in the community that received Meals on Wheels, Locher, Burgio, Yoels, and
Ritchie (1997) found that participants who ate alone relied on physical sensations to determine hunger rather than social conventions of regular meal patterns. Reliance on physical cues in advanced age may not result in sufficient intake as hunger cues weaken with age (Locher et al., 1997; Morley, 2008).

Sharing meals with others facilitates diet through normative functions and increased enjoyment of the activity, but not all older adults’ diets suffer because of eating alone. Some older adults demonstrate adaptive strategies that enable them to overcome the difficulties and unpleasantness of eating alone. The eating environment was made more pleasant by creating a quasi-social environment using television, radio and even pets (Sidenvall et al., 2000). These findings suggest that some older adults actively change their eating environments to promote health. These findings also reveal that older adults who eat alone are able to articulate the experience of eating alone and can provide a unique perspective on the social facilitation of food. Widowed older women who live alone may have fewer opportunities to eat with others and may therefore recognize and be able to articulate the effect of commensality on food intake. Older married couples that eat together may take the experience for granted (Sidenvall et al., 2000). Finally, simply identifying whether an older adult shares meals and the frequency of such activity may not capture the complexity of commensality. The effects of commensality may depend in part on the individual with whom the meal is being shared. Not all caregivers, family members or friends understand the nutritive requirements of older adults. Age stereotypes may result in inaccurate ideas about what constitutes healthy eating for older adults. Some may be unaware that poor appetite and eating habits are not part of normal aging and thus may fail to intervene (Johnson & Fischer, 2004). Spouses who are ill themselves may have a waning appetite and may inadvertently influence the other to eat less. Finally, when there are marriage
difficulties, mealtimes are often the place for the “airing” of conflicts (Burgoyne & Clarke, 1983, p.154), potentially leading to poorer food intake. The social facilitation of food and its positive impact on diet may depend on the quality of the relationships and the type of support and/or regulation received. Additional information regarding the interactions during mealtimes may help to clarify this process.

The possible mechanisms of social support, social control and commensality are complex and our understanding of their role in diet among older adults is limited. A factor analysis of a number of social variables conducted by McIntosh and colleagues (1989) highlights the complexity. The items, number of close friends, friendship density, frequency of getting together, and advise sharing between friends loaded onto one factor and other items--mealtime companionship and help with cooking from friends and relatives--loaded on a second factor. Advice sharing and help with cooking would both be considered social supportive behaviours although they loaded on different factors. Similarly, the network aspects and companionship at mealt ime may represent opportunities for social control but also loaded differently. Thus, the distinction between supportive behaviours (social support) and the benefits of being in contact with others (social control as part of social integration) may not be clear with regards to eating behaviours. Further work is required to elucidate the roles social support, social control and commensality in food intake among older adults. Although the present work is not intended to further this knowledge specifically, reviewing the possible social mechanisms of marriage on eating behaviours will help me to think about these mechanisms in widowhood, which may represent the loss of a key provider of social support, social control, and commensality.
Eating Behaviours and Widowhood

A small body of literature presents convincing evidence that recent widowhood may have negative consequences on the diets and eating behaviours of older women. Most recently, a large quantitative study found lower energy intakes among widowed older adults (65% female) compared to non-widowed (Heuberger & Wong, 2014). Rosenbloom and Whittington (1993) first drew attention to eating behaviours in widowhood when they examined the dietary adequacy and explored the eating behaviours of recently widowed (< 2 years) older adults (94% female) compared to married individuals of the same age, gender, race and similar education level. They found lower diet quality scores among widowed older adults. They also found that widowed individuals reported low enjoyment of meals and their enjoyment of meals had changed in the previous 2 years. For married participants, mealtimes remained enjoyable and had not changed. In one-on-one interviews that were conducted, it was learned that enjoyment decreased because of loneliness experienced at meals. The majority of widowed women described that they had previously enjoyed eating and mealtimes but that it was now a chore after the loss of their spouse. The widowed group also reported poorer appetite and scored lower on an eating behaviour scale measuring eating alone, meal skipping, adequacy of breakfast and variety. On the whole, the researchers concluded that widowhood had “triggered disorganization and changes” (p. S227) in the daily routines associated with eating which resulted a decline in nutritional quality.

In a small Canadian study (N=22, 77% female), recently bereaved (< 2 years) older adults had significantly greater nutritional risk scores than married older adults of the same age (Johnson, 2002). In focus groups with participants, widowed individuals described loss of
appetite due to emotional changes with bereavement and difficulty with mealtimes due to associated memories of the shared activity with their spouses.

Shahar, Schultz, Shahar and Wing (2001) examined dietary practices and weight change over a six-year period in widowed older adults (83% female) compared to married participants of similar age, sex, and race. At the beginning of the study, widowed individuals ate more commercial meals and fewer home cooked foods. Widowed older adults also reported less enjoyment of meals than married older adults. No difference was found on a depression index score and few differences were found in nutrient intakes (lower vitamin E and A in widowed group). However, widowed older adults experienced significantly more weight loss over the six years and in the year following widowhood compared to those that were married. Of note, time since widowhood was not a factor in weight loss over time. It was not analysed whether time since widowhood was associated with nutrient intake or eating behaviours.

The relationship between bereavement and eating behaviours may be mediated by the grief experienced during this time. Rosenbloom and Whittington (1993) found grief resolution to be associated with diet quality, appetite and enjoyment of food. However, another study that examined the potential effect of a bereavement counselling intervention which focused on the psychosocial dimensions of bereavement found no differences in nutritional risk or difficulties with mealtimes between those receiving the intervention and those not (Johnson, 2002). Thus, it is unclear if there is an effect of widowhood on eating behaviours beyond the grief of losing a spouse.

Some women report positive experiences related to their eating behaviours in widowhood. Quandt, McDonald, Arcury, Bell & Vitolins (2000) qualitatively examined nutritional self-management among elderly widows. Widowhood was found to relieve the women of their food-
related obligations as wives. Some women recognized that many of their food-related behaviours were driven by their husbands’ preferences and subsequently altered their habits to reflect their own preferences. This included choice of preparation method, food choice, location of consumption, and even location of purchasing. This experience has been reported in qualitative studies that have included widowed women both in the Canada and in the United States (Johnson, 2002; Quandt et al., 2000; Falk, Bisogni, & Sobal, 1996). Thus, not all changes in food quality may be for the worse with older women, and relief from the obligations of cooking for/with another likely impact the types and forms of food consumed, reflected in health changes. These potential changes need to be considered in light of changes in commensality, social control, and instrumental and emotional support that are provided within the spousal relationship.

**Food-related activities as gendered work**

Food-related activities such as planning, shopping, and meal preparation are a necessary precursor to eating. Consequently, an older adult’s capacity to complete these activities either independently or with support is an important component of their ability to access food to eat (Keller, 2005). However, for older women, these activities may signify meaning in their lives beyond that of the activities that lead to personal nutrition (Sidenvall et al., 2000). Historically, food-related activities were part of women’s work and led to gender identity (Fürst, 1997; Slocum & Nye, 1976). While this may shifting with the division of labour in younger couples and families in contemporary North American households, older adults still display a traditional division of labour (Bove & Sobal, 2006; Curch, 2005; Flagg, Sen, Kilgore, & Locher, 2013; Solomon, Acock & Walker, 2004; Statistics Canada, 2011). In a traditional division of labour, the husband is regarded as the primary “breadwinner” of the family (even if the wife works outside the home) and the wife is responsible for work in the home such as cleaning and food-
related work. Thus the women under study for this work would have largely been responsible for feeding their families. What follows is by no means an exhaustive review of the subject of the gendered nature of food-related work. However, in preparation for this work, I aimed to learn about women and the meaning of this ‘feeding’ role.

Food is central to the marital relationship. Murcott (1983) argues that the cooked dinner "symbolizes the home, a husband's relation to it, his wife's place in it and their relationship to one another" (p.179). DeVault (1991) found that feeding work was an important part of family caring. When families do not eat the food prepared, women may feel their acts of caring have been rejected (Locher et al., 2009). In a qualitative study of mealtimes among older cancer patients and their caregivers, female caregivers “expressed bewilderment, anger, and hopelessness” when patients “did not eat like they should” (Locher et al., 2009, “Female caregivers’ frustration”, para. 1). This experience may be common among widowed women, as many would have cared for their dying husbands (Quandt et al., 2000). Quandt and colleagues (2000) found that women cared for their dying husbands for at least one year during which their meal routines changed. Some of these changes included a shift to healthier meals at home, but also more eating in restaurants. When their spouses could no longer eat their usual diet, they learned to prepare meals in a way that their spouses could eat (e.g. pureeing vegetables) and some started to learn to cook for one. These findings highlight the complex nature of women’s role of feeding their family in late-life.

Food is central to family life (Charles & Kerr, 1988; DeVault, 1991; Mennel, Murcott, van Otterloo, 1992). DeVault (1991) conducted interviews with middle-aged women in the early 1980’s. Participants were mostly responsible for providing meals to their families. DeVault argues that feeding the family is one of the most important ways that women care for their
families. DeVault reasons that through the careful planning, scheduling and “doing” of family mealtimes, the family is constructed. Individuals of the family group are brought together, physically and emotionally. Indeed, greater family cohesion has been suggested in families that eat together regularly (Fulkerson, Neumark-Sztrailer, & Story, 2006). However, when there is trouble in family life, it is enacted around food. Ellis (1983) described violent events (in violent homes) that were the result of "failures of performance" (p.164) of the family meal. Through an extensive review of published studies of battered women, Ellis (1983) argued that food is at the centre of much of the violence experienced by these women. Clearly, the context of the family in which women are performing this role will greatly alter their experience of cooking and subsequently their feelings towards it.

The role of feeding is complex, encompassing identity, emotionality, family life and cohesiveness. Feeding oneself is not a priority demonstrated by a woman’s deference to their husband’s and children’s preferences for food choice (Charles & Kerr, 1988; DeVault, 1991; Stratton & Bromley, 1999). When women no longer have someone for whom to cook (e.g. in widowhood), the feeding role and its activities necessarily change.

In a qualitative study of the meaning of cooking, Sidenvall and colleagues (2000) found that the cooked meal was a gift that older women gave to their loved ones. Cooking was fundamentally something they did for someone other than themselves. The gift included planning an appropriate meal to serve, using fresh ingredients, presenting and enjoying the fellowship of the meal. Women that lived alone were not able to give this gift to themselves. They had difficulty planning and often skipped meals, they expressed loneliness at mealtimes, and the meaning of food changed. One widowed woman explained that before her husband died, they “lived for eating” and now she “eats to survive” (as cited in Sidenvall, et al., 2000, p. 414).
The authors also suggested that women received appreciation for their cooking efforts, akin to a reward for their efforts. In line with the notion of feeding as women’s work, to have that work appreciated is an important motivator.

Many studies that have examined the barriers to food intake have consistently found reduced interest in cooking in widowhood (Callan & Wells; Curch 2005; Gustafsson, Andersson, Andersson, Fjellström, & Sidenvall, 2003; Gustafsson & Sidenvall 2002; Johnson, 2002; Quandt, Vitolins, DeWalt, & Roos, 1997; Rosenbloom & Wittington, 1993; Shahar et al., 2001). In stark contrast, meal preparation and food-related activities remain central to the lives of married women in this age-group (Gustafsson, et al., 2003; Gustafsson & Sidenvall 2002; Sidenvall et al., 2000). Quandt et al (2000) reported that some widowed women found other people to cook for, such as their adult children, siblings, or a neighbour, which enabled them to maintain interest in cooking. This strategy highlights the perception of these widowed women that cooking was an activity performed for someone other than the woman fulfilling that role. Those who live alone all of their lives may not have this same view. Sidenvall and colleagues (2000) who explored the meaning of cooking among retired women did not explicitly examine differences between women who were single and women who were widowed. However, they explained in their discussion that women who were accustomed to living alone had “arranged their lives according to their situation and were rather content with this” (Sidenvall et al., 2000, p.421) suggesting some differences in the experience of cooking and eating alone among single women. Among widows, particularly the recently widowed, cooking and feeding may be perceived as activities that are generally conducted for others (and not for oneself). Thus, they may lose their meaning when living alone after having lived with and fed a spouse for a lifetime. When women lose interest in cooking and reduce meal preparation activities, the types of meals they consume
inevitably changes. There may be a shift towards meals that require simple preparation, prepared foods, or meals that are provided by supports.

This discussion would not be complete without consideration of the fact that when this cohort of older women entered marriage, the gendered roles of food preparation in marriage were not chosen but socially mandated (Chambers, 2005; Goodman & Redclift, 1991). Although many women may have and continue to experience cooking and other food-related activities as acts of caring for their spouse and loved ones, meal preparation and all related activities were women’s work and the efforts required to complete such work were considerable (DeVault, 1991). Furthermore, much of the work was invisible both to the women that did the work and to the family members that received it, resulting in the work being taken for granted by all involved (DeVault, 1991). Not surprisingly, some women feel a “lifting” of food-related wife obligations in widowhood (Quandt et al., 2000). A widow’s relief from a constraining relationship has also been reported in studies examining the experience of widowhood (Martin Matthews, 1991; Chambers, 2005).

**Widowhood as a process**

The general scientific consensus of health during transition to widowhood is that the negative effects of bereavement are normal and most people recover with time (Stroebe et al., 2007). In a three year longitudinal study of over 52,000 older women in the United States, Wilcox and colleagues (2003) found high rates of depression, difficulties with social functioning, and general health problems in the first year of widowhood; these problems stabilized for most widows by year 3 of the study. This may also be true for the eating behaviour disruption of widowhood. Quandt and colleagues (2000) compared the experiences of women widowed within three years or less to those widowed longer. They reported that most widows who had been
widowed longer had overcome the grief that had affected their appetite and increased meal skipping. Although widows’ eating behaviours did not return to the way they had eaten with their spouses, their eating situations seemed more “stable” (p.93). Change in nutritional adequacy was not measured in this study, however an increase in appetite and a decrease in meal skipping may reduce nutritional vulnerability (Keller, 2007).

Change in eating behaviours during widowhood appears to be a process, but it is unclear how and why eating situations stabilize. Quandt and colleagues (2000) noted two exceptions to stabilization in widowhood, in economic difficulty and in disability. In all other cases, the upheaval of women’s eating behaviours upon the death of their spouse seemed to have resolved itself. The authors provided a cursory discussion on the eating behaviours of the women widowed for longer than three years and did not detail how financial and physical difficulties affected their eating behaviours. Nor were the reasons or factors that facilitated the stabilization of eating behaviours explored. Nonetheless, these findings suggest two important implications. First, this finding suggests that the negative consequences of widowhood on eating behaviours may be temporary but further research is required to confirm this. Second, widowed women who have economic difficulties or physical disability may not recover from the changes in decreased food intake that result from bereavement. In Canada, income declined continuously for women widowed between the years 1990 and 2001 compared to relatively stable income reported by their married peers (Li, 2005). This declining income may impact their ability to adjust to widowhood. Disability may also impact widowed women’s ability to stabilize their eating situations.

The relationship between diet and disability is complex as these are mutually reinforcing factors; poor diet accelerates loss of function (Bates et al., 2002), and disease reduces appetite.
and ability to prepare meals (Keller, 2007). Understanding how eating behaviours are part of the bereavement process and change over time may help to untangle these factors and may help practitioners to support their older female clients who are experiencing widowhood.

Finally, for the current generation of older women, their personhood may be profoundly affected as so many were housewives without external careers, devoted to caring for their families. They may feel a loss of purpose with their caring role having come to a close. A major challenge for widowed women is to answer the question “who am I if I am no longer a wife?” (Chambers, 2005, p.23). Widows have described a conscious reflection on their identity as a central part of widowhood (Chambers, 2005; Cheek, 2010; Lopata, 1973; Martin Matthews, 1991; Silverman 2004) and re-defining the self has been described as a key step in successfully moving through bereavement (Silverman, 2004). A shift in identity may impact eating behaviours. Personal and social identities are entwined with eating behaviours, both by driving and being simultaneously reinforced (Bisogni, Connors, Devine, & Sobal, 2002; Fischler, 1988;).

Widowhood is the life stage that begins with the death of a spouse (Atchley, 1988; Carr & Bodnar-Deren, 2009; Lopata, 1996). Bereavement is the psychological process of coping with this loss (Atchley, 1988). Although many studies consider widowhood or bereavement as static states, widows “do not stand still in their mourning” (Silverman, 2004: p. 91) but move between restoration- and loss- oriented behaviour (Stroebe & Schut, 1999). Quantitative studies can capture general trends in wellness of widowed adults grouped by age, gender, and time since death of the spouse. However, qualitative studies are needed explore the more nuanced fluidity that widowed adults experience in their eating behaviours between and within different stages of adjustment (Chambers, 2005; Silverman, 2004).
Theoretical perspectives

In preparation for exploring how older women’s eating behaviours evolve through the transition of widowhood, I sensitized myself with symbolic interactionism which provided a useful lens with which to consider both eating behaviours and identity through the transition of widowhood. I also considered the ways in which social relationships are thought to be health promoting including Durkheim’s theory of social integration, Thoits’ identity accumulation hypothesis, Rook’s model explaining the functions of social bonds in health, and Pierce’s adaptation of Rook’s model for diet in older adults. Finally, I sought to gain a foundation in current conceptualizations of food choice and food systems.

Symbolic Interactionism

Symbolic interactionism, a term coined by Herbert Blumer in 1937 (Plummer, 2008) is rooted in the work of George Hebert Mead (1934). According to this perspective, the meaning of existence is argued to be derived from interpersonal relationships and individuals’ interpretations of the world (Blumer, 1986). Interpersonal interaction produces the social self through three basic processes (Blumer, 1986). Firstly, human beings act towards their environment according to the meaning they attribute to the object. Secondly, human beings learn meaning through interpersonal interaction. Thirdly, the meaning is re-interpreted at each encounter with the object. The object can be anything encountered in their environment (e.g. an object, a person, an ideal, a social group, an institution). Thus, the individual’s action cannot be understood without understanding the individual’s interpretation of the objects in question. As two human beings interact, they each re-interpret meaning and therefore reconsider how they may act. Through the process of repeated interaction, individuals learn specific ways of acting with certain individuals or groups in the form of social roles (Blumer, 1986).
It is through the process of interaction between human beings that shared meanings, including social norms and culture are created and sustained. Food has been said to have a social significance (Mead, 1934; Locher et al., 1997). Through a change in social context, the significance of food may alter in meaning. Rappaport and Peters (1988) argue for a need to understand the changing meaning of food in aging as a way of understanding and thus supporting healthier eating behaviours among older adults. Spouses have an important influence on individual meaning making. Berger and Kelner argue that when two people marry, they “redefine themselves” (as cited in LaRossa & Reitzes, 1993, p.150). Consequently, individuals develop new patterns of interactions and meaning-making with each other and their greater community stemming from the couple identity. In widowhood, all of these patterns change and the surviving spouse must again redefine themselves via interactions with society (Lopata, 2003). Therefore symbolic interactionism provides a useful lens with which to view both eating behaviours and widowhood.

**Widowhood as role loss**

Widowhood involves the loss of the social role of being a wife (Kline, 1975). Social interaction and social roles are essential to appropriate social conduct (Thoits, 1983). Expanding on the social role formation of symbolic interactionism, Thoits (1983) argued that individuals form multiple identities based on the role-relationships they have acquired. These role relationships are maintained by sets of behavioural expectations that have emerged from the interactive and interpretive processes. The role requirements provide individuals information about who they are in their social environment and thus according to this view, an existential sense of meaning. Thus social identities provide meaning and purpose to life. Accordingly, losing an identity may be detrimental to the individual’s sense of meaning and may lead to self-
destructive and deviant behaviour. To protect from this event, Thoits proposes the identity accumulation hypothesis whereby multiple identities provide additional opportunities for meaning in the case that one is lost. These identities have a relative worth that is culturally ranked.

Among older widows, the identity accumulation hypothesis may help to understand the wife role loss. Lopata (1973) argues that the roles of mother and wife were the most important social roles for adult women (now older women) and thus loss of the role of wife was the loss of one of the most socially significant roles a woman could hold. According to the identity accumulation hypothesis, women who have meaningful social involvement outside of the marriage in which to reinvest themselves may feel less disoriented. Finally, Thoits (1985) suggested that the ability to meet the expectations of one’s identities increased feelings of self-worth and mastery over one’s environment contributing to positive affect and psychological well-being. Accordingly, not meeting expectations produces emotional disturbances. Thus, individuals are emotionally driven to meet their identity expectations, further reinforcing the social norms shaping them. This may help to explain why married women continue to re-affirm their role of meal preparer and find great satisfaction in cooking, despite great disability (Gustafsson et al., 2003). In contrast, cooking loses its meaning in widowhood (Sidenvall, et al., 2000).

**Widowhood as the loss of a health promoting social bond**

The interest in social relationships and health has evolved over time, but is rooted in Durkheim’s seminal work on suicide (Brisette, Cohen & Seeman, 2000; Durkheim, 1897/1951; Thoits, 1983). He examined rates of suicide among workers who had migrated to industrial areas and found increased prevalence among workers with fewer social ties. The reduced social ties
were thought to produce a loss of social resources and a reduction in social constraints based on well-defined social norms and roles. Durkheim’s theory of social integration (1987/1951) proposed that a strong social network preserves health through two mechanisms. First, contact with a stable social structure provides normative regulation and constrains the individual from deviant behaviour such as suicide. Second, membership in a stable social structure provides individuals with a meaningful existence. According to Durkheim, existential meaning and protective norms are derived from the group as a whole and from the individual relationships. An important part of Durkheim’s work that is directly relevant to my work is his suggestion of protective norms involved in marriage and parenting. According to Durkheim, these roles provide both existential meaning, but also obligation. In his suicide studies, he found lower rates among married adults and parents. He suggested that the meaning and obligation associated in these roles altered individuals’ motivations and lifestyle.

Rook (1985) proposed a theoretical model to explain how social bonds influence health. Rook proposed that social bonds influence health through three functions, namely, companionship, social regulation, and social support. Companionship influences well-being through intimacy and shared activities resulting in increased feelings of self-worth and positive mental health improving one’s overall quality of life and mood. Social regulation influences health by either encouraging healthy behaviours or discouraging unhealthy behaviours. These influences could be intentional (such as social control discussed above) or simply as a result of spending time together. Regulation influences health by deterring deviance from expected behaviour within the relationship. It also provides stability in the social structure resulting in behaviour that is congruent with expectations of the relationship. Regulation is only health promoting in relationships that encourage healthy practices. Finally, social support impacts
mental health by reducing the negative impact of stressful events and is only influential in periods of stress. Support in times of stress results in fewer stress-related illnesses, psychiatric symptoms, and improved coping responses. Rook (1984) also suggests that some social ties may have a negative impact on health. These include having one’s privacy invaded, being taken advantage of, having promises of help broken, and knowing others who consistently provoked feelings of anger. Newsom, Mahan and Rook (2008) found problematic ties were predictive of increased number of health conditions, greater functional limitations and lower self-rated health.

Pierce (2000) adapted Rook’s model to food intake, proposing that companionship, regulation and support impact diet. In this case, companionship promotes feelings of self-worth improving mood and thus may affect appetite (Wikby & Fägerskiöld, 2004). Regulation may promote the regular eating of meals. Eating with others may be an example of an opportunity for social regulation. Pierce maintained a mediating effect of support on diet in the presence of stress. Pierce tested the stress-buffering hypothesis of social support and diet quality among low-income older women where the stressor was functional limitations. Support was related to grocery acquisition and meal preparation and was measured by number of types of support and number of helpers. Few relationships were found between disability and diet quality. The diet quality of individuals with severe disabilities did not differ across number of helpers. However, the diet quality of high functioning women was related to a higher number of helpers. Although these women did not need the support, their diet quality benefitted. This finding may lend support to the companionship effect of social bonds on diet. More work is needed to understand the functions, both positive and negative, of the social bond on eating behaviours.
Food choice and food systems

Understanding food behaviours is complex as such behaviours are the product of multiple individual, social, and environmental processes that are not necessarily consistent or connected (Fine, Heasman, & Wright, 1996; Sobal, Kettel Khan, & Bisogni, 1998). Food behaviours consist of all behaviours related to the acquisition, preparation, serving, consuming, and disposing of food (Sobal & Bisogni, 2009). Furst, Connors, Bisogni, Sobal, and Falk (1996) proposed that the re-occurrence of making food behaviour decisions over the life course leads to the development of personal systems for food choice. The system includes value negotiation that involves the weighing of different considerations in making food choices (e.g. managing relationships, ideals of health, nutrition, taste, monetary considerations, convenience) and the strategies or scripts that evolve through habitual choice patterns. The strategies or scripts simplify the complex task of food-related decisions. One’s food ideals, personal food-related needs, preferences, identity, and resources influence the personal system. Personal systems are embedded within the social and food context to which they relate, the most proximal being their household’s food system (Sobal, Bove, & Rauschenbach, 2002; Furst et al., 1996; Schubert, 2008). There are established processes and roles regarding acquisition, preparation and consumption of food (De Vault, 1991). The sometimes competing priorities of other members affect the food system and consequently also affect the personal system (Furst et al., 1996). Consequently, meals shared between the couple are the result of a complex negotiation about food choice (what and how much), choice of preparation, and timing of mealtimes. These negotiations usually do not occur for each meal, but couples make them over the duration of their relationship. Change in the social context can be a source of change to food behaviours (Quandt, Arcury, & Bell, 1998).
Summary

In summary, nutrition presents an important opportunity for improving the quality of life of a rapidly growing aged population. Food intake is commonly poor in older adults and many are at nutritional risk. Widowed older adults are at increased nutritional risk and widowhood is largely an experience of older women due to sex differences in life expectancy. Eating is a social activity that is deeply entwined with the couple identity. In widowhood, women lose interest in eating and cooking; appetite and the quality of their diet can suffer, especially in the initial bereavement stages. Women of this generation may have strong meal-preparer identities that are tied to their husbands, thus food may lose its purpose in widowhood. It is not clear if the changes in eating behaviours in widowhood are long lasting, one study has suggested that eating behaviours stabilize with time but further research is required to confirm this.

Widowhood may be linked to diet through the loss of the marital influences on diet, the stress of the conjugal loss, and the loss of the meal preparer role. The marital influences on diet include social support and social control. Neither of these mechanisms has been studied exclusively in the marital context. However, social support from all sources appears to be an important factor in the diet of older adults, particularly in a vulnerable population that relies on others for food-related activities such as shopping for and preparing meals. The dependent/caregiver relationship is complex and requires further exploration into the experience of food-related support. Perhaps the most direct way marriage can influence diet is the activity of eating together, a form of social control. Research has produced strong evidence to suggest that eating alone increases risk of poor intake. Marriage may provide natural opportunities for eating with others but does not guarantee it. The conjugal loss is one of the most stressful experiences in life and this stress may create disorder in women’s lives, eating behaviours included. This
experience may be compounded by the loss of an important role of caring for and feeding the husband. Widowhood is considered a process, within which grief is lessened or overcome, but it is not clear how eating behaviours change and possibly stabilize over time.

Although there has been some empirical work exploring the eating behaviours of older widowed women, there has been no theoretical work to explain why eating behaviours change. This study intends to fill this gap by generating a theory explaining why eating behaviours change among older widowed women. The empirical work suggests two phases of eating behaviour change in widowhood: change towards behaviours that increase nutritional vulnerability in early widowhood and change towards behaviours that decrease nutritional vulnerability as time passes. Developing an understanding of how widowed women move through these stages in a theoretical framework will help health practitioners and families support their older female widowed clients and loved ones through this transition.

In preparation for this theory-oriented endeavour, I sensitized myself with symbolic interactionism, theories that elucidate the link between social relationships and health, as well as theoretical conceptualizations of food behaviour.
CHAPTER 3: RESEARCH OBJECTIVES, QUESTIONS, AND DEFINITIONS

Research Objectives

The objective of this study was to explore the process of change in eating behaviours and appetite of cognitively-well community-living older women through the transition of widowhood and to develop a substantive theory to explain this process.

Research Questions

The following research questions have guided the research. What is a substantive theory that explains the process of described change in the experience of eating behaviours and food-related activities among older widowed community living women who live alone?

a. How does the process unfold?

b. What are the major stages in the process?

c. Who are the important participants in the process and how do they participate?

d. What might be the underlying causal factors of the process?

2. How do widowed older women experience appetite, eating and food-related activities?

3. How do women understand their eating behaviours to have changed since the death of their spouse?

Key Definitions

1. “Older women” is defined in this study as women 65 years and older.

2. “Widowed women” is defined as those who have been married in the past and whose spouse has died. Their legal status is also widowed such that they have not remarried nor have claimed common-law status with a companion.

3. “Living alone” is defined as living alone the majority of the time, such that a visitor that may regularly come for two days a week but does not live there, the individual is still considered to
‘live alone’. Similarly, family or friends that visit regularly or stay for extended visits are also considered visitors.

4. “Community living” is defined as free living and not residing in a senior’s residence with assistance provided, an institution, or a hospital. In the case of this study, community-living will further be defined as person who is primarily responsible for the preparation or negotiation of their own food (i.e. control over purchasing prepared meals) and are not living in an assisted residence where one or more meals per day are required as part of the cost of lodging.

5. “Eating behaviours” is defined as all behaviours that relate to food intake namely, planning, grocery shopping, meal preparation, and eating. It excludes nutrient intake and food intake such that I am not measuring what foods and nutrients individuals are consuming.

5. “Appetite” is defined as the interest and desire to eat.

6. “Cognitively-well” is defined as having the cognitive ability to provide informed consent to participate in the study and to be able to verbally articulate thoughts in interviews.
CHAPTER 4: METHODOLOGY

The proposed project utilized qualitative methods, specifically, grounded theory methodology (GTM) to achieve the research objectives. In this section, I describe my positioning as a researcher, the methodology and rationale, sampling and recruitment, data collection, and data analysis.

Positioning

Research paradigm

I approach science with a critical realist worldview as outlined by Bhasker (1975). Critical realism provides a framework for both natural and social inquiry, combining a realist ontology with a subjective epistemology. There is both a natural and a social world that exist independently of our knowledge of them. Understanding of the world is created through scientific (social) consensus and is always fallible:

Science is produced by the imaginative and disciplined work of men [sic.] on what is given to them. But the instruments of the imagination are themselves provided by knowledge. Thus knowledge is produced by means of knowledge. The objects from, and by, which knowledge is generated are thus always themselves social products (as is the knowledge generated). (Bhaskar, 1975, p.185)

A researcher is necessarily non-neutral. Throughout this endeavour, I have carried my assumptions about the transition of widowhood and how eating behaviours may be affected as well as the sensitivity that I had developed through an understanding of relevant theory and literature. These assumptions have shaped my interactions with participants, the data created and
the interpretation of that data. I aimed to be reflexive throughout the research process to remain attentive to my role in knowledge creation and to be able to present it in the research findings.

Despite having only a fallible way of apprehending reality, there does exist a “real” world to strive to understand. Bhasker (1975) identifies three domains of reality namely: empirical, actual and real. The empirical encompasses objects (social and natural) that can be experienced and perceived by our senses. The actual includes the events that happen in the world independent of our perception of them. The real is described as the non-observable causal mechanisms of the actual. These causal mechanisms are enduring. In the natural world, these consist of the natural laws that are perpetually working (e.g. gravity) independent of human existence. In the social world, there are patterns of events which are caused by underlying mechanisms (Lawson, 2003). Some of these mechanisms are social structures, which are just as real as the natural laws and exercise power on individuals (e.g. gendered foodwork among older women). However, these forces are social products and dependent on humans as they have been developed through social interaction and shared understandings that have been maintained in social discourse over time (Gergen, 1985). They are less enduring than natural causal forces as individuals continuously interact with these structures and can modify and transform them. In social inquiry, critical realism maintains an approach to research similar to social constructionism, including both the interpretive and objective uses of the term (Harris, 2008).

The social constructionist research paradigm is based on the assumption that the researcher and the participant share in the construction of knowledge (Daly, 2007). Researchers must seek out information-rich cases (Patton, 2002). These are usually individuals that have had an experience of relevance to the research question and can articulate it. In this way, participants together with the researcher, construct knowledge. Then, by looking for consensus among the
multiple social constructions of knowledge, the researcher can achieve an interpretive understanding of participants’ experiences. Under critical realism, individuals are not necessarily aware of the structural influences on their behaviour (Baskhar, 1979) and researchers must engage in a process of theorizing or abstraction (Sayer, 1998) to propose explanations of the phenomena of interest.

There are two key differences between critical realism and social constructionism that are directly relevant to my work. First, critical realism attempts to explain the natural world with the same language as the social world and provides a framework for explaining interactions between and within the different realms. Second, the primary objective of research within critical realism is to generate knowledge (albeit fallible) of underlying mechanisms (McEnvoy & Richards, 2003), whereas social constructionists are interested in the act of social construction itself (Best, 2008). I am both interested in understanding how individuals are shaped and constrained by social structures and how they act on the structures, reinforcing or transforming them, but only insofar as they can explain the research question.

**Reflexivity**

Part of understanding my role in knowledge creating, is attending to the assumptions and perspectives that I carry into the research process in an ongoing process of reflexivity. Personally, food is intertwined with my social relationships. Growing up, food (and beverage) was central at all family gatherings. It continues to be the reason we come together, sit around a table and reconnect with one another. Food is used to pass on tradition and family history. Every year in May, I buy the first local asparagus to appear in the market and prepare it in the exact same way my grandmother has always done: slowly, cooked in olive oil with a few pieces of salami and then set in eggs. During this ritual, I think of her growing up in rural Italy anxiously awaiting the
first vegetables of spring, and feel rooted in this history. The meaning of food is inseparable from the people that I share it with.

In 2009, I was involved in a qualitative study in which I interviewed 30 relatively healthy older adults that were living alone about the barriers they faced to healthful eating and the strategies they might have used to overcome these. The research question was to characterize diet resilience, whereby older adults maintain diet quality despite having characteristics known to negatively impact their food intake (e.g. living alone). The majority of the sample were widowed women, some recent, some over 20 years. At the time, I was very interested in the indirect social control or normative function of a spouse on diet (Pierce, 2000; Umberson, 1987). An example of this would be to eat three times a day simply because it is what your spouse does; it is *just what you do* and you have someone to notice if you do not. Living with a child or a companion would have the same function. It may have been due to the sample’s relative good health that most of these women were managing well without this normative influence that I was so curious about. However, many described food apathy due to having to eat alone or cook for one, which is consistent with the literature in this area (e.g. Rosenbloom & Whittington, 1983). Some spoke longingly of the companionship they missed at mealtimes, but they found ways to keep eating despite missing their spouse or feeling alone. Through my analysis of these women, I noticed that they were telling me that they had intrinsic motivators to eat every day. They either believed fundamentally that good nutrition was directly related to their good health or that they tremendously enjoyed eating and derived daily pleasure from it (Vesnaver, Keller & Shatenstein, 2012). I was left wondering if they had always had that motivation or if they had learned it as an adaptive strategy in widowhood. I wondered if these women had always been so resilient or if they too experienced the stages of ‘loss of self’ and ‘redefining of self’ experienced in
widowhood (Silverman, 2004). I further thought about how these stages may have been expressed in their eating behaviours. I started thinking about my widowed grandmothers. Their eating behaviours provided examples on the extremes. One is very resilient in her eating behaviours despite suffering from many debilitating conditions. For decades before her husband’s death, they had very independent eating behaviours. My other grandmother represented the other extreme. Since the death of her husband, she had diminished appetite and lost weight. She talked about the meals they ate together and how they starting sharing portions as his appetite waned with illness. She died two years after his death, suffering only from frailty. These women’s eating behaviours in widowhood seemed inextricably linked to the couple experience of eating. These experiences suggested to me that women’s cumulative experience of eating and food in their marriages were important in understanding the process of bereavement and eating behaviours.

These are the experiences that led me to the present research questions. They sensitized me to subject matter and influenced my thinking. Given my role in data creation, I was cognizant to use this sensitivity to elicit rich data and not to simply impose this assumption on participants, as this would heavily weigh the negotiation of experience towards confirmation of my preconceived ideas. In this effort, I actively sought out and listened for examples and explanations that did not fit my assumptions. The continuous practice of reflexivity throughout data collection, analysis and writing enabled me to consciously examine my part in data construction.
Research Methodology and Rationale

Qualitative methods

Qualitative methods were selected for this inquiry because the techniques they offered fostered an exploration of the complexity of eating behaviour through the life transition of widowhood among older women. Widowhood creates great disorder in women’s lives and alters their eating behaviours (Rosenbloom & Whittington, 1983). There is little understanding of why this happens and how eating behaviours change through the bereavement process. Qualitative methods offer tools to explore social phenomena, acknowledging and illuminating its complexity rather than the reduction required of quantitative methodologies (Camic, Rhodes & Yardley, 2003; Furst, Connors, Bisogni, Sobal & Falk, 1996). They provide methods to analyze and describe individuals’ subjective experience, resulting in findings that are useful and relevant (Camic et al, 2003). Therefore, qualitative methods are particularly appropriate to guide the inquiry of complex, multi-factorial social phenomena that have not yet been fully understood (Devers & Robinson, 2002).

Grounded Theory Methodology

There are many qualitative methodologies. Grounded Theory was selected to generate a substantive theory explaining process of shifts in eating behaviours through the life transition of widowhood among older women in order to address the research question and was congruent with my positioning as a researcher. Grounded Theory methodology rests on the premise that useful social theories can be inductively derived from data (Glaser & Strauss, 1967). Grounded theory was initially developed to help graduate students like myself generate practical social theories (LaRossa, 2005), thus it provides “systematic, yet flexible guidelines for collecting and analyzing qualitative data” (Charmaz, 2006, p.2). Grounded theory is not merely a set of
procedures that one must carry out blindly, but include new ways to think about textual data, foster continuous fresh engagement in the data, and through an iterative process, develop and sharpen analytic skills (Charmaz, 2006; LaRossa, 2005). The inductive and emergent nature of grounded theory facilitates the exploration of the complexities of the phenomenon under study, encouraging the pursuit of new paths of analytic inquiry when they arise so that a resulting theory offers both fresh and relevant insight (Charmaz, 2006). There have been many interpretations of grounded theory (LaRossa, 2005). I chose to follow Charmaz’ constructivist grounded theory methodology (Charmaz, 2006) because the underlying assumptions of her approach are compatible with a social constructionist epistemology and a critical realist worldview. Although Charmaz termed her method constructivist to distinguish it from classic objectivist grounded theory, she more recently stated that her method is rooted in social constructionism (Charmaz, 2008). Charmaz is forthright that her methodology deviates from an objective classic grounded theory described by Glaser and Strauss in two ways: neither data nor theory is discovered but constructed by researchers and that any theoretical explanation of social phenomena is not an exact picture of the world but an interpretive one (Charmaz, 2006). This is consistent with a critical realist worldview whereby all scientific knowledge is a social product and thus necessarily non-neutral and value-laden (Bhaskar, 1975). Furthermore, grounded theory is by nature explanatory and provides a method which enabled the development of a theory to explain the process that underlies changes in eating behaviour that occur during widowhood to better understand and explain the complexity of this phenomenon.
Methods

Research design

As widowhood itself is a process (Quandt et al., 2000; Silverman, 2004), I aimed to construct an understanding of eating behaviours in widowhood by interviewing individuals that were likely experiencing different stages of widowhood. In this way, I triangulated the data collected from individuals with these differing perspectives to build a richer and more complete understanding of the process. Accordingly, I aimed to interview women that represented a full range of positions along the process, approximated by time since widowhood. The assumption underlying this approximation was that the process aligned with time and thus was linear and sequential. While I anticipated that the process likely did not progress in a linear fashion such as time, the literature suggests that time is a factor regarding the physical and psychological effects of the death of a spouse (Wilcox, et al., 2003). Based on this and other research (Quandt et al., 2000), I sampled along time since widowhood anticipating that longer term widows (>3 years) would be more likely to have recovered from the devastating effects of grief and be able to provide a perspective that was reflective on the whole process; more recently widowed participants (3 years and less) would be more likely to still be experiencing the disorganization in eating behaviour suggested in prior research (Rosenbloom & Whittington, 1998). As directed by grounded theory methodology data collection was concurrent with analysis whereby the first interview was transcribed and analysis was initiated prior to collecting more data.

Ongoing consultation of the literature increased my theoretical sensitivity and enabled me to incorporate additional perspectives in my analysis. These methods enabled the construction of a substantive theory explaining the eating behaviours of older women experiencing the transition of widowhood.
Sample and Recruitment

A combination of purposive, theoretical, and convenience sampling was used. Initial purposive sampling was guided by time since widowed with sampling continuing one participant at a time, using theoretical sampling to develop emergent categories (Charmaz, 2006). The initial sampling frame directed recruitment to participants widowed five years or less. Inclusion criteria included 65 years and older, cognitively well, living alone, and English-speaking. Participants had to also have been living independently in the community and largely responsible for their own food acquisition and preparation (i.e. not living in an assisted living situation with provided meals). The criteria were broad in order to enter the field with a wide focus, narrowing if necessary as the research evolved. Living alone was selected as an inclusion criterion to reduce the complexity introduced by including different living arrangements. Widowed women that live with adult children or new partners may have many other factors impacting their eating behaviours (such as a shared eating environment) that may have detracted from the focus of this inquiry. Furthermore, the majority of Canadian widows live alone (Statistics Canada, 2011; Statistics Canada, 2013). Thus it was an important group to target.

Potential participants were recruited from the Greater Toronto Area in Ontario, Canada by poster advertisement in senior centres and senior apartment complexes and by word-of-mouth (see Appendix A). The study was also advertised in several grocery stores, churches and bus stops in one neighbourhood in Toronto as well as advertised in a newsletter circulated to approximately 500 seniors by West Toronto Services for Seniors. No interested potential participants came through these recruitment methods. I also contacted several bereavement groups in Toronto regarding recruitment and received no response. Due to low response in general to my advertising campaign, I began recruiting in person at four senior recreation centres.
I made presentations during congregate meals; I developed a large poster and sat with materials of interest to older adults to generate interest. Most participants came through these more active recruitment methods. The number of participants needed for the study was not known a priori. Recruitment was expected to continue until saturation was achieved. The concept of saturation in grounded theory relates to illumination of categories and well understood categories grounded in empirical data, and not the number of individuals who have contributed to that understanding (Charmaz, 2006; Glaser & Strauss, 1967). Due to the careful scrutiny and constant revision of data required of grounded theorists, researchers must be judicious in the amassing of data. Data must be ample enough for illumination of categories, yet small enough to “be kept in the researcher’s mind as a totality under investigation at all stages of the research” (Crouch & McKensie, 2006). Categories were saturated at 14 interviews. A fifteenth interview, initially put aside due to the long period since widowhood (15 years), was included in the study to ensure saturation. No new concepts emerged from this interview. Other grounded theories related to eating behaviours in a similar population had achieved saturation by interviewing 11-40 individuals (Jacobsson, Pihl, & Fridlund, 2004; Falk, Bisogni, & Sobal, 1996; Wong, 2006).

Data Collection

Overview of the process. Advertisements and purposive sampling led to older widowed women self-identifying themselves and calling me. During this initial contact, I collected some basic information over the phone (age, years of widowhood, length of marriage in years, education, income, ethnicity or cultural group, self-rated health, responsibility for food related activities) to confirm eligibility of these women and potentially to determine order of interview, depending on emerging concepts (Appendix B) (Wuest, 2012). However, recruitment was much slower than anticipated and I decided to schedule the interview for all eligible participants as
soon as possible. Questions beyond those needed to determine eligibility were moved to the in-person interview. As the older women’s population is heterogeneous, these characteristics helped me to identify the diversity of my sample as well as describe my sample in presentation of the findings. During the initial contact, participants were explained the nature, purpose and procedures involved in participation. The inclusion criterion for participants to be cognitively well was assessed by asking potential participants to repeat back the purpose of the study and what was expected of them. If any were unable to do so, they would have been thanked for their time and not interviewed; this never occurred. Often, widows shared considerable detail about their experience during this contact that was captured in field notes. These notes were used to prepare for or guide the interview and often provided a starting point to the conversation. Although field notes were not included in the formal analysis, they often provided analytic insights (Glaser & Strauss, 1967).

Participation involved one in-person in-depth interview preferably in the participant’s home, but the option to meet in a location of their preference was available. Three participants preferred to be interviewed in a private room at the senior centre where they were members. Prior to the interview, I again reviewed the nature, purpose and procedures involved in the study with participants and provided an opportunity for their questions. Informed written consent was obtained after all questions were answered and prior to beginning the interview (Appendix A). With consent, the interview was digitally recorded. Interviews lasted 1-2 hours. At the end of the interview, participants were given a $20 gift card to their choice of a grouping of restaurants, Tim Horton’s (coffee shop), or a Loblaws affiliated grocery store. Participants were also given several resources regarding diet and mental health (see Appendix C). These included a booklet written by Dr. Heather Keller for eating well in later life, Canada’s Food Guide, and contact
numbers for EatRight Ontario (a free hotline to a speak with a dietitian) and for the Toronto Distress line (a free hotline to be connected with mental health supports in the community). Participants were asked if they agreed to be contacted in the future for clarification or follow-up of their interview by phone. All participants agreed and some provided alternative contact information such as their email. Two participants were contacted for clarification by phone. Field notes were written immediately after each interview. Field notes included description of contact with participant before and after the recorded interview, details about the participant’s home, mood, and physical appearance, and any feelings, comfortable or not, that came up during the interview. Emergent analytic insights were also captured. I transcribed the first four interviews to immerse myself in the data and to develop a consistent system for transcription (Daly, 2007). As best as could be recalled, notes regarding non-verbals were included in the transcript. The remaining interviews were transcribed by a research assistant and reviewed for faithful representation of the interview as I had experienced it. Recordings, transcripts and all related analysis and memos were kept in encrypted files on a password protected computer. Data were organized using ATLAS.ti (version 7). All procedures were be approved by the Ethics Review Board at the University of Guelph prior to recruitment (Certificate # 11MY004).

In-depth interviews. GTM calls for a data collection method that is open-ended and emergent but also directed and shaped (Charmaz, 2006). Interviews were active using techniques described by Holstein and Gubrium (1995). Consistent with a social constructionist epistemology, this technique acknowledges that interviews are collaborative whereby data is not collected but co-created by interviewer and interviewee (Gergen, 1985; Holstein & Gubrium, 1995; Mills, Bonner, & Francis, 2006a). I opened the interview with a broad, open ended-question such as “can you tell me a bit about your eating habits?” (See Appendix B). Interviews continued in a
conversational nature, using a semi-structured guide as needed to focus the conversation on the research questions (Holstein & Gubrium, 1995). The guide’s purpose was to help me address the current questions, not to constrain the interview. Together, the participants and I explored topics that were initiated by them as well as any spontaneous hunches that I developed during interviews. Active interviewing (Holstein & Gubrium, 1995) is a flexible style that suggests interviewers should take an active role by keeping participants on the topic and encouraging responses from the participants. The interview involves mutual disclosure whereby participants are encouraged to participate in the creation of knowledge by being made aware of the research agenda. I used a form of member checking in which I asked participants to comment on my emergent insights as my analysis progressed (Guba & Lincoln, 1982). Unlike traditional interviews where each interview must be treated separately without “informational spillage” (Holstein & Gubrium, 1995, p.46), understanding builds from one interview to another, and information from preceding interviews is used in succeeding interviews. This is appropriate and necessary within an emergent GTM design.

Given my impactful role in data creation, it was important to balance the exploration of significant questions without forcing the data into preconceived categories (Charmaz, 2006). In this effort, I engaged in continuous reflexivity about my role in the interview and my influence on the participant and on his/her articulated experience. For this style of interviewing to be effective, gaining trust and establishing rapport with the participant early in the interview is essential (Fontana & Frey, 2000). This was another reason to share information about my research question as I anticipated this would help to foster interest and participation in the development of understanding of eating behaviours in widowhood. This included sharing my role as a student and learner in the subject. When I felt it helpful, I shared with participants the
personal roots of my research interests. When the topic seemed difficult to talk about, I used external examples as probes to take the focus off the individual. I often engaged them in a discussion on the research question in an abstract way before asking them direct and personal questions about their experience. In an effort to foster an intimacy with participants I disclosed information about myself (Charmaz, 2002; Daly, 2007). This very focused and shared process provided the rich data necessary to develop a substantive grounded theory explaining the eating behaviours of older women experiencing widowhood.

Both the subjects of widowhood and eating behaviours are heavily laden with social norms and meanings. Prior research has shown that older women frame their talk of healthy food choices in morality (Curch, 2005). Milburn (1995) speculated that the focus on health in qualitative studies of food choice might be due to a combination of heavy social pressures concerning healthy eating and the nature of the co-construction of data between interviewer and informant (Milburn, 1995). She observed that the interactive co-construction changed through a prolonged engagement in the field, whereby the shackles of social pressures came off and accounts of actual dietary practices were expressed. I tried to be clear about my role as a researcher interested in issues related to eating among seniors, and I was careful to clarify that I was not a dietitian and therefore could not comment specifically on the healthfulness of their diet. I emphasized that I was not there to judge the healthfulness of their diet, but to try to gain an understanding of the effects of widowhood on eating in older women. All participants knew of a widowed woman that ate extremely poorly after the death of their spouse, and thus all could understand the importance of the work, and in contrast to their examples almost all of these were resilient in their eating and recognized that. Consequently I believe this helped them to release the health aspect of the diets and focus on process.
It may be difficult for some older women to express any positive feelings or experiences related to widowhood due to the social construction of widowhood as a time of loneliness and grief (Chambers, 2005). Perhaps because it was their eating behaviours and not their mourning that was the focus of the interview, participants did express positive feelings and experiences related to widowhood particularly in their freedom to make personal choices regarding food choice and meal scheduling. Loneliness and grief were topics that were discussed in interviews but they usually did not colour the entirety of the interview.

I was also aware of the potential for women to be engaging in spouse sanctification (Lopata, 1973) or marital aggrandizement (O’Rourke, 2004) whereby women erase all faults of their husband and marriage and speak as if the marriage and the relationship were perfect. Marital aggrandizement has been related to well-being in widowhood (O’Rourke, 2004) and may have a positive impact on identity during this period of transition. One participant that had been widowed less than a year appeared to be engaging in marital aggrandizement and it may have impacted her widowhood experience, but it did not appear to influence her eating behaviours directly.

**Data Analysis and Interpretation**

Analysis began with the post-interview field note guided by the following questions (Charmaz, 2006). What is going on? What is the participant saying? What are the participant’s assumptions about widowhood? About diet in general? What are my assumptions? Under which conditions does widowhood have an influence on diet? Does this influence change over time? I also reflected on the data collection process. This involved operational notes (described below) that helped me to think about my interview questions, the types of data I still required, and my role as interviewer to inform future interviews. In grounded theory, this is called theoretical
sampling. Theoretical sampling is critical to the emergent nature of grounded theory methodology. It enables researchers to consider their analysis, identify gaps in understanding and seek out new information by altering the interview questions or recruitment strategy in subsequent data collection (Glaser, 1978). I transcribed the interview (or had it transcribed) verbatim as soon as possible. Immediacy of transcription helped to ensure better capture of non-verbal data, as the interview interaction was still fresh in my memory. Once complete, I began a formal analysis process guided by the constructivist methodology presented by Charmaz (2006). Fundamental to grounded theory is the constant comparative method (Charmaz, 2006; Glaser & Strauss, 1967; Corbin & Strauss, 2008), whereby the researcher makes comparisons across data at each level of analysis. According to Glaser and Strauss (1967), data are fragmented into small meaningful segments. Coding is used to identify and understand these segments. The segments are then compared to one another to recognize similarities and differences. Finally, through a systematic process, fragmented data are structured into meaningful categories and their properties that together form an explanatory theory. This process is continuously refined as each level of interpretation is compared to the data to ensure fit.

Coding in qualitative analysis is where the researcher makes sense of and interprets the data collected (Charmaz, 2006). Preliminary analysis begins during transcription. Initial analytic hunches, and codes were noted as I transcribed the first interviews and then as I reviewed the remaining. The process of coding the data once the interviews and transcripts were complete grounded any provisional theoretical constructions in the data. When possible, interviews were fully transcribed and analysed before the next interview. This helped to direct further data collection.
Charmaz suggests three stages of coding: initial, focused, and theoretical (2007). Initial coding is the process of naming each segment of data (Charmaz, 2006). The researcher considers one segment of the data at a time, interprets what is meant by the participant in each segment, and attaches a simple and precise label (Charmaz, 2006). These initial segments are a line of transcript, sentence or phrase. Through the process of initial coding, the researcher develops analytical directions drive the next stage of coding. Glaser (1978) suggests three questions to be constantly asked of the data during this coding stage to focus on the analysis on theory generation. The question “what is this data a study of?” helps to focus the coding on the research questions. A second question “what category does this incident indicate?” facilitates coding data in a way that is related to the emergent theory. Finally, asking the question “what is actually happening in the data?” helps to focus the coding on process. Although these questions may not have answers during the early stages of the research, they become easier to answer as the theory develops. Once I established strong analytic directions in the data, I returned through all transcripts to that point and began focused coding. Focused coding is the process of reducing the amount of initial codes by selecting the most meaningful and explanatory labels (Charmaz, 2006). This process is largely driven by the analytic directions that are developed in the initial stage. In these prior two stages, using active labels (e.g. being connected) are recommended to remain close to the data and articulate the process which is being understood (Charmaz, 2006). Corbin and Strauss (2008) describe an additional stage of coding before the final theoretical coding. Axial coding is the process of understanding the relationships between codes in the data. Corbin and Strauss (2008) suggest organizing codes into categories to understand their relationships or the process that is underlying the phenomena of interest. Suggested categories include conditions or influences, actions/interactions, and consequences which will reveal the when, where, why,
how and the consequences of a phenomena (Corbin & Strauss, 2008). Glaser and Strauss (1967) also provide a number of coding families which help to guide the researcher in this process. Charmaz cautions that using these types of coding frameworks may be limiting and that some researchers may be better served by their own intuition (2006). I used these strategies as analytic tools to test my understanding of my categories, identify alternative explanations, and explore new ways of thinking about my analysis.

The final stage of coding is theoretical whereby the most significant categories are selected for synthesis into a unifying theory using theoretical coding (Charmaz 2006). Daly (2007) terms this process “creating the theoretical storyline” (p. 235). Grounded theories are in essence narratives that are created from the analysis of the data (Daly, 2007).

Although these stages of coding are presented separately and sequentially, in practice, coding was not linear (Charmaz, 2006). The stages of coding were used as tools to help me understand the data collected. One defining characteristic of grounded theory is that the analyst continues until a theory is developed that explains the process of interest. The analysis does not end when all the data has been coded but changes into a process of theorizing to explain the linkages among the categories generated by the analysis. In this work, I sought to describe a process. Therefore, the resultant theory must describe temporal stages of eating behaviours in widowhood (Charmaz, 2006). Morse (1994) describes the final stages of grounded theory analysis:

Theorizing is the constant development and manipulation of malleable theoretical schemes until the ‘best’ theoretical scheme is developed…The final solution is the theory that provides the best, comprehensive, coherent, and simplest model for linking diverse and unrelated facts in a useful, pragmatic way. (p. 32)
Coding was messy, going back and forth between stages, re-coding and refining categories as required. When gaps were identified, I started anew, first theoretically sampling the dataset by asking new questions of the data. Then theoretically sampling in interviews with the next participants. This process continued until my understanding of the phenomenon was saturated, no new information emerged from the data, and a coherent theory was achieved (Daly, 2007).

Using a process of abduction, I sought theoretical explanations outside of the immediately available data and theory to help me interpret the data and generate a number of possible explanations (Charmaz, 2006; Daly, 2007). These theoretical explanations were drawn from my own experiences, creativity, and broader literatures. Using a peer-debriefing strategy, I sought out input from colleagues and primarily my advisor on my understanding of the data and remained open to new interpretations and analytic directions that improved the fit of the data. Alternative explanation were thoroughly examined in light of the data until one was found with good fit and explained the largest amount of data (Morse, 1994). Preliminary conceptual models and all major shifts in analytic directions were reviewed with my advisory committee. Finally, I worked to produce a grounded theory that is credible, original, resonant with participants, and useful to dietitians and nutrition researchers (Charmaz, 2006).

**Memo-writing.** Memo writing was used throughout data collection and analysis to document and organize the emergent process of conducting grounded theory (Charmaz, 2006; Daly, 2007). It is the process of informally recording all thoughts related to the research at any point in the data collection-transcription-analysis cycle. Corbin and Strauss (2008) described five different types of notes researchers use to document the process. These include analysis memos, code notes, theoretical notes, operational notes and diagrams. Analysis memos can be the form of continuous journaling of any and all thoughts that pertain to the analysis of the data. This
includes capturing hunches about the data, codes and categories, linkages between categories and areas in need of further exploration. Code notes include thoughts about language in the analysis of data. Are the words used for naming of concepts precise and accurate? Do they capture the idea presented in the data? Theoretical notes include any sensitizing concepts related to the data and thoughts about emerging themes and theory. Operational notes help the researcher to organize and summarize their data collection, providing an audit trail of methodological processes. This included notes about sampling strategies, new or modified questions to ask and other procedural items. Finally, visual notes or diagrams were used extensively to help me understand the relationship between concepts (Corbin & Strauss, 2008). Memo-writing was essential to organizing and documenting the emergent process of developing a substantive theory from interview data. The act of writing down analytical hunches also spurred new insights and drive analysis forward, accelerating the process. Many memos provided the foundation for the final presentation of the findings in publication.

Use of literature. In constructivist grounded theory guided by a critical realist framework, engaging with the literature was important to analysis and was ongoing throughout the research project. The literature provided sensitivity to the data (Corbin & Strauss, 2008) and “[contributed] another voice to the researchers’ theoretical reconstruction” (Mills, Bonner, & Francis, 2006b, p.5). Chambers (2005) discussed the importance of engaging with the literature throughout her study of widowed women narratives. She found that by being aware of what she called “the public narrative” of widowhood as dominated by pathology, homogeneity and discontinuity, she was able to examine how her informants manage this narrative. She states that her informants “conform to the popular public narrative of later life widowhood: they are old, female, widowed and lonely” (Chambers, 2005, p.239). Seeing this in the context of
understanding the public narrative helped her to see the “roots” or generative mechanisms of their loneliness as life-long low self-esteem, a lack of a social identity; a life structured by gender and generation and a dependence of family. Being aware of the shared social knowledge of widowhood and eating behaviours helped me to not only recognize it in my data, but also help me to work towards an understanding of the underlying mechanisms. A familiarity with the theoretical literature is also important when developing theory particularly when generating theoretical codes (Glaser, 1978; Morse, 2002). The theoretical perspectives discussed in the literature review formed the basis for my theoretical sensitivity as I embarked data collection and analysis. Therefore, these concepts were easier for me to see when they were present in the data. However, all concepts earned their way into the analysis (Glaser, 1978). All researchers come with concepts that they have become intimately familiar with through their training. Glaser (1978) cautions careful use of these concepts, their fit must be verified by systematic comparison of incidents of the concept within the data. The concepts from my training and from my theoretical preparation for this project, like all analytic concepts I came across in my ongoing review of the literature or personally generated were subject to earning their way into the analysis and resultant theory (Charmaz, 2008; Glaser, 1978). Concepts used in the final theory that were drawn directly from the literature were cited in the category descriptions.

Summary

A qualitative research approach guided by grounded theory methodology within a critical realist worldview was used explore the process of change in eating behaviours of older women living in the community experiencing the transition into widowhood. Fifteen in-depth one-on-one active interviews were carried out with older widowed women. Sampling was a combination of purposive, convenience and theoretical strategies and potential participants were recruited
from the Greater Toronto Area of Ontario, Canada. Interviews focused on participants’ experiences with bereavement and how these affected their eating behaviours. Data analysis used the constant comparative method to generate a substantive theory grounded in the data. Memos were written throughout the process of inquiry and were integral to the analysis. Sound knowledge of theory and empirical literature relevant to the data is an important part of theorizing within a critical realist framework.
REFERENCES


Callan, B.L. & Wells, T.J. (2003). Views on community-dwelling, old-old people on barriers and aids to nutritional health, *Journal of Nursing Scholarship, 35*(3), 257-262


Vesnaver, E., Keller, H.H., Payette, H., & Shatenstein, B. (2012). Dietary resilience as described by community-dwelling older adults from the NuAge study- "If there is a will-there is a way!" Appetite, 58(2),730-738.


PART 2: JOURNAL ARTICLES
CHAPTER 5: OVERVIEW OF JOURNAL ARTICLES

Two manuscripts were prepared based on the results of the research undertaken. In the analysis, loss of commensality emerged as the catalyst for food behaviour change in widowhood. The first paper focuses on this first category of the process, the experience of loss of commensality. The results describe the loss and substantiate the experience as the catalyst for change by describing how women attribute two pivotal shifts in their food behaviours to the loss. In addition to detailing the first category of the process under study, the first paper also addresses the following research questions:

2. How do widowed older women experience eating and food-related activities?

3. How do women understand their eating behaviours to have changed since the death of their spouse?

The second paper focuses on the overall process underlying shifts in food behaviour as described by older widowed women living alone in the community. The paper addresses the first research question:

1. What is a substantive theory that explains the process of described change in the experience of eating behaviours and food-related activities among older widowed community living women who live alone?
   a. How does the process unfold?
   b. What are the major stages in the process?
   c. Who are the important participants in the process and how do they participate?
   d. What might be the underlying causal factors of the process?
The following figure provides a map to the articles and the findings:

**Paper #1: Alone at the Table: A qualitative study of food behaviour and the loss of commensality in widowhood**

**Experiencing loss of commensality meant:**
- Noticing the loss
- Sometimes are less enjoyable alone
- Eating alone means feeling alone
- Eating alone for subsistence and pleasure

<table>
<thead>
<tr>
<th>Shift 1: Simplifying foodwork</th>
<th>Shift 2: Being free from commensal habits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not worth it</td>
<td>Free from couple preferences and habits</td>
</tr>
<tr>
<td>Preferring the simple</td>
<td>Free from the commitment of commensality</td>
</tr>
</tbody>
</table>

**Paper #2: A Theory of Food Behaviour Change in Late-Life Widowhood**

**Aligning Food Behaviours with the Food-Related Self**

**Falling into New Patterns**
- Disrupted scripts
- Unscripted eating behaviour
- Food is de-personalized
- Feeling down

**Re-establishing the Personal Food System**
- Becoming mindful of food behaviours
- Reflecting on the food-related self
- Managing a meal-preparer identity
- Adjusting behaviours and rituals
- Realigning the food system
- Coping with change

**Influences**
(couple's food system, gendered experience of nutritional care, values and food-related resources, social integration)
CHAPTER 6: PAPER #1

Alone at the table: A qualitative study of food behaviour and the loss of commensality in widowhood.

Eating alone is a widely accepted determinant for increased nutritional risk in older adulthood (Hays & Roberts, 2006). Sharing meals has been associated with higher quality diets across the lifespan (Larson & Story, 2009; Locher, Robinson, Roth, Ritchie, & Burgio, 2005), potentially due to increased variety (Dean, Raats, Grunert, Lumbers, & The Food in Later Life Team, 2009; Kimura et al., 2012), longer eating times (Pliner, Bell, Hirsch, & Kinchla, 2006), and interaction during mealtime (Paquet et al., 2008).

Widowhood, an expected event for married women, usually results in a loss of regular commensality. This paper focuses on the experience of that loss in relation to food behaviour.

Background

Commensality, the act of eating with other people (Sobal & Nelson, 2003), has been of great sociological and anthropological interest because although one’s biological nutritional need can be met by consuming food as an individual, across societies meals are often shared (Fischler, 2011). Sociability has been described as an essential feature of the meal (Douglas, 1984; Makela, 2000; Sobal, 2000). Shared meals are thought to be an important activity of socialization. It defines members as a social unit and reinforces the social roles within that unit (Douglas, 1984; Simmel, 1998), thereby drawing social boundaries between those that eat together, and those that do not (Douglas, 1984; Pliner & Rozin, 2000).
There has been a long standing and increasing interest in the nutritional outcomes of shared meals, as eating with others alters the quantity and quality of foods consumed. Eating alone has long been established as a risk factor for nutritional vulnerability among older adults (Posner, Jette, Smith, & Miller, 1993), and continues to be associated with increased nutritional risk in quantitative observational research (Lennie et al., 2006; Shahar et al., 2005; Sharkey, 2002). Several researchers have shown in experimental studies that consumption is higher in the presence of others (De Castro & Brewer, 1992; Hetherington, Anderson, Norton, & Newson 2006; Pliner, Bell, Hirsch, & Kinchla, 2006). The relationship has also been found in an observational study among homebound older adults (Locher, Robinson et al. 2005) and in an intervention study whereby a Meals-on-Wheels volunteer stayed with the meal recipient over mealtime (Suda, Marske, Flaherty, Zdrodowski, & Morley, 2001).

Several studies have reported that older adults eating alone report less enjoyment of meals (Callen & Wells, 2003; Moss, Moss, Kilbride & Rubenstein, 2007; Sidenvall et al., 2000; Sheahan & Fields, 2008; Wikby & Fägerskiöld, 2004), however the reasons for which have not been fully explored and are unclear. Simmel (1998) argued the shared meal experience is part of socialization of children within a family and society. It provides an opportunity for the learning and continual reinforcement of social norms including what, how, when and with whom to eat. The shared meal thus encourages commensal partners to eat within dietary norms, which may impact the choices and quantity of food consumed. Locher and colleagues (1997) found that among homebound older adults, the regularity of meals depended on whether or not they shared meals with
others. The researchers argued that without the commensal reminders of social dietary norms, lone eaters ate when they felt hungry and not when socially prescribed.

Widowhood may be considered an expected life stage for older married women due to differences in life expectancy and cultural norms around age differences at marriage (Carr & Bodnar-Deren, 2009). Losing a spouse is one of life’s most stressful events, as it is marked by the loss of a key social and emotional relationship (Carr & Bodnar-Deren, 2009). Dietary practices are inextricably linked to this relationship through a lifetime of shared meals, a shared food environment, and ongoing negotiated food choice (Sobal & Bisogni, 2009).

Widowhood has been linked with poorer dietary quality (Han, Li, & Zheng, 2009; Heuberger & Wong, 2014; Rosenbloom & Whittington, 1993). Several studies have found widowed older adults more likely to skip meals, experience reduced enjoyment of mealtimes, and have poor appetite compared to partnered peers, all of which may contribute to diet quality (Johnson, 2002; Quandt, McDonald, Arcury, Bell, & Vitolins, 2000; Rosenbloom & Whittington, 1993; Wells & Kendig, 1997). However, no studies to our knowledge have focused on the experience of the meal in widowhood and particularly the loss of regular commensality that is typical of widowhood. In a small Canadian study (N=22, 77% female), recently bereaved older adults had significantly greater nutritional risk scores than married older adults of the same age (Johnson, 2002). Participants had expressed difficulty at mealtimes due to memories of shared mealtimes with their spouses (Johnson, 2002), suggesting a role for the loss of shared meals as a mechanism for altered food habits in widowhood. Understanding the experience of losing
regular commensality may shed light on how and why eating alone increases nutritional vulnerability and potential ways of supporting those who are bereaved.

This paper reports on a section of a larger grounded theory study examining the shifts in food behaviour in widowhood. The experience of loss of commensality emerged as an important category in the analysis as the catalyst to changes in food behaviour in widowhood (ref paper #2). This experience is the focus of this paper. Specifically, the research questions to be addressed are: (a) how did widows experience losing commensality, and (b) what shifts, if any, in their food behaviour do widows attribute to this loss of commensality?

Methods

A critical realist approach employing qualitative in-depth interviews was used to explore the loss of commensality in older widowed women, in which the perspective of the participants were viewed as constructed but founded in reality (Bhasker, 1975). Grounded Theory Methodology’s “systematic, yet flexible guidelines for collecting and analyzing qualitative data” (Charmaz, 2006, p.2) guided the data collection and analysis approach.

Sample

Participants were recruited through advertisement and in-person at senior recreation centres and one senior apartment complex, and by word of mouth in a large Canadian city. Women aged 65 years of age or older, widowed within five years, living alone in the community, cognitively well, and English-speaking were invited to participate. Three participants widowed longer were included in the study because of their eagerness to share their experiences and their assessment that they could recall and
reflect on their experience (Kvale, 1996). Of the fifteen widowed women that participated, all but two participants were white and of Canadian or European descent; half of the participants came to Canada as adults. Participants were aged 71 to 86 years \((M = 77, SD = 5.3)\) (Table 1). All but two participants had children, most living in the same city. All but two reported that they had sufficient income to meet their needs. The women had a range of educational backgrounds (Table 1). All had participated in the workforce at some point in their lives. Some left the workforce for family obligations \((n=3)\) and one remained active in non-paid work outside the home at the time of the interview.

**Data collection and analysis**

Interested participants contacted the first author (EV) by phone. Screening questions were asked to ensure eligibility and to facilitate sample diversity. Variation was initially sought in years of widowhood. Other demographic variables, having children, self-reported health, years of marriage, ethnicity, and financial adequacy were included to facilitate anticipated theoretical sampling. As the research question evolved and these variables were not needed for theoretical sampling, these questions were asked during interview instead. The screening and demographic questions were standardized and provided the demographic description detailed above. Often, widows shared considerable detail about their experience during this contact that was captured in field notes. These notes were used to prepare for or guide the interview and often provided a starting point to the conversation.

In-person interviews were conducted at a time and place of the participants’ choice. Informed signed consent was obtained at that start of the interview. Participants
were reminded that they could withdraw from the study at any time. Interviews were active (Holstein & Gubrium, 1995), conversational in style, following a loose and flexible structure. Participants were ‘partners’ in the research process (Charmaz, 2003). Viewed as experts of their own experience, participants were encouraged to participate in the creation of knowledge by being made aware of the research agenda. Interviews focused on how women’s experiences with eating, shopping and meal preparation had changed in widowhood. Specific questions about the loss of commensality and the experience of eating alone were asked. EV attended to the terms participants used for each topic, but also probed participants with diverse terms (e.g. for a meal: mealtimes, lunch, supper, breakfast, snack, in-between eating, or generally what times of the day do you eat?) to elicit a larger range of meanings, experiences, and understanding of the topic.

Data collection was concurrent with a constant comparative analysis. Throughout analysis, each code, concept and category was examined relative to the others and assessed for similarities and differences (Charmaz, 2006). As the study progressed, the interviews became more structured to facilitate theoretical sampling, enabling exploration of emergent concepts and categories (Corbin & Strauss, 2008). Interviews ranged from 1-2 hours in length and were digitally recorded. The first four interviews were transcribed by EV to immerse herself in the data and to develop a consistent system for transcription (Daly, 2007). Notes regarding non-verbals were included in the transcript based on the interviewer’s recall. The remaining interviews were transcribed by a research assistant and reviewed for faithful representation of the interview as experienced by EV. Field notes were written immediately after each interview. Field notes included description of
contact with participant before and after the recorded interview, details about the participant’s home, energy level, mood, and physical appearance, and any feelings comfortable or not that came up for EV during the interview. Emergent analytic insights were also captured. EV conducted all interviews. EV is white, female, in her early thirties, married, and a doctoral candidate in nutrition. Data were organized using Atlas.Ti (version 7). Analysis was inductive, deductive, and abductive (Charmaz, 2006, Daly, 2007). Line-by-line coding enabled interpretive naming of each segment of data. The most meaningful and explanatory labels were chosen in focused coding. Axial coding was used to organize codes into categories to understand how they were related to one another. Finally, theoretical coding was conducted selecting the most significant categories for synthesis into a unifying theory (Charmaz, 2006; Strauss & Corbin 2008). Throughout analysis, EV used her knowledge of the empirical and theoretical literature on widowhood, food behaviour in widowhood, social influences of food behaviour among older adults, and commensality to sensitize her to these concepts during interviews and analysis. EV regularly met with authors HK and OS to review the analysis, discuss challenges, and seek alternative understandings of the data. EV met regularly with all authors to review audit trail of data collection and analysis to enhance credibility, transferability, and confirmability (Patton, 2002). No concepts remained if they did not “earn” their way into the analysis (Glaser, 1978). This study was approved by the Ethics committee of the University of Guelph (Certificate #11MY004).

**Results**

For the most part, widowhood meant transitioning from sharing daily meals with their spouses to having significantly fewer opportunities for commensality; eating in
widowhood meant eating alone. The experience of losing regular commensality included noticing a loss of commensality, feeling alone when eating alone, resulting in decreased enjoyment of meals, and eating for subsistence and pleasure. Two resulting shifts in food behaviour were described: a) simplifying foodwork, and 2- being free from commensal habits.

**The experience of losing commensality**

All participants in this study described having shared meals with their spouses on a regular basis, yet at the time of interviews, all participants now ate the majority of their meals alone.

**Noticing the loss.** The loss of the shared meal did not necessarily occur with the death of the spouse. When and how participants noticed the loss varied. Although the nature of participants spouses’ participation in mealtimes and food behaviours in most cases declined over time, many participants realized the loss of commensality quite suddenly. Many felt the loss when their husbands were no longer at home either because they moved to an assisted living facility, the hospital or into a hospice. Some participants discussed experiencing continued commensality when they shared meals with their spouses in these facilities. Others felt the loss most when their husbands could not physically participate in the meal either by not sitting at the table or because they could no longer consume a ‘proper’ meal. Although for most participants, there was a distinct shift from a time where meals were shared to a time when they were not, some slowly gained ease with eating alone. For instance, one participant became accustomed to eating alone when her husband came in and out of their couple meals at the end of his life:

“Well it feels kind of funny, but you know you have to do it. But, well I’d been eating
alone a lot because my husband was in the hospital on and off for 6 years eh” (86 yrs, widowed 1 yr). As women noticed their loss of commensality, they recognized their newfound solitude in food-related activities and in life. For example, this participant widowed five years still tells of the moment with vivid emotion:

When he came home from his operation, he ate with me for one week. And the rest of the time, he couldn’t. And I just had to sit at the table, and eat [by] myself. And he sat in the living room cause he couldn’t sit in the hard chair. And I thought, sitting there, 'I’m gonna be eating alone the rest of my life!’ (70 yrs, widowed 5 yrs)

Realizing the loss meant acknowledging the change in the social context of their food behaviours. They no longer had a partner with or for which to plan, prepare, and share meals with.

**Eating alone meant feeling alone.** In widowhood, participants described that the acts of sitting alone at the table for a meal or planning the meal for themselves were constant reminders of the loss of their spouse, and often served to underline their aloneness in life. One woman was not able to sit at her dining table to eat meals anymore. She said: “It’s difficult to sit at the table now and just to eat alone. There’s something missing. I’m missing a person” (78 yrs, widowed < 1 yr).

Another described relatively independent food behaviours from her husband. They had different diets and ate many meals separately, sometimes, consuming different foods, and sometimes consuming them at different times when outside activities were prioritized over commensality. Even if shared meals were not a cornerstone of their
relationship, eating alone still provided a reminder of her loss. When asked about how eating her meals alone in widowhood differed from her marriage she shared:

…even if I was eating alone, there were days I would say to [my husband] ‘I’m cooking my meal now, do you want me to get you anything?’ You know just the finality of it now, I don’t have a choice. (73 yrs, widowed 4 yrs)

In marriage, she ate alone if she and her husband were hungry at different times, or if one had an outside engagement during mealtimes. Despite often eating alone in marriage, in widowhood the act took on a different meaning. She no longer had the option to share her meal because her husband was dead and the meal taken alone was a constant reminder of this fact.

**Mealtimes are less enjoyable alone.** When asked about the differences between eating alone and eating with their spouses, all participants described mealtimes alone as less enjoyable than when shared with their spouses. Participants described that mealtimes with their spouses were not only an occasion for the consumption of foods, but for many couples, they were a source of connection and intimacy. For example, one couple were increasingly separate in their activities due to the husband’s illness; he stayed home while she continued their outside life. Mealtimes were an opportunity for her to include him in her experiences and for them to reconnect as a couple:

…he might not have talked much but we were together and we were eating together and I would tell him things you know what happened especially in the last year when he didn’t go out as much and when I went out to do things and I would tell him about it. (77 yrs, widowed 1 yr)
Mealtimes were often a main and guaranteed opportunity for daily conversation. A widow who ran a business with her spouse felt strongly about the importance of connecting at meals as other times of the day were busy:

We’d discuss the day’s goings on at work and everything else so there was always that communication. You don’t see it so much these days but like you know when I was back home with my mom and my dad, and everybody else, we always sat down at the table and we ate together and we communicated together. (78 yrs, widowed 7 yrs)

Although all participants described shared meals as more pleasant than eating alone, the intensity with which this was described ranged: “When I make something that’s nice and I like it, yeah it’s nice and enjoyable but it’s not quite the same [as when eating with her husband]” (73 yrs, widowed 4 yrs). Even in relationships that were not described as ones offering much companionship, the conversation at mealtimes was highlighted: “You miss the conversation, even if sometimes you felt like telling him like 'take a hike'. That's okay cause at least you're having a conversation with somebody!” (74 yrs, widowed 4 yrs).

However, for some, the negative quality of the relationship predominated participants’ memory of shared meals with their spouses; loss of this regular commensality was a relief.

The superiority of sharing meals over eating alone was expressed as a common experience, even when these participants could not specifically articulate what and why exactly these shared mealtimes were better than eating alone: “I don’t know, it was better. At least you had companionship, you weren’t eating alone” (81 yrs, widowed 2 yrs).
Questions probing this claim were met with incredulous stares and remarks, indicating a strong cultural assumption of the negativity associated to eating alone.

Meals were understood as regular, expected, times of food consumption, usually discussed using the words breakfast, lunch/dinner, and supper/dinner. There were particular meals for each couple that were usually shared. It was generally these meals that became less enjoyable in widowhood. Other meals that were usually consumed alone (e.g. breakfast) were often not affected. All meals were understood as distinctly different from unplanned or less expected intake referred to as snacking, grazing, picking, or just “grabbing something” (74yrs, widowed 4 yrs).

**Eating alone for subsistence and pleasure.** Despite less enjoyable mealtime experiences, participants still ate. When participants were probed regarding their current food choices and motivations for eating, they talked about their consumption in relation to subsistence and/or gustatory pleasure. For some, hunger, health, and survival largely governed food habits in widowhood. When asked about eating alone, one widow assured the interviewer: “oh I eat when I am hungry honey” (85 yrs, widowed 3 yrs). Eating was something that had to be done for general health and wellbeing or survival, but was not described as being particularly pleasant or unpleasant: “I eat because I feel I’ve got to eat. You know what I mean? I’ve got to live. I’m not prepared to not eat anymore, and to die” (78 yrs, widowed 7 yrs). Some felt conflicted between their difficulties with mealtimes alone and their desire to eat well in order to age well. In order to resolve this dilemma, one participant changed the location of her meals and the meanings she associated with it calling it her “downtime” (78 yrs, widowed < 1 yr). As a proper meal could only be
consumed in company, constructing her mealtime differently enabled her to enjoy a simple evening meal in her sitting room without feeling deprived.

Despite less enjoyable ‘mealtimes’ described by many, this was distinct from the pleasure derived from eating food itself; enjoyment of consuming foods that participants liked did not appear to be affected. When asked about enjoyment and pleasure of food, one participant responded: “I do! Whatever I make myself I usually make it so that I love it. Ya I enjoy eating” (83 yrs, widowed 1 yr). Sometimes, focusing on the pleasure of certain foods offset the decreased enjoyment of mealtimes. When asked about the experience of eating alone, a recent widow shared:

Well it’s not as joyful anymore but I still can still enjoy, like for instance in the morning I usually enjoy my breakfast because it is a comfort food, peanut butter and honey this I enjoy and chocolate milk, that is really food I enjoy so you know I eat it alone, I read my paper with it and I enjoy that but then the rest of the day I couldn’t care less. (77 yrs, widowed 1 yr)

Even among participants that felt highly distressed about the loss of shared meals, they described that the taste of foods they liked and their ability to consume those foods as unaltered.

**First shift: simplifying foodwork**

The majority of participants described that they had significantly decreased the frequency and complexity of meal preparation. Many described that they were not ‘cooking’ at all. The result of the simplification varied greatly. For some women, not cooking anymore meant that they no longer prepared elaborate meals, but that they still prepared most meals from basic groceries. Others relied partly on commercially pre-
prepared food items while some relied completely on single-serve pre-prepared frozen meals. The majority of participants had been responsible for meal preparation in their marriages. The work and time required for such preparations was described as a relatively important part of their days. In widowhood, most had significantly decreased the frequency and complexity of cooking meals. Those that had not been responsible for meal preparation in their marriage had taken over these tasks during their husband’s illnesses and they too simplified foodwork in widowhood. The reasons for the reduction in meal preparation activities described by participants included that the cooking was *not worth it* in widowhood and some actually *preferred the simple* preparations they adopted in widowhood.

**Not worth it.** Most participants did not believe that their individual consumption merited the efforts that cooking required. Participants who had prepared the couple/family meals described numerous rewards of such work that extended far beyond the end product of the cooked meal. The work of meal preparation enabled participants to provide the nutritional care for their husbands, in some cases to ensure his health. Meal preparation also provided participants with daily opportunities to master and be appreciated for an important skill. The cooked meal in the couple enabled participants to experience a shared meal. The absence of the shared meal was an important reason participants gave for no longer cooking: “when you have to eat alone, it [cooking] doesn’t seem to be that appealing anymore” (81 yrs, widowed 2 yrs). This shared meal drew the couple together in a space of intimacy and bonding, and one’s cooking efforts were praised as a participant explained: “no I don’t like to [cook] anymore, for yourself you don’t care that much and before the people were appreciating it” (77 yrs,
widowed 1 yr). In widowhood, for the most part, meal preparation did not have any purpose beyond preparing food for personal consumption, and thus the tasks related to cooking were deemed simply not “worth it” (81 yrs, widowed 2 yrs). When cooking was not considered worth it, simplification of foodwork occurred. Participants expressed that they ‘should’ be cooking more than they did and home cooked meals were discussed as healthier and tastier. Despite these feelings, prepared meals and convenience products were often good enough as they did not require much effort and yet they satisfied hunger.

Some participants had enjoyed the tasks of meal preparation while others had not. Even among those that had enjoyed preparing the meals in their marriage, elaborate cooking was reduced in widowhood. Without the reward or obligation of commensality, many did not feel that cooking for their individual consumption was an enjoyable activity. This notion was expressed as part of the typical widowhood experience “I think most women will tell you it’s no fun cooking for one” (78 yrs, widowed 4 yrs). However, a few participants took great pleasure in preparing more elaborate meals, but even in widowhood, these were usually prepared for others such as friends or family. Those that enjoyed the activity but did not have the opportunity to prepare meals for their networks suffered a loss of this pleasurable activity.

Many participants described additional challenges with planning meals for themselves in widowhood, increasing the efforts needed in meal preparation. For example, “well my first problem is I don’t know what I want to eat. I’m having more difficulty planning meals. I don’t know what I want, so I don’t know what to shop for” (71 yrs, widowed < 1 yr). The choice to eat prepared foods was often the simplest as it enabled participants to make last minute decisions about what they felt like whether they
were going out to eat, or selecting a meal from the freezer. As well, when they shopped, they could look at the prepared meals to be inspired for what they might like to eat. They did not have difficulty planning meals when they were cooking for others (in past or present). One participant cooked for her son once a week and when asked about how she plans for that meal, she said: “you take a lot more care I think with what you make and I just ask him ‘would you like so and so?’ and I’ll make whatever he wants” (78 yrs, widowed 4 yrs). The combination of increased efforts in meal planning with reduced rewards meant that many chose to cook for themselves less in widowhood.

**Preferring the simple.** Some participants simplified foodwork because they now preferred simpler foods and no longer had to consider the preferences of another. For example, one widow who described taking care to make nutritious choices stated:

> When you’re by yourself it’s just something to fill your nutritional needs you know. I don’t mean I eat bad, like eating toast or tea or anything like that, no, no. But I don’t think that a person *has* to have a big meal. I don’t even enjoy a big meal anymore, I prefer to have just cereal and I’ll have my fruit maybe a couple hours later you know I might just do an open-faced sandwich or something you know; bun and some egg. (73 yrs, widowed 8 yrs)

Thus, widows sometimes chose easier preparations out of preference for basic foods rather than merely because they did not have sufficient motivation to engage in more elaborate meal preparations.

**Second shift: being free from commensal habits**

When participants were asked how their current habits differed from those during their marriage, they described the freedom they felt from the habits developed to suit the
needs and preferences of the couple. The regularity of commensal meals that occurred among couples provided a structure of food behaviours that was counted on, determining the what, where, and with whom of food intake and supporting activities. Participants described well-established patterns of shared meals including which meals were shared (breakfast often being consumed alone), general characteristics of those meals (e.g. “our proper meal” (78 yrs, widowed < 1 yr), and the specific times of shared meals. The patterns often depended on if one of the partners worked, if they rose together in the morning, and general preferences established by the couple. All but one participant explained planning their activities around the meals in order to prioritize commensality. Being free from commensal habits included freedom to engage in behaviours outside the established couple preferences and participate in activities that would have conflicted with the commensal meals.

**Free from couple preferences and patterns.** In widowhood, some participants maintained some parts of their previous food-related rhythms, but many did not. Some felt a freedom from these rhythms to choose foods or eating patterns other than those established in their couple. For example, they could eat at times other than the normal preferred times established when they were part of a couple.

Well I eat when I’m hungry that’s it. I mean that could be any time, that could be around 11 o’clock when I really get hungry or it could be 3 o’clock and then I don’t eat anything maybe just before I go to bed a little bit so it depends. (77 yrs, widowed 1 yr)

Participants believed that the regular mealtimes of couplehood were due to the expectation that the other needed to eat: “you can eat when you want because nobody
expects you to have something ready at a certain time right? So you only eat when you’re hungry” (77 yrs, widowed 1 yr).

**Free from the commitment of commensality.** Because there was no longer the expectation of the shared meal at a particular hour, widows had the freedom to engage in activities (eating and otherwise) that previously would have interfered with the commensal meal. Widows did not need to plan time to prepare a meal, to be home at a specific hour, or to be hungry for a specific hour. For example, when asked about her evening meal the day before the interview, one widow explained that she had had tea and cookies with friends in the afternoon and had not been particularly hungry for an evening meal and so she had a small sandwich. She concluded with “when you live on your own you can eat what you want, when you want you know?” (78 yrs, widowed 4 yrs). The interviewer probed her about how this scenario would have been different had she lived with someone else. She responded:

My husband was a meat and potatoes man, you couldn’t give him a sandwich for supper, he was a farm boy. Big meals you know? And he would want his lasagna and salad or his steak and potatoes. So that’s how it differs because you have to consider somebody else. What they would like and when you’re by yourself, you’ve only got yourself to think of. (78 yrs, widowed 4 yrs)

When her husband was alive, she may have chosen not to have cookies with her friends, in order to have an appetite for the shared meal with her husband. Many participants explained that their snacking in the afternoons had increased in widowhood specifically because they felt free of the expectation of an evening meal.
Discussion

This is the first qualitative study to explore the experience of the loss of commensality in relation to food behaviour. Older widowed women provided a unique perspective on this experience as widowhood almost always includes a drastic change in the frequency of commensal meals. The findings contribute to our understanding of commensality and its role in food behaviours.

The widows in this study realized the change quite suddenly and attributed a number of shifts in their food behaviours to this loss. These included altered experience of mealtimes, a simplification of meal preparations, and a shift away from the rhythms established by the commensal meals. For many this meant a drop in cooking activities and in regular mealtimes.

The finding that mealtimes were less enjoyable in widowhood than they were in marriage is consistent with previous research that showed significant difference in enjoyment of meals between widowed and married older adults (Callan & Well, 2003; Rosenbloom & Whittington, 1993; Shahar et al., 2001). The reasons for enjoyment were not always clear; conversation was one element of shared mealtimes that was highlighted by participants in this study and may contribute to enjoyment. Although conversation was a defining characteristic of commensal meals for the widows in this study, the attributes of commensal meals (e.g. location, connected activities or rituals, content) are culturally determined and conversation may not be universal (Ochs & Shohet, 2006). Yet, regardless of culture, commensality is thought to be a defining activity of family members, drawing the boundaries of family units (Douglas, 1984; Mennel, Murcott, &
van Otterloo, 1992; Ochs & Shohet, 2006). It follows that eating alone underlined the change in family structure and reinforced the feeling of aloneness among widows.

For the widows in this sample, the superior experience of shared meals over those consumed alone was a common assumption, suggesting that widows held definitions of the ‘meal’ that include sociality (Douglas, 1972). Academic definitions of the meal differ among disciplines (Meiselman, 2009). Examples of defining attributes include the time of day, the amount of food consumed, and the number or category of people present. Due to the diversity of language used in the interview to elicit a range of understandings, we learned that the pleasure derived from a social meal was understood as distinct from the pleasure derived from the actual consumption of food. Thus, a meal and eating may be seen as distinct. When asked to think about meals, widows focused on their loss of the social meal. Widows may hold onto definitions of a meal that include commensality, thus by definition, a meal consumed alone is inferior in experience. Previous research has identified the pleasure of food itself to be an important motivator to overcome obstacles to eating well in later life (Vesnaver, Keller, & Shatenstein, 2012). The present study asked widows to contrast their experiences of eating alone with those of shared meals with a spouse, orienting widows to their loss of social meals. The experience of eating in widowhood may be described differently if not explicitly asked in contrast to their experiences in marriage. Further work focusing only on the experience of eating alone may shed light on the role of attending to consumption or ‘eating’ of food rather than the meal proper, as a way for widows to experience their food behaviours more positively.

One mechanism of marriage hypothesized to improve health outcomes is the increased experience of social regulation (Berkman, Glass, Brisette, & Seeman, 2000).
Durkheim’s theory of social integration (1987/1951) proposed that contact with a stable social structure provides normative regulation and constrains the individual from deviant behaviour. The regular social contact by the spouse may provide encouragement of the couple’s dietary norms and dietary norms from the larger social environment (Vesnaver & Keller, 2011). These include standards such as the number of meals eaten a day, the times at which they are eaten and the types of food consumed at each occasion. Widows in this study described very different intake patterns than those they kept while sharing meals with their spouses, suggesting a loss of this regulatory mechanism.

Prioritization of commensality amongst couples described by participants in this study and elsewhere (Sobal, Bove, & Rauschenbach, 2002) may enhance the effects of social regulation during the shared meal. Participants had prioritized commensality during their marriages, often altering personal choices about food consumption or other activities in order to fully participate in the commensal meal. Participants described that shared meals with their spouses held a function beyond shared food intake; shared meals were also an opportunity for intimacy and bonding. Couples may regularly share meals for this benefit, thus further reinforcing the dietary norms of the couple and enhancing the social regulatory mechanism of commensality.

In the absence of regular commensal meals, Locher, Burgio, Yoels, and Ritchie (1997) found that older homebound adults relied on physical sensations to determine hunger rather than social conventions of regular meal patterns. Similarly, in this study, in the absence of the expected commensal mealtimes, some used hunger as an indicator to eat when they were eating alone. Relying on feelings of hunger may leave older adults nutritionally vulnerable due to increased satiety and smaller appetites (Chapman,
MacIntosh, Morley, & Horowitz, 2002). Further research examining types of meal patterns and meal scheduling strategies and dietary adequacy among older adults that eat alone may support the development of health promotion messaging that is relevant and acceptable to older adults.

Consistent with many qualitative studies of food behaviour among older adults that have found reduced interest in cooking in widowhood (Callan & Wells, 2003; Gustafsson & Sidenvall 2002; Johnson, 2002; Quandt, Vitolins, DeWalt, & Roos, 1997; Rosenbloom & Wittington, 1993; Shahar et al., 2001), the older women here significantly reduced their meal preparation activities. Meal preparation in marriage had been a substantial amount of work involving multiple components. Without the obligation of the preparing meals or the reward of commensality, widows generally did not wish to spend time preparing meals. In fact, decreasing the complexity of meals is not unique to widowhood but has been found with temporary shifts in commensality among married couples such as when one spouse is away for the commensal meal (Sobal, Bove, & Rauschenbach, 2002). Sidenvall et al (2000) had found that older women viewed the meal preparations as efforts that were exclusively for others, a ‘gift’, but women that ate alone were not able to give the gift to themselves. Here, meal preparations were evaluated as ‘not worth it’, if the meal was to be consumed alone. De Vault (1991) observed and argued that the work involved in planning, preparing, and leading family meals correspondingly “constructs” the family. In view of this, widows that had been cooking in their marriages may have not only provided basic sustenance for their couple, but by enabling the shared meal, constructed the couple. When the work only resulted in sustenance, as when eating alone in widowhood, the work was viewed as not ‘worth it’.
While many of the women expressed guilt over their lack of elaborate preparations, few were distressed about their new habits. The guilt may be suggestive of a social expectation and norm that cooked meals are superior to snacks, grazing and pre-prepared meals. A study of older women who had recently reduced their meal preparation activities were found to be redirecting their energies to other occupations; making choices about how they preferred to spend their time and energy (Lane et al., 2014). Thus widows may be actively prioritizing their activities, demoting meal preparation once mealtimes are no longer commensal as the meal no longer resulted in rewards of companionship and appreciation.

In this study, when participants reduced their meal preparation, they largely relied upon meals prepared elsewhere (restaurants, grocery stores, commercially). Evidently, widows in this sample had access to these products as a result of service and/or product availability and their physical and financial capacities with which to acquire such products. Older widows living in rural or remote areas, smaller urban centres with less variety of foodstuffs and food services, or with limited financial resources or poor health may have fewer alternatives to meal preparation.

It is not clear how the shift in eating patterns with widowhood affects overall nutritional health. Eating alone has overwhelmingly been found to increase nutritional risk among older adults (Hetherington, Anderson, Norton & Newson 2006; Lennie et al., 2006; Shahar et al., 2001), however, a decrease in complexity of meals and an altering of meal patterns does not necessitate a poor diet. Dietary measurement studies might examine the food choices and patterns of widows that have shifted to simpler meals and
snacks but are meeting their nutritional requirements, thus elucidating possible strategies for eating well within their new food behaviours.

This qualitative study enabled the in-depth exploration of the experience of the loss of commensality and food behaviour among older widowed women and the identification of key changes in food behaviour that were understood by participants as a direct result of their loss of regular shared meals. The findings suggest a framework of hypotheses for further research. Like all exploratory work, these findings are tentative. The analysis relied on retrospective in-depth retrospective interview, which enabled the collection of reflective data (Morse, 2001). Prospective observation may have yielded a different understanding. The size and selection of the sample, while appropriate for this study, do not support generalization. Participants were recruited from senior apartment complexes and recreation centers and thus had knowledge of, interest in, and were accessing community resources and services. Participants described regular contact with friends and family. The role of the loss of commensality may be experienced differently from those more socially isolated. The sample here was predominantly white; other cultural or ethnic groups may experience loss of commensality differently. This research focused on the experience of women, widowers would have unique challenges in widowhood due to the cultural expectations regarding men and women’s roles in food-related activities. Finally, grief is thought to play a role in the changes of food behaviour seen in widowhood (Rosenbloom & Wittington, 1993). While an element of grief may be present in the theme eating alone meant feeling alone, participants did not focus on grief as an important contributor to their change in food behaviour. Grief may have been a personal and difficult subject to discuss. Multiple interviews may have fostered greater
trust with the interviewer, thus facilitating the reflection and discussion of difficult topics. The present inquiry did not enable examination of grief as a factor and further research is needed to better understand its role.

Conclusions

We reported a qualitative study of the experience of loss of commensality in relation to food behaviour among older widowed women. Mealtimes were described to be less enjoyable, but pleasure experienced with food was intact. Altered food behaviours included shifts away from regular meals and simplified meal preparation strategies. Further research is needed to understand the nutritional implications of these shifts and how older widows can be supported in this transition. This research suggests that focusing on pleasure of eating via taste and other sensory attributes, as well as values held such as health as a driver of food choice, while downplaying the ‘proper meal’ may help support women when they lose regular commensality late in life.

References


Lane, K., Poland, F., Fleming, S., Lambert, N., MacDonald, H., Potter, J., ... & Hooper, L. (2014). Older women's reduced contact with food in the Changes Around Food Experience (CAFE) study: choices, adaptations and dynamism. *Ageing and Society 34*(4) 645-669.


Vesnaver, E., Keller, H.H., Payette, H., & Shatenstein, B. (2012). Dietary resilience as described by community-dwelling older adults from the NuAge study- "If there is a will-there is a way!" *Appetite, 58*(2), 730-738.


Table 1 Characteristics of Study Participants

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<td><strong>Age (yr)</strong></td>
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*(some or completed)*
CHAPTER 7: PAPER #2

A Theory of Food Behaviour Change in Late-Life Widowhood

Widowhood is an expected event for married older women (Carr & Bodnar-Deren, 2009) and has been related to poorer diet quality (Heuberger & Wong, 2014; Rosenbloom & Whittington, 1993). Late-life nutritional inadequacies can contribute to the progression of loss of function and disease (Bates et al., 2002) and consequently, a reduction in quality of life (WHOQOL Group, 1995). Some research suggests that a decline in diet quality in widowhood is temporary (Wilcox et al., 2003), however little is known about how or why eating behaviours shift in widowhood. This paper aims to address this gap with a focus on theory generation to explain eating behaviours during this vulnerable period.

Widowhood is generally regarded as a women’s issue due to sex differences in life expectancy, age differences with spouses, and the higher likelihood of remarriage of men (Carr & Bodnar-Deren, 2009). In 2001 in Canada, women 65 years and older were expected to live three years longer than men of the same age (O’Donnell et al., 2005). However, older women of today often married men that were older than them due to cultural norms, further increasing their likelihood of outliving their spouse (Carr & Bodnar-Deren, 2009). Consequently, in 2011, widows accounted for over 45% of Canadian women aged 65 years and older and they outnumbered older widowers four to one (Statistics Canada, 2011). Understanding the contributing factors of health among older widowed women will help this growing segment of the population to live in the community as long as possible.
A small body of literature presents convincing evidence that widowhood is related to altered diets and eating behaviours. Widowhood, measured as a legal marital status, has been associated with poorer energy intakes, nutritional status, and diet variety (Conklin et al., 2014; Han, Li, & Zheng, 2009; Heuberger & Wong, 2014). Furthermore, longitudinal research has shown that loss of spouse is related to a decline in diet variety, decrease in vegetable and red meat intake, and weight loss (Kwon, Suzuki, Kumagi, Shinkai, & Ukawa, 2006; Lee et al., 2005; Shahar, Schultz, Shahar, & Wing, 2001). Recently widowed older adults (widowed ≤ 4 yrs) compared to married peers are more likely to report poorer appetite, meal skipping, poorer diet quality and variety, and lower fruit and vegetable intake (Johnson, 2002; Rosenbloom & Whittington, 1993; 1997; Wells & Kendig, 1997; Wilcox et al., 2003).

Qualitative inquiry has helped to elucidate some of these findings. Johnson (2002) conducted focus groups with recently widowed (< 2yrs) older adults (N=22, 77% female) and reported that the widowed participants described loss of appetite due to emotional changes with bereavement and difficulty with mealtimes due to associated memories of the shared activity with their spouses. Participants also described reduced motivation to cook for themselves and consequently were either skipping meals or making less healthful choices. Rosenbloom and Whittington (1993) learned in one-on-one interviews that the majority of widowed women had previously enjoyed eating and mealtimes but that eating became a chore after the loss of their spouse and made worse by loneliness experienced at mealtimes. The researchers concluded that widowhood had “triggered disorganization and changes” (p. S227) in the daily routines associated with eating which resulted in a decline in nutritional quality. Quandt, McDonald, Arcury, Bell, and Vitolins
(2000) followed 12 recently widowed older women (widowed <3 yrs) over a period of three years. They reported that widowhood generally resulted in a lifting of food-related obligations as a wife. Widowed women reacted to this lifting in two ways. Some appreciated an opportunity to eat according to their personal preferences. Thus, not all changes of widowhood are necessarily negative. However others experienced a complete disorientation by the lifting of their obligations characterized by loneliness, apathy towards food and lack of appetite. Some women did not experience any lifting of food-related obligations, as these remained ongoing with other family members.

Furthermore, Quandt and colleagues (2000) compared their recently widowed sample (n=12) to a larger sample of longer term widows and found that the eating situations of those widowed longer had stabilized; most had overcome the grief that had affected their appetite and increased meal skipping. Change in nutritional adequacy was not measured in this study; however, an increase in appetite and a decrease in meal skipping may reduce nutritional vulnerability (Keller, 2007). Wilcox and colleagues (2003) also found fewer increases in nutritional and other health vulnerabilities among longer term widows (widowed > 1 yr) compared to those widowed within 1 year. These results mirror the understanding of physical and psychological health during transition to widowhood whereby the negative effects of bereavement are normal and most recover with time (Stroebe et al., 2007). However, in older adulthood, even short-term nutritional inadequacies can have negative health-related consequences (Raynaud-Simon, 2009).

Widowhood is the life stage that begins with the death of a spouse (Carr & Bodnar-Deren, 2009; Lopata, 1996) and bereavement is the psychological process of coping with this loss (Atchley, 1988). Although many studies consider widowhood as a
static state, widows “do not stand still in their mourning” (Silverman, 2004, p.91) but move between restoration- and loss- oriented behaviour (Stroebe & Schut, 1999). Eating behaviours after the death of a spouse may similarly oscillate during widowhood. The current study was undertaken to generate a theory explaining why food behaviours change among older widowed women. A theoretical understanding of this transition in relation to food behaviour may aid family members, researchers, and health practitioners to better support older women in this nutritionally vulnerable period.

Understanding food behaviours is complex as such behaviours are the product of multiple individual, social, and environmental processes that are not necessarily consistent or connected (Fine, Heasman, & Wright, 1996; Sobal, Kettel Khan, & Bisogni, 1998). Food behaviours consist of all behaviours related to the acquisition, preparation, serving, consuming, and disposing of food (Sobal & Bisogni, 2009). Furst, Connors, Bisogni, Sobal and Winter Falk (1996) proposed that the re-occurrence of making food behaviour decisions over the life course leads to the development of personal systems for food choice. The system includes value negotiation that involves the weighing of different considerations in making food choices (e.g. managing relationships, ideals of health, nutrition, taste, monetary considerations, convenience) and the strategies or scripts that evolve through habitual choice patterns. The strategies or scripts simplify the complex task of food-related decisions. One’s food ideals, personal food-related needs, preferences, identity, and resources influence the personal system. Personal systems are embedded within the social and food context to which they relate, the most proximal being their household’s food system (Sobal, Bove, & Rauschenbach, 2002; Furst et al., 1996; Schubert, 2008). When there is more than one member in the household, there are
established processes and roles regarding acquisition, preparation and consumption of food (De Vault, 1991). The sometimes competing priorities of other members affect the household food system and consequently also affect the personal system (Furst et al., 1996). Consequently, meals shared between the couple are the result of a complex negotiation about food choice (what and how much), choice of preparation, and timing of mealtimes. These negotiations usually do not occur for each meal, but couples make them over the duration of their relationship. Scripts are not set in stone, but shift as needed to accommodate change in the system or influences (Blake, Bisogni, Sobal, Jastran, & Devine, 2008). Widowhood represents a shift in the social and food context in which the personal system is embedded. Shifting in these contexts can be a source of change in personal food behaviours (Quandt, Arcury, & Bell, 1998). The aim of this study was to develop a theoretical framework of food behaviour in older widowed women living alone in the community.

**Methods**

A critical realist worldview guided the research approach in which a realist ontology is combined with a subjectivist epistemology (Bhasker, 1975). Grounded Theory Methodology, “systematic, yet flexible guidelines for collecting and analyzing qualitative data” (Charmaz, 2006, p.2), guided the data collection and analysis approach. The research was theory oriented with the aim of developing a theoretical framework of eating behaviours among older widowed women. In-depth interviews were used to explore the experiences and understandings of the participants as understood through the eyes of the researchers. Perspectives of the participants were understood in the research as constructed but founded in reality (Sayer, 2000).
Sample

Participants were recruited through advertisement and in-person at senior recreation centres and one senior apartment complex, and by word of mouth in a large Canadian city. Women aged 65 years of age or older, widowed within five years, living alone in the community, cognitively well, and English-speaking were invited to participate. Three participants widowed longer were included in the study because of their eagerness to share their experiences and their assessment that they could recall and reflect on their early widowed experience (Kvale, 1996). Of the fifteen widowed women that participated, all but two participants were white and of Canadian or European descent; half of the participants came to Canada as adults. Participants were aged 71 to 86 years ($M = 77$, $SD = 5.3$) (Table 1). All but two participants had children, most living in the same city. All but two reported that they had sufficient income to meet their needs. The women had a range of educational backgrounds (Table 1) and all had participated in the workforce at some point in their lives. Some left the workforce for family obligations ($n=3$) and one remained active in non-paid work outside the home at the time of the interview.

Data collection and analysis

Interested participants contacted the first author (EV) by phone. Screening questions were asked to ensure eligibility and to facilitate sample diversity. Variation was initially sought in years of widowhood. Other demographic variables such as having children, self-reported health, years of marriage, ethnicity, and financial adequacy were included to facilitate anticipated theoretical sampling. As the research question evolved
and these variables were not needed for theoretical sampling, these questions were asked during the interview instead to simply characterize the sample. The screening and demographic questions were standardized and provided the sample characteristics detailed above. Often, widows shared considerable detail about their experience during this initial phone contact that was captured in field notes. These notes were used to prepare for or guide the in-person interview and often provided a starting point to the conversation. Although these initial field notes were not included in the formal analysis, they often provided analytic insights (Glaser & Strauss, 1967).

In-person interviews were conducted at a time and place of the participants’ choice. Informed signed consent was obtained at that start of the interview. Participants were reminded that they could withdraw from the study at any time. Interviews were active (Holstein & Gubrium, 1995), conversational in style, and followed a loose and flexible structure. Participants were ‘partners’ in the research process (Charmaz, 2006). Viewed as experts of their own experience, participants were encouraged to participate in the creation of knowledge by being made aware of the research agenda. Interview questions focused on how the women’s experiences with eating, shopping and meal preparation had changed in widowhood.

Data collection was concurrent with a constant comparative analysis. Throughout analysis, each code, concept and category was examined relative to the others and assessed for similarities and differences (Charmaz, 2006). As the study progressed, the interviews became more structured to facilitate theoretical sampling, enabling exploration of emergent concepts and categories (Corbin & Strauss, 2008). Interviews ranged from 1-2 hours in length and were digitally recorded and all were conducted by EV. The first
four interviews were transcribed by EV to immerse herself in the data and to develop a consistent system for transcription (Daly, 2007). Notes regarding non-verbal data were included in the transcript based on the interviewer’s recall. The remaining interviews were transcribed by a research assistant and reviewed for faithful representation of the interview as experienced by EV. Field notes were written immediately after each interview. Field notes included description of contact with participant before and after the recorded interview, details about the participant’s home, mood, and physical appearance, and any feelings comfortable or not that came up for EV during the interview. Emergent analytic insights were also captured. EV is white, female, in her early thirties, married, and a doctoral candidate in nutrition.

Data were organized using qualitative data analysis software (ATLAS.ti, version 7). Analysis was inductive, deductive, and abductive (Charmaz, 2006; Daly, 2007). Line-by-line coding enabled interpretive naming of each segment of data. The most meaningful and explanatory labels were chosen in focused coding. Axial coding was used to organize codes into categories to understand how they were related to one another. Finally, theoretical coding was conducted by selecting the most significant categories for synthesis into a unifying theory (Charmaz, 2006; Strauss & Corbin 2008). Throughout analysis, EV used her knowledge of the empirical and theoretical literature on widowhood, food behaviours in widowhood, social influences of foodways among older adults, and commensality to sensitize her to these concepts during interviews and analysis. EV regularly met with authors HK and OS to review the analysis, discuss challenges, and seek alternative understandings of the data. EV met regularly with all authors to review the audit trail of data collection and analysis to enhance credibility,
transferability, and confirmability (Patton, 2002). No concepts remained if they did not “earn” their way into the analysis (Glaser, 1978). This study was approved by the Ethics committee of the University of Guelph (certificate # 11MY004).

**Results**

**Overview of the Theory**

All the women interviewed in this study described shifts in their food behaviours resulting from their husbands no longer sharing meals and the food system due to illness and/or death. The kinds of shifts described were diverse, including changes in food intake, complexity of meal preparation, frequency of preparation activities, food choice, definitions of mealtimes, scheduling of mealtimes and snacks, location of meals, and frequency of commensality (ref paper #1). We interpreted the shifts in food behaviours in widowhood as a process in which widows were aligning their food behaviours with their food-related self (henceforth, ‘Aligning process’). We observed women moving through two sub-processes: *falling into new patterns* and *re-establishing the personal food system*. These enabled women to redirect their household food system from one that satisfied the couple to one that satisfied their personal food needs. Although these sub-processes are described as chronologically distinct and sequential, some women experienced them as overlapping and/or iterative. A number of *influences* enabled or constrained different aspects of the aligning process and determined their unique trajectory. The main categories of influences on the aligning process were *the couple’s food system, gendered experience of nutritional care, values, food-related resources, and social integration*. A visual overview of the process is provided in Figure 1. One woman’s journey through the process is summarized in Figure 2.
**The Food-Related Self**

The food-related self includes the food-related preferences, dominant food-values, and food-related identity that drive one’s food decisions and behaviours (selection, acquisition, preparation, consumption of food). The food-related self is dynamic and changes over the life course (Sobal & Bisogni, 2009). In widowhood, the food-related self shifts from one that shares a household food system with another to one that requires a personal food system only to sustain oneself. This is not a linear shift, but in constant interplay with the aligning process; as food behaviours shift, the self is also changed. Similarly, as the self shifts, food behaviours change. This interaction between food behaviours and the self is discussed throughout the aligning process theory.

**Loss of Commensality**

The loss of commensality initiates the process of aligning food behaviours with the widowed self. The loss of commensality occurs when the couple no longer shares meals. Thus, losing commensality can happen prior to widowhood during a husband’s illness. It can also happen suddenly or over time depending on the nature of their spouses’ declining participation in mealtimes and food behaviours. One widow explained how her eating shifted during her husband’s long and slow decline at the end of his life: “at the onset you eat together then gradually you lose— I would say the last three or four years before he died, I would be having my own meal”(Participant (P)10). Food behaviours may also start to shift as the husband’s appetite changes with disease:

I was eating a lot lighter foods because he didn’t have the appetite for the heavier foods, like the potatoes and stuff. He just wanted soup and a salad or maybe a
sandwich. I wasn’t going to cook a meal for myself when he couldn’t eat you know.” (P09)

Finally, loss of commensality may occur when the spouse can no longer physically participate in meals, if he moves from the home into a facility, or upon his death.

Loss of commensality resulted in two types of shifts in dietary patterns among widows, namely simplification of foodwork and feeling unrestrained by commensal food behaviours. These shifts are further discussed in another publication (ref paper # 1). In the present work, we focus on the aligning process underlying these shifts.

**Falling into new patterns**

**Disrupted scripts.** Food behaviour scripts are the procedural knowledge that informs the sequence of behaviours for particular situations (Blake, Bisogni, Sobal, Jastran, & Devine, 2008). For example, the script that leads to breakfast consumption at home may include actions such as rising at a particular hour, turning on the radio or television, putting on the coffee, getting cereal from the pantry…etc. All of the actions combine to form the script that is often executed in the same manner each time the situation is encountered. Participants fell into new patterns when some of the scripts from their couple food system no longer worked in their new context. These included any scripts that were dependent on the spouse. The resultant disruptions varied depending on the unique characteristics of the couple’s food behaviours, however the scripts commonly disrupted included those related to shared meals and planning and preparing food in consideration of the spouse. For example, this woman was having difficulties with planning and shopping after her husband passed:
My habit was: shop with sales flyers on the weekend, buy the best buys, plan my meals around that. So um, shopping was different. Buying more, having more stuff in the house on hand. Working with that. [Interviewer (I): how come that doesn’t work for you anymore?] Well, having to make a meal for one is much different - look most recipes make for four. So I find when I do that, I’m making up a batch of something and I’m eating it you know like most of the week. It gets boring. (P12)

Others had scripts disrupted regarding the kinds of meals they consumed, such as eating what was thought to be a ‘proper’ meal: “if I’m having a proper meal…company is crucial” (P15). Without company for the shared meal, this widow felt unable to fathom planning, cooking, and consuming what she understood to be a proper meal. Often the script of the timing of eating occasions was disrupted, such as preparing breakfast at a specific time based on the spouse’s normal rising time (P13). Others had scripts disrupted that in part determined food choice for the day such as important elements of the shared meal: “He always preferred to have a piece of meat at supper” (P11). For those largely not responsible for food behaviours in their couple, their scripts such as “coming to the table” (P08) no longer resulted in consumption of a meal. Yet, participants still engaged in food behaviours despite these broken scripts. How participants responded to broken scripts varied and is further discussed below.

**Unscripted eating behaviours.** Food behaviours result from a spontaneous negotiation of values within the constraints of one’s food context and resources (Furst et al., 1996). When situations that had previously been scripted were faced without a script, it seemed that women were spontaneously negotiating their dominant values and
resources to guide their eating behaviours. For example, many women subsisted on fast food and convenience foods when their husbands were in hospital or other institutions, while others struggled to prepare foods at home for themselves in the limited time before, after, and between visits to their spouse. These divergent behaviours could be understood within the context of the participants’ expressed values regarding preparation of food, as some did not consider pre-prepared foods viable options. These negotiations and resultant behaviours were also free from any guiding norms or structures of the couple’s food system. The example described previously, in which the timing of breakfast had been scripted based on the spouse’s rising time, resulted in the participant no longer rising as early. She explained: “well I eat when I’m hungry that’s it. I mean that could be any time, that could be around 11 o’clock when I really get hungry or it could be three o’clock” (P13). She felt no need to maintain the schedule and structure from her couple’s food system.

The resulting unscripted behaviours varied between participants. For example, behaviours in response to disruptions in scripts related to commensal meals varied from not eating “proper” meals altogether (because in their view a proper meal is not possible in solitude), to turning on the television or radio during meals to feel less alone, to carrying on with the same behaviours but with reduced enjoyment. The scripted situations that were disrupted by the loss of commensality varied, further adding to the variation found in widows’ food behaviours. As these new food-related behaviours were repeated, new patterns began to fall into place. These new patterns were considered temporary during this period of getting used to a new social context. Because of their perceived temporary nature, women suspended evaluation of these behaviours and felt
free to step outside of the dominant food-values they held. Consequently, new patterns were often not congruent with the women’s expressed food values and ideals. For example, one widow shared how she fell into new patterns of eating pre-prepared foods:

> It changed a lot because I mean he didn’t want to eat, therefore you didn’t cook much eh. You try to cook something that he might eat, but he didn’t eat it you know? It got to the point where you didn’t have the appetite to eat yourself. [I: Why did it affect your appetite?] I don’t know, I just didn’t feel like it, or I’d eat the wrong food you know. I’d eat something frozen and fast-food…I don’t know, I thought it was easier … (P08)

Despite judging her choices as wrong, convenience was prioritized over her expressed values of health and eating home-cooked foods.

**Food is deprioritized.** For some, the challenges of disrupted scripts were compounded by deprioritizing personal nutrition for the period of time when they were caring for ill spouses and/or shortly after the death of their spouses. Among caregivers, the focus was on feeding their ill husbands and shuttling to and from various health care providers; they ate in-between, whatever there was, and often purchased foods. One participant shared: “when my husband was dying I ate. I was at the hospital three times a day, sometimes four for over a month at one period of time. Everything I ate though I purchased cooked. I didn’t cook then” (P05). Another woman who lost a lot of weight during her husband’s illness explained: “and then he was in and out of the hospital a lot and you know, I’d skip lunch and when I came home I’d be too tired to cook so I’d have a sandwich or something” (P09). Discussions about participants’ food behaviours at home during their husband’s illness centered on their husband’s appetites and intake:
His appetite was reduced, he wasn’t eating as well and then it got to a point when he would say ‘I can’t eat that’ and I said ‘well what’s the matter with it? You don’t like it? Would you like me to prepare something else.’ ‘No, it’s not, I like it but I can’t eat it.’ So that was discouraging. Think, preparing what I thought would be a meal that he’d enjoy and having him look at me and say ‘I can’t eat that.’ (P12)

Upon their spouse’s passing, there were an overwhelming number of tasks to be attended to including new responsibilities with steep learning curves. For example, like many participants, the following woman re-directed the conversation away from food when discussing the challenges surrounding the illness and death of her spouse:

When he first died it was dramatic, he died of cancer, and it was dramatic. And I, well I didn’t stop eating, but I had an awful lot of [difficulties], we had our own business, a tool and die making business. And you know he got sick and I still had to try to run it, but I mean, I’m not a tool and die maker so, you know what I mean? I was having to bring stuff home like quotes and stuff... I was just running ragged here you know? (P07)

In this period of transition, convenience and ease of preparation were prioritized. Scripts help to reduce the cognitive processing required in food decisions (Blake et al., 2008). When scripts were disrupted and food was deprioritized, food behaviours were more impulsive and less conscious. Participants simply did not have the time or energy to allocate any more attention to food.

**Feeling down.** Finally, some participants described new patterns of food behaviours due to depression or a depressed mood. In widowhood, participants described
that they spent more time alone and in the house, they felt lonely and sometimes overwhelmed, and they grieved their spouse and the couple world many felt expelled from. Depression was said to affect appetite and interest in preparing meals. As this participant explained:

Well you know if you’re feeling depressed and lonely and fed up you can’t be bothered to cook. [I: were you hungry at all when you were not cooking?] Not, not specially. I really can’t remember, I mean but [the cooking] was very minimal. I would just have soup or something you know? You know when you’re truly depressed you have no appetite. (P07)

When another participant was asked what eating was like in the first year after her husband’s death: “Oh I was not hungry and I was very depressed” (P03). She described lying on the couch not wanting to do anything, which included fixing something to eat. Some participants started to constantly snack between meals and associated this with their mood. For example:

When I’m depressed I pick. If there’s candy in the house, I’m into the candies, if there’s cookies I’ll eat cookies or if there’s ice cream I’ll have ice cream. I pick a lot when I’m depressed. So when I pick a lot, I don’t eat meals because I’m not hungry, I’ve already eaten. (P09)

Eating was used as a coping mechanism to deal with negative emotions. It was also used as an activity to fill long afternoons and evenings spent alone. Snacking as coping was interpreted as distinct from the snacking that was part of general grazing patterns that some participants had developed. The former was related to mood, and participants often
struggled with this behaviour. The latter generally replaced the three meals per day structure rather than interfered with it.

**Summary.** Participants fell into new patterns when couple-dependent food behaviours scripts were disrupted. Food behaviour decisions were made spontaneously based on dominant values and resources held at the time by participants. As decisions and resultant behaviours were repeated, patterns developed. Deprioritized food compounded the challenges of disrupted scripts for some participants. Behaviours resulting from disrupted scripts were often discordant with participants’ expressed food-related values. Women sanctioned their new patterns as long as they felt their situation was temporary. These new patterns were not viewed as a long-term personal food system. Finally, some participants described new food behaviours and patterns that were attributed to depressed mood.

**Re-establishing the Personal Food System**

**Becoming mindful of food behaviours.** Widows discussed becoming mindful of their food behaviours and evaluating the new patterns they had fallen into due to the disruption of scripts that resulted from the loss of commensality. They evaluated how their food behaviours aligned with their food-related preferences, dominant values, and food-related identity in their new social context. This evaluation was usually triggered by a realization that their new patterns deviated from their couple’s patterns, their espoused values, or perceived social norms. Some participants were alerted by solicited or unsolicited feedback from their community. A widow who had fallen into the pattern of replacing her noon and evening meals with continuous grazing shared how she became aware that others did not share her pattern:
Well people would say ‘what did you have for supper?’ [I: Who would say that?]

Friends would, oh they’d talk about food and say ‘what did you have for supper?’ ‘Um well, mmm’. And very embarrassed and I thought they’re going to think that I – well I don’t know what I thought, I just thought that people should have one meal. One – breakfast definitely and one meal a day. (P14)

Becoming aware that her new patterns deviated from social norms triggered evaluation. She ultimately decided that her new patterns were not meeting her values of health and worked to re-align them. Physical feedback such as body weight, change in sleep patterns or general feelings of wellness also triggered evaluation of their food behaviours. This participant noticed a decrease in sleep quality when she stopped eating a substantial evening meal in widowhood: “I was waking up at night and being restless and [couldn’t] get back to sleep and I thought is it because I’m hungry?” (P15). Yet, evaluation did not always lead into re-establishment of the personal food system. Sometimes participants’ new patterns were evaluated to be discordant with their longer-term values, but still viewed the patterns as temporary: “I’m in transition now” (P05).

For other women, evaluation led to a decision to re-establish the personal food system. As this woman described, she made a decision to take responsibility for her physical, emotional, and financial health, “you have to get yourself together” (P07). Being overwhelmed by widowhood could only go on for a finite period in her view. When food behaviours were judged to be misaligned with their food-related self, widows expressed dissatisfaction with their food behaviours and related in interviews what they ‘should’ be doing. When a woman’s doctor recommended weight loss, she evaluated that her new patterns were not aligned with her values of health. She started feeling uneasy
with her new patterns of increasing snacking and a drastic reduction in the amount of cooked meals she consumed:

I think I should do more than I do. I have one friend who it’s T.V. dinners and MacDonald’s. That’s all she eats and I have another friend who cooks, she’s 93 years old and she cooks every night. She cooks herself dinner. And here am I, 20 years younger, well not quite 20 years younger but here I am; I don’t cook. (P09)

She managed her discomfort with her misalignment by presenting her own habits as a middle ground between unhealthy and healthy patterns. Feeling this misalignment prompted women to work to re-establish their personal food system and thus realign their food behaviours. Evaluating the alignment occurred regularly throughout the Aligning process with each shift in food behaviour or self (as described below).

**Reflecting upon the food-related self.** In the process of re-establishing their personal food system, participants used the opportunity to reflect upon their food-related self to which they were aligning their behaviors. For some it was an opportunity to re-evaluate their food preferences. Did they like to eat three square meals a day? When did they like them? When they fell into new patterns, some tried food behaviours that were new to them and discovered that they liked these new ways, while others found confirmation that these behaviours were not appropriate for their more permanent personal food system. The evaluation included any aspect of food behaviours, including ones related to the buying of food, food choice, methods of preparation, and how, where, when and with whom food is consumed. One woman described how she learned that she loved to eat a “comfort meal” late at night in bed. This is what she called a supporting meal (to her main midday meal), replacing her supper:
It started when I become very active in live performances. When I realized that when I eat [a] meal, I go to sleep. Then I stopped eating my meal before I go – I don’t eat a meal before I attend an event. And that’s when I find out what I love [to eat a comfort meal in bed], I enjoy that. (P10)

She never discovered this way of eating in marriage “well because you had family meals”; it became her preferred way of eating, even when she was not attending an evening event.

One’s dominant values that drive food behaviours were also reflected upon. Women asked the question, what is important to me about food in this new context? Women’s food-related values were diverse (see Influences for full description of range). For example, many women discovered that they enjoyed simplified or no meal preparation, but many also held the dominant value that foods should be home-cooked, which resulted in internal conflict for some. To resolve the conflict, some adjusted the prioritization of their values. For example, this woman never liked cooking but valued providing her husband with a cooked evening meal when she was married: “I used to leave the business early and go home and cook meals so that by the time he came home there was a proper meal.” (P07) In widowhood, a proper meal to eat alone was not as important to her and she valued the convenience of pre-prepared foods instead: “when you’re all by yourself you can just pick whatever you want. So I always go [to the store] and pick a nice salad, ‘oh yes that will do’. You know, I look forward to that” (P07).

Women shifted their value prioritization when previously dominant values no longer made sense in their new context. They also shifted their value prioritization if they
discovered new food-related preferences in widowhood, which conflicted with previously dominant values.

The food-related self also includes food-related identity, which was fairly constant in widowhood. However, elaborate meal preparation declined for most participants (ref paper #1), resulting in a need to make sense of this identity in their new context.

**Managing a meal-preparer identity.** Participants often brought up the identities tied to their values of food preparation. For example, a woman had spent most of her time in the kitchen in marriage, preparing three meals a day, and prided herself on “being the kind of person” that made everything from scratch “if I wanted a rotisserie chicken, I didn’t go buy one – I roasted it.” In widowhood, she felt she did not have the same opportunity or desire to cook. She re-invested the time she previously spent in the kitchen in activities outside of the house, and had come to describe herself as someone who was too busy to spend so much time in the kitchen “I spend most of my day out of the house [now]” (P12). This was a common way for the many women in this study who held strong meal preparer identities to manage the drastic decrease in demand for their food-related activities. With the loss of their spouse, they no longer had anyone to prepare meals for beside themselves. For many, this loss combined with a declining interest in meal preparation resulted in much less time spent involved in food-related activities. Many shifted their focus and energy to other activities outside of food. Concurrently, women shifted their identities to include these other activities as well.
Strong identities related to meal-preparation for a family or spouse did not always require abandonment in widowhood. One widow had continued cooking regularly, but less often. She used her meal-preparer identity to explain why she continued cooking.

“I eat pretty well the same thing, only I don’t cook for two, I only cook for one […] [I: some women find they lose interest in cooking] Well you know what, I started cooking when I - oh I cooked all the time, I had no choice, I had to cook myself. So, so I cook. And I don’t mind cooking really, cause when I was in my younger days you know, when my legs were better, I use to make my own bread and I use to have a big garden.” (P06)

When probed if she felt any relief in widowhood, not having to make certain foods for her husband, or having to cook less often she responded: “I used to like doing that. It didn’t bother me none. Cause that was my job.” Pride in her lifelong role and the skills she developed helped her to continue cooking for herself despite physical challenges.

**Adjusting behaviours and rituals.** In order to re-establish the personal food system, some participants adjusted their food behaviors. The adjustment often required some trial and error; new behaviours were trialed in an effort to align food behaviours with the food-related self (preferences, dominant values, and identities). These behaviours were thought of as temporary until evaluated as satisfactory. For example, participants tried different strategies of meal preparation, shopping, or meal patterning. A participant explained: “I have been trying to become a bit more disciplined about [cooking]…like I’d be cooking up tonight, a bean and vegetable mix sort of a curry, and then brown rice and that will last me for about four days” (P04). When successful, these strategies become part of the re-established personal food system. When not, the
strategies got retired “I realized that being out all day and coming home tired to try and cook a meal wasn’t working” (P15).

Rituals are repeated behaviours that are laden with symbolic meaning (Fiese et al., 2002) such as preparing of specific foods on weekends or holidays, or methods of preparation that connect oneself to a cultural community. When rituals were adjusted, participants found ways to maintain the symbolic meaning that the behaviour had promoted. For example, participants discussed special meals often linking them to their cultural group or childhood family. One participant who no longer cooked was able to replace these special foods she and her mother had prepared “cabbage rolls and dumplings, those were our meals” (P03) with purchased meals from a local restaurant that she found satisfactory. Others however continued to prepare these special meals, even if it was the only meal preparation activities they engaged in, possibly because they found no satisfactory substitutes. Some behaviours also helped to preserve former couple rituals and symbols. Although no longer physically shared with the spouse, engaging in these rituals alone within their new personal food system helped some widows to preserve the memory and the enjoyment of that ritual. For example, one widow continued to have a glass of wine with her evening meal and remembered the joy of clinking glasses with her husband over a meal (P01).

Sometimes members of participants’ social networks encouraged trialing of new behaviours. One widow related how her daughter helped her to find a new strategy that fit well in her personal food system. She had been struggling with eating foods that had been kept too long in her refrigerator. She recognized this behaviour as unhealthy but was unable to keep track of how long foods had been kept. Her daughter began periodically
cleaning out her fridge for her and introduced her to catered single-serve frozen meals as a potential solution. The widow tried the meals and found them to be very satisfactory:

They’re good. Honey, they give you a menu, you pick whatever you want. So my daughter and I, we take a menu and mark soup and everything, dessert and they’re just good! I don’t think I want to cook again. It’s good and it’s for $6 a day! (P03)

This behaviour helped her to align her values of ‘home-cooked’ foods (the service provides foods that she considers familiar and wholesome), frugality, and health by eliminating her challenges with food management.

**Routinizing the food system.** As women became satisfied with how their food behaviours aligned with their food-related self, they re-scripted certain food behaviours and routinized their new personal food system. Widows that achieved this were satisfied with their personal food system and spoke about their choices with confidence “oh I don’t worry about [my eating habits] because I eat a balance. I look for the kind of food that I’m eating and it has nutritious value, right? So it keeps me healthy” (P10). The food decisions became more scripted and thus routine; for example, the same widow shared her daily pattern “I don’t eat breakfast. I’ve not have had the habit of eating breakfast for a long time now, more than 50 years. So my main meal is lunch. Unless I’m having company then I switch it to dinner. So I get one main meal a day and the other is considered a support meal” (P10). Her support meal was a new structure of meal she introduced when she re-established her personal food system. As adopted behaviours were repeated in the new personal food system, they became more stable. The new system supported feeding the food-related self in its current state and resultant food behaviours were congruent with dominant values. For example, a widow who required
company to consume a “proper meal” arranged “[to] meet friends for one proper meal a day” (P15). When she was unable to arrange the meal, she went to a local grocery store and found company “in their little dining area, there’s always someone I can look at and they will smile, and a conversation starts, and I end up moving to their table, they say ‘well don’t eat alone, come here!’” (P15).

Women described often not being able to achieve perfect alignment of their new routinized food behaviours with their preferences, values, and identity due to constraints in resources, health, and social context. A participant had described herself in her marriage as an excellent cook who enjoyed receiving her friends: “my friends were always delighted to be invited to my house for dinner, and always praised the meals that I served them and that felt good” (P12). However, in widowhood, not only did she lose her spouse, but her other social relationships changed. She explained, “I don’t know what’s happened to the friendships we had, a lot of the friends were friends of my husband’s, and those friendships although they’re still there but we’re not socializing anymore together.” She also described being “out of practice” and she had difficulty cooking elaborate meals as she had before. When asked if she had interest in rebuilding those skills, she said quietly “no, I’ve put it aside.” Although she still spoke as if she held onto the identity of ‘cook extraordinaire’, she felt unable to align all the necessary components to enact the identity and had accepted her current reality. Similarly, to value above anything else the sharing of a meal with an intimate companion was very difficult to uphold in widowhood. In re-establishing the personal food system, widows sometimes were able to find ways to live within these constraints; adjusting values to prioritize eating for survival over sharing the meal was one way for the widow to overcome this
challenge. However, some simply accepted that their food behaviours could not align perfectly in this new context and their personal food system was routinized with imperfect alignment.

**Coping with food behaviour change.** The very fact that widows needed a personal food system that was distinct from one’s previous couple’s food system underlined their widowhood and their loss. As women re-established a food system for one, they were confronted with their new social context. Some experienced strong emotions with these changes. In widowhood, the many daily activities of food behaviours such as eating alone, shopping and cooking for one were constant reminders of their present solitude in their food behaviours. For some this extended beyond food behaviours to a feeling of aloneness in the world. One widow had not only experienced the death of her husband but was profoundly affected by the death of her friends, cousins, nephew, and neighbours compounding her loneliness. This was reflected in her response to a question about her feelings towards no longer sharing daily meals: “Well sure I miss it. Now I feel alone. I feel like an old duck sitting here by myself” (P06). Sitting at the table alone was a symbol of her increasing age and that of her contemporaries. Another participant, was confronted with her new reality every time she shopped for herself:

It’s discouraging. I go into the grocery and of course the produce department is where you go first and there are all of these people walking along throwing in big bunches of veggies you know all your salad ingredients, but I’m going through what can I simply pick up that would be okay for just me. (P12)
This widow saw herself as distinctly different from ‘all these people’ among whom she used to count herself. In marriage, she needed no special foods, packaging, or services (such as asking grocery staff to halve packages of produce or meat).

While this woman felt estranged from the larger group, others described identifying with a new social group of widows. Identifying oneself as the ‘widow’ sanctioned deviations from the couple system, as they believed these new behaviours were normal for this group. This sanctioning facilitated changes to their longer-term personal food system in widowhood. For example, one widow that had shifted to eating mostly pre-prepared foods rationalized this new behaviour by saying that “I never used to do it before when I had a husband. But I do it quite a bit now. I don’t know it’s just that I think most [widows] will tell you it’s no fun cooking for one” (P09). Furthermore, participants described that many of their friends were also widows enabling social eating behaviours that may not have been part of their couple food system. For example, “a lot of us older girls, we were all in the same boat so we’d go out for lunch just cause it was Tuesday or something you know?” (P07)

For others, their food behaviours were a way to hold onto their couple and the roles they played in that relationship. One participant that had been widowed for five years provided a striking example as she engaged in food behaviours that were harmful in her present context but enabled her to hold onto aspects of being a ‘wife’. She emphasized on numerous occasions throughout the interview how poor and ‘erratic’ her diet was. For example:

I am not a good eater. I am very finicky, and I hate cooking for one. And I throw out more food than I eat. [I: Can you tell me about why that is?] Well I am used to
cooking for more than one; always have been. And I’m just so tired of food. It’s not important to me anymore, except I have to eat. (P05)

She purchased too many groceries, sometimes cooked in large quantities, sometimes did not cook at all. In this case, she was unable to cope and unable to leave behind her couple-dependent scripts, resulting in behaviours she was not satisfied with, but still unwilling to change. We learned that she held a strong cooking-related identity centered on cooking gourmet meals for her husband. She had cultivated this role in her retirement, while he was still working.

See I retired at 64 and I had all the time to cook, or to think about cooking. When [my husband] came home, that was a special time of day for me. We were quite isolated, the two of us.

He died before retiring. She felt robbed of the time they would have had together and she held on strongly to the meaning of cooking for her husband, which was an important role she played in their relationship. She struggled with her diet and she expressed that she should be eating better. She spoke with pride about being a “good cook”, and still enjoyed consuming good food, but maintained that she was not able to cook for herself, “cook for what, one person? I didn’t even know if I know how to do that! Never be able to change habits you’ve had for a long time” (P05).

Similarly, she also continued to shop as if she was cooking for others: “Oh I shop. I shop, way more than I can eat. Yeah, my cupboards are full of stuff. I don’t know what it is!” Cooking and shopping only for herself may have signified that she would have to accept that she was alone, that her role as a wife with an appreciative husband was no longer. It should be noted that she did not maintain all habits from her couple’s food
system: she no longer cooked the evening meal and she no longer ate three meals a day, suggesting that her reluctance to cook for herself was not simply a result of difficulty in changing habits as she stated, but of her state of coping with her aloneness.

The meanings women attached to the changes in food behaviours also affected how they coped with the changes experienced. When women associated the changes with the loss of their husband, they related their experiences with greater distress, loss of control, depressed affect, and struggle. When women attached new meanings to the changes such as freedom to eat according to their preferences, re-evaluated values and identities, they related their experiences from a place of control, independence, and self-determination. For example, one widow was not able to eat meals at her dining table anymore because the dining table was only for sharing meals, she said: “And it’s difficult to sit at the table now and just to eat alone. There’s something missing, I’m missing a person.” (P15). Although she related this with great feeling and a sense of loss, she actively attempted to change the meanings she attached to her meals. When describing how she took her meals (in her recliner) she said: “Well I say to myself ‘well this is my down time, I’ve had a busy day, it’s time for me to relax’. So I can easily relax in a quiet environment and don’t miss a person to eat with.” (P15) Another participant expressed no desire to alter the meanings she associated with certain changes. When she looked at her dining room table, she saw an empty chair that was vacated shortly after her spouse came home from the hospital for the last time. She explained with great emotion:

For one week he ate with me. And the rest of the time, he couldn’t. And I just had to sit at the table, and I eat myself. And he sat in the living room cause he couldn’t sit in the hard chair. And I thought, sitting there, I said, 'I’m gonna be eating alone
the rest of my life!’ It was um, quite a revelation. And it ended up he couldn’t eat at all. (P05)

In widowhood, she never ate at the dining table, and showed no interest: “I don’t want to sit at the table by myself, I did that” (P05).

At different times in the interview, women related the same change from different lenses, sometimes fiercely independent and in charge, and at other times, feeling lost, and left behind. For example one widow referred many times to the freedom she had in widowhood to eat “when you want, whatever you want” (P09), this freedom allowed her to snack with girlfriends in the afternoon because there was no expectation of a shared meal in the evening. However this same freedom turns into a burden when she felt alone and there was no one to wait for to share a meal: snacking turned into overeating and drinking through the afternoon and evening. Thus coping with a changing personal food system was sometimes an oscillation between focusing on the past with a sense of loss and focusing on the present with a sense self-determination.

**Summary.** Women re-established their personal food system as they made mindful adaptions to their food behaviours. In this sub-process, widows evaluated the alignment of their food behaviours with their food-related self. They reflected on and sometimes re-evaluated their food-related preferences and dominant values. Some managed or modified their meal-preparer identity in widowhood. Some behaviours shifted as needed to align with the self and when satisfactory, food behaviours were re-scripted and routinized. Participants coped with these changes to their food behaviours and self in different ways. Women experienced these categories not as linear steps in a re-
establishing process but as intertwined, one dynamically compelling or reinforcing another.

**Influences**

The unique trajectory of the aligning process for participants was determined by a set of influences that enabled or constrained different aspects of the process. The main categories of influences on the aligning process were the couple’s food system, gendered experience of nutritional care, values, resources, and social integration.

**The couple’s food system.** In this research, the couple’s food system was described as unique as the couple itself. This food system involved a set of established food behaviours that had been negotiated over the lifetime of the couple. There were defined agreements and roles regarding acquisition, preparation and consumption of food. What foods were kept in the pantry? Who made those decisions? Who did the grocery shopping? Mealtimes were the result of complex negotiation about food choice, choice of preparation, timing of mealtimes and other ritual activities connected to the meals (such as prayer, talking about the day’s activities, watching television). The agreements and roles within the couple’s food system were not fixed, but shifted as needed to accommodate change through the life course (e.g. change in diagnosis, children leaving home). The food behaviours that made up the couple’s food system were sometimes described as deeply ingrained habits. These habits were carried into the aligning process as the widow’s starting point. How each member of the couple was involved in the couple’s food system also impacted how the surviving member needed to readjust to the absence. For example, readjustment from a system where the husband was responsible for the shopping (and was the sole licensed driver) would be quite different than if the
wife had done all the shopping. There would also be significant readjustment within planning if meals were arranged primarily around the husband’s unique preferences than if they had shared preferences, or if planning was centered on the wife’s preferences. These are only a few examples of how different couple systems result in drastically different ways in which the aligning process unfolded.

**Gendered experience of nutritional care.** For women, feeding is a highly complex construct that is interwoven with caring for one’s family and the gendered expectations of feeding responsibilities (DeVault, 1991). Whether or not women cooked in their marriage or their feelings about the activity, all drew from this gendered discourse when relating their responsibilities to feed their families, ultimately complicating their relationship with food beyond simply self-nourishment. How women engaged with this gendered activity throughout their life course impacted how they aligned their food behaviours in widowhood. For example, some women who were very focused on the nutritional care of their families to the exclusion of their own needs, had difficulty acknowledging and accepting their needs and preferences as valid targets for their new personal food system. Others were so relieved to be free of the burden of responsibility to others that they eagerly focused on their own needs. Furthermore, women judged their level of engagement in food-related activities in widowhood in light of this discourse; for example labeling themselves as poor participants if they were ‘never much of a cook’ or saying they *should* be cooking more in widowhood (even if they never liked it or never did it in marriage). Women’s relationship with the gendered expectations of feeding responsibilities followed them into widowhood despite no longer having anyone to feed.
Values. Each woman’s individual set of food-related values and their relative prioritization influences the food-related decisions she makes (Connors, Bisogni, Sobal, & Devine, 2001). Participants described diverse values that influenced their decisions including taste, pleasure, convenience, health, food quality, survival, economy, management of relationships, commensality, and food preparation. The set of values held by an individual set out a certain range of behaviours from which she chose, particularly when her scripts were disrupted. For example, if health had been a primary driver of food decisions in the past, a woman was less likely to regularly turn to options she viewed as less healthful. It also informed how she re-established her personal food system. Women with different sets of values adjusted their personal food system to reflect their own values, resulting in very different sets of food behaviours.

The importance of food for the individual in general influenced how long she engaged in unscripted eating as she fell into new patterns. Women who ascribed high importance to the smooth functioning of their personal food system did not tolerate temporary patterns for long and quickly worked to re-establish their personal food system. Those for whom food was less important in their larger set of values required temporary patterns for longer as they prioritized other aspects of their life.

Resources. A woman’s financial, physical, and social resources affected the options for food behaviours she had available to her. For example, many women relied on pre-prepared foods, eating in restaurants daily, and a variety of paid support services, options only available to those with sufficient financial resources. Similarly, cooking required sufficient physical health to shop and engage in preparation activities. Finally, when these resources were lacking, a social network they could rely on to help them in
their food behaviours also affected how their alignment process (such as help with shopping and transportation). Social resources were not only used to make up for physical and financial challenges, but also to facilitate certain preferences such as sharing meals. For example, one woman shared meals with friends three times a week, and she had sufficient social resources to enable her to do this. Another woman relied heavily on her daughter to do her grocery shopping that she did not feel comfortable asking anything more saying that “And my people can’t be with me all the time because they’re working. They got more to do than to picnic you know?” (P06). Thus not only the existence of resources but how women utilized these resources impacted their trajectory.

**Social integration.** Durkheim’s theory of social integration (1987/1951) proposed that contact with a stable social structure provides normative regulation and constrains the individual from deviant behaviour. Social contact influenced how women experienced the aligning process. When women were falling into new patterns, some participants described that family members were providing active social control, asking questions about what they were eating. In some cases this oversight by family was viewed as helpful, keeping them from “going off the deep end” (P02) with respect to food. Despite being helpful, this form of contact was often also viewed as annoying. Constant contact reminded participants of what their usual eating patterns looked like and thus they deviated less from these patterns. Some participants described feeling freer to deviate when their contacts were not present. One participant explained that she was happy her daughter did not live with her and thus did not witness her behaving in a way unlike her usual self. Similarly, when participants were re-establishing the personal food system, social contacts provided them information about other possible ‘normal’
behaviour. Particularly when participants were connected with other widowed women, they learned of social norms regarding this group, sometimes facilitating behaviours that would have seemed unacceptable before. Thus a woman’s social community and her type of contact with this community affected her alignment process.

**Discussion**

Several studies have reported significant differences in diet between older widowed and married persons and a small body of research has identified a number of concepts that shed light on this difference. However, this is the first theory-oriented study which sought to develop a theoretical framework to explain the shifts in food behaviours in widowhood. The critical realist approach and qualitative methods provided new understandings about the nature and underlying mechanisms of the shifts in food behaviour in widowhood.

**Loss of Commensality in Widowhood Transforms Older Women’s Eating Behaviours**

The changing food behaviours in widowhood highlighted by the two emergent sub-processes is consistent with prior literature that suggests that diet and food behaviours change after the death of a spouse (Johnson, 2002; Rosenbloom & Whittington, 1993). Our analysis highlighted the loss of commensality as the key catalyst of change, which often occurred prior to the spouse’s death. Similarly, Quandt et al. (2000) found the transition of widowhood began prior to the spouse’s death with their terminal illness. The concept of food behaviour scripts enabled a new perspective of the changes in food behaviours associated with this transition. Unscripted behaviour for some resulted in new habitual food behaviours. The first type of shift in behaviour occurred...
with little attention paid to the shift, which was understood by these women as temporary for the period of the transition.

It has been suggested in prior literature that in widowhood, there is initially a shift towards dietary vulnerability and then a recovery from such vulnerability (Wilcox et al., 2003). The re-establishment of the personal food system conceptualized here characterized by conscious re-definition of the food-related self suggests a transformation rather than a recovery from stress (Martin-Matthews, 1999). The transformation included the trial of new behaviours and for some the solicitation of others for feedback regarding their food behaviours. Further research should examine whether the re-establishment process may also include receptivity to outside intervention.

Our findings of stabilized food behaviours of the re-established personal food system echo the findings of Quandt et al (2000) that found more stable eating behaviours among longer-term widows. Routines leading to satisfactory behaviours provide comfort and predictability (Jastran et al., 2009). However, stability does not indicate the healthfulness of the diet. Widowhood, irrespective of time since the death of their spouse, has been associated with poorer vegetable and energy intake (Heuberger & Wong, 2014; Wilcox et al., 2003) and poorer nutritional status (Han, Li, & Zheng, 2009). Research examining the quality of diet in widowhood once a widow describes that she is satisfied and stable in her eating habits would help to elucidate the longer-term effect of widowhood on diet quality.

**Re-defining the Food-Related Self in Widowhood**

Participants were in many ways re-defining their food-related self. They reflected on and adjusted their food-related preferences and values. Prior research has found that
widowed women shift their food choices to follow their own preferences (Johnson, 2002; Quandt et al., 2000), suggesting that in cases where couple’s differed on food preferences, women deferred to their husband during marriage. Our results are congruent with prior work and extend the understanding of the shift; women’s preferences are dynamic and food choice in widowhood shifts towards both long-held preferences and new ones developed in widowhood. Preferences included not only food choice, but other food-related activities such as acquisition and preparation.

Widows have described a conscious reflection on their identity as a central part of widowhood (Chambers, 2005; Cheek, 2010; Lopata, 1973; Martin Matthews, 1991; Silverman 2004) and re-defining the self has been described as a key step in successfully moving through bereavement (Silverman, 2004). Our results show widowed women engaging in a similar process with respect to their food behaviour; they engaged in a conscious reflection of their food-related self, independent from the self that shared a household food system and food behaviours with a spouse. This reflection enables the establishment of a new personal food system that is aligned with the widow’s present food-related self.

**Study Strengths and Limitations**

This qualitative study enabled the development of a substantive theory of why food behaviours shift in widowhood. The findings suggest a framework of propositions for further research as well as practice. Like all interpretive research, another researcher may come to different conclusions with the same data. The size and selection of the sample, while appropriate for this study, do not support generalization. The in-depth retrospective interviews enabled the collection of the reflective data needed to efficiently
understand a process (Morse, 2001). Participants were recruited from senior apartment complexes and recreation centers and thus were a group with knowledge of, interest in, and ability to access community resources and services. Participants also reported regular contact with friends and family that could have influenced their perceptions. The shifts in food behaviours may be experienced differently among those more socially isolated. The sample here was predominantly white and lived alone; other cultural or ethnic groups may experience loss of commensality differently, especially those that may live in multigenerational households. This research focused on the experience of women. Widowers would have unique challenges in widowhood due to the cultural expectations regarding men and women’s roles with food behaviours. Finally, grief is thought to play a role in the changes of foodways seen in widowhood (Rosenbloom & Wittington, 1993). Participants did not express grief as being an important contributor to their change in food behaviours. Furthermore, the methods here did not enable examination of grief as a factor and further research is needed to better understand its role in altered personal food systems.

**Implications for Research and Practice**

The loss of commensality typically experienced in widowhood transforms older women’s dietary behaviours. Lack of appetite is well documented as a symptom of grief (Shear et al., 2011). Other types of dietary changes should be anticipated with the loss of commensality, often occurring prior to the death of the spouse. Furthermore, dietary behaviours continue to change as women adapt their food behaviours within their new life stage. Assuming that diets change can alter the perspective of how to support women through this transition. Resources to guide food choices that are healthful but prioritize
convenience may help shape the new patterns women fall into and support women during the initial transition. Women that hold dominant values of health may be receptive to nutrition education efforts when they are evaluating their alignment and re-establishing their personal food system. Expression of incongruence between behaviours and dominant values may indicate evaluation of alignment. Diet in widowhood is not static and therefore widowhood examined as a static factor may mask the underlying process. Further research is needed to identify measureable markers of the aligning process.

This model of food behaviour shift in widowhood can serve as a conceptual framework in future research focusing of food behaviours among older widowed women. Such research would likely elucidate concepts not included in this model leading to a fuller understanding of the complexities of this transition period.

References


http://www.statcan.gc.ca/subzero.lib.uoguelph.ca/dli-idd/dli-idd-eng.htm


Table 1 Characteristics of Study Participants

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*(some or completed)*
Figure 1: Visual model of the theory Aligning Food Behaviours with the Food-Related Self
One Woman’s Journey through the Aligning Process

One woman explained her journey in food behaviours in widowhood resulting in an adopted system quite succinctly:

I lost interest in making a big meal, I think I just grazed a lot, for many months before I started to think ‘I have to start making meals’. I always made a breakfast. The breakfast was very important in my life, even my parents, um my mother always made us porridge, and that’s when my habits changed and I became um you know eating the way I am eating now. I don’t intend to really change a lot of it. I’m comfortable with it, I feel good, I have a lot of energy and I’m not muddled.

This participant had fallen into a pattern of eating breakfast and then grazing the rest of the day after her husband passed. Although her preference is to graze, eating a meal for breakfast was a foundational value that she never considered dropping.

Although seemingly happy with her new patterns, she realized through conversation with others that her patterns were very different from theirs:

Friends would talk about food and say ‘what did you have for supper?’ ‘Um well’. And very embarrassed, I thought they’re going to think that I – well I don’t know what I thought. I just thought that people shouldn’t have one meal. One – breakfast definitely and then one meal a day.

Finally, she decided that she would eat breakfast, graze during the day, and have a cooked meal for supper. She realized that she felt anxious at the end of a day of grazing wondering if she had taken in sufficient nutrients.

‘sometimes I think have I really eaten all the things? because if you don’t you could be, and then I think ‘oh my goodness you better get a spoonful of peanut butter because that’s the only protein I’ve had today’’. Having one cooked meal a day facilitated getting sufficient protein in her diet. She explained, “it’s forcing me to put it together in order to round out my meal, uh especially my protein, that difficult for me.” Although she may have been initially alerted to her patterns because they deviated from the social norms in her group, she used the information to support her strong values of health and longevity.

Even my children say ‘oh mom you’re so disciplined. Most people wouldn’t read like you would’. And I said well, I said ‘that’s alright, everybody makes their own choices’. And they make their own and I make mine, and I’m happy with my choice. I do believe that it’s conditioning over time. That you’ve formulated these beliefs that certain things are not good for you and you stick to something. And I want to be around a little longer cause my family uh, my dad died at 82 but he, but I guess he had longevity [for his time], but my mom died at 57. And I have one brother who had lived to be 78 but I’m hoping to out-live them all!

At the time of the interview, it had been several years since she had re-established her personal food system. As she described above, she remained quite satisfied with the system and was stable in her food behaviours.

Figure 2: One woman’s journey through the aligning process
PART 3: BROADER DISCUSSION
CHAPTER 8: DISCUSSION

This study explored the process of change in eating behaviours among late-life widowed women to build an understanding of women’s experiences with eating and food behaviour during this period and how they understood it to have changed. The research was theory-oriented in that the primary goal was to generate a substantive theory of eating during this segment of the population’s transition through widowhood.

Qualitative grounded theory methods enabled flexible exploratory strategies with which to build an interpretive understanding of food behaviours during the transition of widowhood. A critical realist worldview enabled me to immerse myself in participants’ perspectives about their experience, while looking for patterned undercurrents suggested by their experiences, prior research on relevant phenomena, and relevant theoretical frameworks.

The following discussion will tie together the two papers by positioning the work as whole relative to previous research, discussing the limitations and strengths of the work, and providing some conclusions and implications.

Key Findings Integrated with Previous Research

Key Findings and Nutrition

The literature reviewed in the introduction presents evidence that diet quality decreases with widowhood, leading to increased nutritional vulnerability amongst this population. The present work did not include measures of food intake, diet quality, or nutrition risk and thus the findings cannot contribute to this evidence. However, the study does offer a conceptualization of eating behaviour change in widowhood. While the conceptualization cannot directly inform changes to nutritional status in widowhood,
aspects of the conceptualization and their potential nutritional consequences are discussed in the next sections.

**Nutritional consequences of simplified foodwork.** Simplification of foodwork often meant relying on commercially prepared foods. The reliance on foods prepared outside the home has been found in other studies of older Canadians, widowed and otherwise (Farevaag, 1999; Vesnaver, Keller, & Shatenstein, 2012). In an American study, foods prepared away from home were found to be higher in sodium, total and saturated fat, and contained less dietary fiber, calcium, and iron on a per-calorie basis (Guthrie, Lin, & Frazao, 2002). A more recent study has found higher energy intakes and lower diet quality related to consuming foods prepared away from home (Todd, Mancino, & Lin, 2010). Although, older adults were included in these studies, they were not analyzed separately with regard to the differences in nutritional value of home and away foods. Older adults may hold ideals that food prepared at home is superior (Falk, Bisogni, & Sobal, 1996) and consequently may select pre-prepared foods that they perceive to be ‘home-made’; a strategy expressed by several participants in the present study. An important challenge for older adults living alone is food management and food safety. Many foods are packaged in quantities too large to be consumed by an individual before spoilage (Falk, Bisogni, & Sobal, 1996; Vesnaver, Keller, & Shatenstein, 2012). While purchasing larger quantities may result in frustration over waste for some, it may result in the consumption of spoiled foods for others, which is a concern among caregivers and clinicians (Keller, Dwyer, Senson, Edwards, & Edward, 2006; Pavlou & Lachs, 2008). A diet of pre-prepared food products may not be inherently less healthful than food prepared in the home, particularly if it enables a wider variety of foods without the risk of
consuming spoiled foods. Research is needed to assess the healthfulness of a diet reliant on pre-prepared foods selected by older adults living alone.

**Nutritional consequences of divergence from commensal habits.** Participants described that their food behaviours in widowhood were not constrained by the food habits developed in the relationship. They no longer felt required to adhere to the couple’s previously agreed upon mealtimes, consume foods that were selected in consideration of their spouse’s preferences, or manage their appetites in anticipation of the commensal meal. While deviation from these habits does not provide any indication of dietary healthfulness, deviation in this study often meant irregular mealtimes, which has been related to nutritional vulnerability (Lee, Templeton, & Wang, 1996). Commensality had ensured regular mealtimes for most in this study and without this regulatory mechanism, many described irregular intake patterns. Locher and colleagues (1997) have also found that older adults that do not eat with others report more irregular meal patterns. Similarly, young adults entering commensal relationships show a regulating of their meal patterns (Sobal, Bove, & Rauschenbach, 2002). For some older adults, regular mealtimes provide frequent and expected opportunities for intake despite waning appetites due to medication and/or age-related decline in appetite hormones (Donini, Savina, & Cannella, 2003; Roberts & Rosenberg, 2006). Among older adults, a reliance on physical cues to prompt food intake may lead to insufficient intake, especially if these cues are absent (Chapman, MacIntosh, Morley, & Horowitz, 2002).

**Nutritional consequences of the aligning process.** Research to date has generally characterized food intake in widowhood without differentiating if the intake results from stable adaptive habits after the process of change uncovered in this research
(e.g. Heuberger & Wong, 2014). The process suggests that women shift their behaviours to align with their food-related self (preferences, values, identities). Thus, the healthfulness of the new behaviours is dependent on the individual’s interest in and understanding of the healthfulness of their food habits, holding health as a dominant value, and their having preferences for healthful habits. The outcome of the process, a stable personal food system, is not related to dietary outcomes and both unhealthful and healthful extremes are possible according to the proposed model. Intervention may be possible particularly if targeted to the type of change process they are experiencing (falling into new patterns or re-establishing the personal food system). The implications for intervention design are further discussed in the Implications sections.

**Tea and toast syndrome.** I had entered the field with an expectation of interviewing many women that exhibited a “tea and toast” syndrome whereby older adults subsist on very light foods with extremely limited overall intake (Kerstetter, 2009; Litt, 1997). I had expected this in part due to the conceptualization of change in mealtime activities in widowhood as a shift toward vulnerability and as a loss of meaning among older women (Sidenvall et al., 2000; Rosenbloom & Whittington, 1993). In contrast, I met few women describing these types of eating behaviours. The only participant that described very limited and irregular food intake expressed dissatisfaction with her habits and that she wished she ate better. Although attempting to interview more women with poorer intake by targeted word-of-mouth strategies, no such individuals expressed interest. This is an important limitation to the scope of my research as discussed in the Limitations section. One can tentatively speculate using the proposed model how such food behaviours could be developed in widowhood. One possibility is that these
vulnerable behaviours may relate to temporary patterns as result of the experience of depression or they may relate to more stable patterns whereby the widow matched her food behaviours with her preferences and perceived needs as part of a re-established personal food system. However, the model was developed through the experiences of women that described more fulsome food intake and needs to be examined in a population with a greater range of eating behaviours.

**Widowhood, Process, and Food Behaviours**

*Widowhood is transformative for older women’s food behaviours.* A key question in the widowhood and diet literature has been whether the changes in eating behaviours are temporary disruptions from which widowed women recover, similar to their recovery from other psychological and physical disruptions (Wilcox et al., 2003). This study addresses this question through the conceptualization of two sub-processes of eating behaviour change experienced in widowhood. The first is a temporary shift, attributed to a combination of stressors surrounding widowhood and the change in the social context of the food system. The second is an adaptive shift whereby women make mindful decisions and behaviour changes to create a personal food system that they are satisfied with. The temporary shift may be conceptualized as linked to the loss of commensality and the stress of the events surrounding the loss of a spouse. The adaptive shift however is related to the fact that in widowhood, the woman creates a food system to feed one person – herself. I understood from my participants that their adaptation was transformative rather than a recovery from stress, which aligns with what others have found in women’s general adaptation to widowhood (Martin-Matthews, 1999).
This conceptualization of transformation rather than recovery may be due in part to the particular nature of the sample (high social engagement and relatively well). As a researcher, I also carry a resilience lens from previous work (Vesnafer, Keller, & Shatenstein, 2012), which sensitized me to hear participants’ stories of the resilience and the transformation of their eating behaviours and food system in widowhood. When women described *falling into new patterns*, a sense of loss—of a partner, a role, and a way of eating—was very present in their narratives. Once women were *re-establishing the personal food system*, that sense of loss was less present; women were focused on reconfiguring their food system, re-evaluating their needs and preferences, and putting strategies into action that resulted in food behaviours they would be satisfied with.

**Reflection on the food-related self.** The reflection on the food-related self was integral to the re-establishment of the personal food system in widowhood. This involved evaluating one’s food-related needs, preferences, values, and identities. The food-related self provides the core with which their food behaviours becomes aligned in widowhood. For many, a preference for simple preparation was developed in widowhood and thus the value of convenience directed many food purchases. Aside from managing a food-preparer identity, most food-related identities prior to loss of the spouse (e.g. “a picky eater”, “vegetarian”, “a light eater”) remained consistent through widowhood.

Redefining the self has been found as pivotal to health behaviour change in a grounded formal theory study (Kearney & O’Sullivan, 2003). The authors constructed a framework in which the redefining of the self was prompted by a discomfort with a perceived incongruence between behaviours and long-standing values and goals. This notion is similar to the discomfort described by participants in this study when they
realized a misalignment between their behaviours and their food-related self (part of the category *becoming mindful of food behaviours*).

Widowed women have described a conscious reflection on their identity as being a central part of widowhood (Chambers, 2005; Cheek, 2010; Lopata, 1973; Martin Matthews, 1991; Silverman 2004) and redefining the self has been described as a key step in successfully moving through bereavement (Silverman, 2004). The *reflection on the food-related self* that was conceptualized as part of the *re-establishing* sub-process in some ways mirrors this reflection on identity. It was beyond the scope of this research to examine how the aligning process and bereavement process may intersect or interact. However, the findings lay a foundation warranting further inquiry into how these processes may be similar, interacting, or different.

**Commensal Meals as a Mechanism of Social Regulation**

One mechanism of marriage hypothesized to improve health outcomes is increased social regulation (Berkman, Glass, Brisette, & Seeman, 2000). Regular social contact with a spouse may provide encouragement to adhere to social dietary norms and the couple’s dietary norms (Vesnaver & Keller, 2011). These include standards such as the number of meals eaten per day, the times at which meals are eaten and the types of food consumed at each occasion. The finding that women in this study shifted their food behaviours in ways that were different from patterns that had been developed in the couple lends support to this hypothesis.

Prioritization of commensality amongst couples described by participants in this study and elsewhere (Sobal, Bove, & Rauschenbach, 2002) may enhance the effects of social regulation during the shared meal. Participants had prioritized commensality
during their marriages, often altering personal choices about food consumption or other activities in order to fully participate in the commensal meal. Participants described that shared meals with their spouses held a function beyond shared food intake; shared meals were also an opportunity for intimacy and bonding. Couples may regularly share meals for this benefit, thus further reinforcing the dietary norms of the couple and enhancing the social regulatory mechanism of commensality.

In widowhood, frequent social contact may also regulate general eating patterns. For example, the discussion of food or the sharing of food behaviours with others may serve as a reminder of what is perceived to be ‘normal’ behaviour. Furthermore, if the contact is with a close family member or friend from before widowhood, the widowed individual may be reminded of the expectations they perceive others have of their behaviour. Prior research has shown that widowed older adults with high social contact had greater variety of fruit and vegetable intake compared to widowed older adults with low social contact (Conklin et al., 2014), lending support to the social regulatory influence of others on food behaviour. It should be noted that the regulation effect depends on the norms espoused by the social group (Umberson, Crosnoe, & Reczek, 2010).

**The Role of Grief**

At the outset of the project, I was interested in the role that grief might play in the shifting food behaviours of widowed women. Rosenbloom and Whittington (1993) found that a measure of grief resolution (Grief Resolution Index) was associated with enjoyment of meals, diet quality, appetite, and eating behaviour among recently widowed older adults. Yet, Johnson (2002) compared nutrition risk and focus groups findings
between widowed older adults who were receiving bereavement counseling and those that were not and found no differences.

Although grief was a factor in the falling into new patterns for some women, it was not the only reason food behaviours shifted, and thus does not enter the theory as a driving concept. The conceptualization of the initial shift in food behaviour presented here expands our understanding to include other sources of stress to the personal food system including those related to food-provision during caregiving, limited time during caregiving, and non-food related tasks to attend to shortly after the death of the spouse. Stressors indirectly related to bereavement have also been found to have important consequences on effective coping in widowhood (Stroebe & Schut, 2010).

It should be noted that other than seeking variation in time since widowhood, my recruitment methods did not specifically target women exhibiting different types of grief or levels of coping. Within time since widowhood, the sample represented a good range of women widowed six months to 15 years. Although not specifically assessed, women also seemed to exhibit variation in coping. For example, two participants expressed that they were having difficulty coping after five years, potentially suggesting chronic grief (Ott, Lueger, Kelber, & Prigerson, 2007). Regardless, grief is not the only mechanism by which food shifts occur in widowed women.

Reflections on the Food Choice Model

Furst, Connors, Bisogni, Sobal, and Falk (1996) inductively developed a model explaining food choice in adults. The framework was then used to develop a theoretical understanding of food choice in older adults (Falk, Bisogni, & Sobal, 1996). Managing relationships was found to be a common dominant value for older adults. The influence
of this value was described mainly as altering food choice, such as eating foods that
others like when sharing meals. In this study, consistent with DeVault’s work (1991) on
family meals, the influence of managing relationships extended beyond the choice of
food, also influencing the decision to share meals. Thus, the scope of food behaviours
that may result from the influence of this value is broadened. Although the food choice
model was developed to conceptualize the determinants of a single food choice event, the
present work builds on this understanding.

In the first paper focused on loss of commensality, I identify the numerous effects
that the importance of sharing meals had on food and non-food-related behaviours,
extending beyond food choice during the shared meal (a single food choice event). For
the preparer, time is taken to plan, shop for, and prepare the meal. For both consumers,
intake is managed during the day to ensure appetite for the shared meal and non-food
activities are scheduled around the shared meal. Daily intakes and activities were
influenced by the dominant value of managing the relationship with their spouse and thus
were also affected in widowhood. This work contributes to a broader conceptualization of
food choice beyond the single food choice event particularly when regular commensal
meals are involved.

**Gendered Nature of Foodwork**

I embarked on this research project in part because I was interested in how the
gendered role of meal preparation might be involved in the shifts in food behaviours
observed in widowhood. I focused much of my earlier analytic process on this aspect.
However, during theoretical coding, I made a deliberate decision not to focus on the
gendered nature of foodwork as the central storyline. While it was an integral and
important influence and has been included in my theory as such, I did not feel it was the primary focus of my participants as they explained their shifts in food behaviour.

Participants’ and their families’ beliefs about women and food affected the range of food behaviours that were considered acceptable and “normal” by these participants. Some women had internalized the prioritization of serving others’ nutritional needs over their own. This long-held habit made redefining the food-related self more difficult. A more thorough discussion and analysis of this influence is warranted; however, for the present work, I did not feel it to be the central process explaining change in food behaviours in widowhood. As such, I attempted to heed the advice of my colleague Wenger (2012) who argued that a key challenge in gender analysis is to resist the simple story. In discussing my dissertation research with others (professional and lay people), I have found that a common understanding is that widowed women stop cooking because they no longer have anyone to cook for. While my research shows that loss of the shared meal reduces the interest and willingness to cook for many, the reasons underlying those decisions are more complex than what the common narrative suggests.

It has been argued that cooking is a way for women to define and assert their femininity (Fürst, 1997). The way women felt about cooking—whether it was a burden forced on them, an integral part of their feminime identity, or some combination—did not seem to be related to the decision to reduce the amount of cooking in widowhood. For many participants, cooking seemed more about seeking an experience of a shared meal than it was about providing a cooked meal for their spouses. Sidenvall et al. (2000) conceptualized that the meaning of cooking for older women was to give a gift of a nicely planned, cooked, and presented meal to others. When women in this study were asked
about why they were no longer cooking or cooking less, they did not respond as I would have anticipated based on the literature. Rather than responding “who for?”, they responded with a variation of “there is no one to eat with” (P08). The view taken here is that the gift is not the cooked meal, but specifically the sharing of the cooked meal, given to herself as much as to others. The context in which these findings were constructed were different in two important ways. Sidenvall and colleagues (2000) developed their understanding from data collected in the late 1990’s in Sweden. There may be both cultural and generational differences in the meaning of cooking. Nonetheless, the present work broadens the understanding of the meaning of cooking among older women by highlighting the importance of the shared meal.

**Limitations**

This qualitative study enabled the development of a conceptualization of why and how food behaviours shift in widowhood. The findings suggest a framework of propositions for further research. Like all interpretive research, another researcher may come to different conclusions with the same data.

When considering the conceptualization developed in this work, it is essential to understand the context in which it was developed. Participants were recruited from senior apartment complexes and recreation centers and thus were a group with knowledge of and ability to access community resources and services. Most participants were highly socially engaged in their communities. The shifts in food behaviours may be experienced differently among those more socially isolated. As well, the sample was predominantly white; other racial or ethnic groups may experience widowhood and shifts in food behaviours differently. The research was situated in Canada; participants had all been
residing in Canada for some time if they were not born in Canada. Thus, the theory developed in this work is situated within a very particular context of widowhood. Widowed women elsewhere may have very different experiences (Lamb, 1999). A final limitation of the selected sample is that this research focused on the experience of women. Widowers are known to have unique challenges in widowhood due to the cultural expectations regarding men and women’s roles in foodways (Moss, Moss, Kilbride, & Rubinstein, 2007).

Related potentially to sample selection, participants for the most part described seemingly fulsome diets and struggled with eating too much rather than not enough. All participants ‘knew’ of other widowed women that ate little after their spouses passed away. Despite attempts to interview women that fit such a description through word-of-mouth strategies, I was unsuccessful within the constraints of the recruitment methods as designed. I believe a different recruitment strategy would be needed to target such a population, likely with the participation of community outreach groups. I decided not to alter my methods to attempt to recruit such participants as I anticipated a different process underlying shifts in food behaviour in this group. It is however an important group to explore. The voices of women that drastically reduce their intake in widowhood need to be included in future work on food behaviours and widowhood and explicit strategies to seek out and recruit these women will need to be devised. There are likely concepts or processes outside of the current theory such as chronic grief (Hansson & Stroebe, 2007) or appetite (Wong, 2005) that would be involved.

At the outset of the interview, I explained to participants the research questions in detail, along with the current gaps in understanding and other rationale for the research. I
invited them to help me understand eating in widowhood in part by sharing their personal experiences with the subject but also by reflection on larger concepts. I sometimes felt that participants were uncomfortable with the role, particularly when they reminded me of the dynamic of me as ‘researcher’ and they as ‘participant’. For example, I always asked at the end if there was anything else about the experience that we had not talked about that they thought was important, to which the reminder came “I don’t know what you need to know…you have your objective, so therefore you’re the one who has a task to accomplish. I’m only just a well you can look in and say ‘I’m going to get this’” (P10).

While I hope that participants felt like they could introduce issues they thought were important, and indeed concepts were brought forth that were new to me and unexpected, I must still assume that the data largely reflects the kinds of questions I asked. Thus, the scope of the findings must be viewed within the framework of the researcher and may have missed concepts important to the participants.

Finally, this study did not follow participants through their experience of loss of commensality and widowhood but rather relied on women’s retrospective accounts of their experiences of change in food behaviour in combination with my conceptualization of where the different participants were situated in the process. In the same way marital aggrandizement may affect the retrospective accounts of women’s relationship quality, a similar phenomenon may exist with commensality aggrandizement that this research cannot account for. Future research should track changes in food intake, food behaviours and attitudes before and after the loss of commensality and at several time points in widowhood.
**Strengths**

The qualitative criteria for trustworthiness include credibility, dependability, confirmability, and transferability (Guba & Lincoln, 1982).

Credibility or truth value of the findings was enhanced by triangulation of data sources, member checking, and debriefing. Triangulation of sources was achieved by obtaining multiple perspectives from different stages of the process. Originally conceptualized as time since widowhood, the soliciting of accounts from women that had been widowed different lengths of time resulted in a sample that represented a range of different points along the eating behaviour change process, though their ‘location’ in the process was not related to time. A form of member checking was used whereby emergent categories were checked with new participants as my understanding of the process evolved. In this effort, participants were encouraged throughout the interview to be partners in the research process. At the outset of the interview, I was fully transparent regarding the research questions and my understanding to date about the topic of study. Furthermore, as theoretical concepts emerged, participants were asked to comment on how my concepts resonated (or clashed) with their experience and understandings. I debriefed by regularly meeting with my thesis advisor Dr. H. Keller to share my emergent understanding of the data and be challenged with alternative explanations to consider in the analysis. Dr. Keller’s research expertise is in older adult nutrition and she has substantial experience with constructivist grounded theory. When Dr. O. Sutherland joined my advisory team as co-advisor, she challenged my theoretical coding helping me to evaluate alternative explanations. Several very different conceptualizations of the process were considered and proposed prior to the current model. Attending to negative
cases in my data helped me to refine my theory until all cases were included.

Dependability refers to the consistency of the findings and process of inquiry (Guba & Lincoln, 1982). A detailed audit trail of the data collection and analysis ensured dependability of the findings. Sampling and recruitment strategies were documented in the audit trail. Interviews were recorded and transcribed. Detailed field notes were taken immediately following the interview. All methodological and analytic decisions were documented and major direction shifts in the analysis were regularly reviewed with my thesis advisory committee.

Confirmability is related to dependability as it refers to how well the findings are supported by the data and the transparency of the influence of the researcher’s values and assumptions (Guba & Lincoln, 1982). To enhance confirmability, I engaged in ongoing reflexivity and presented any personal characteristics that I believed to contribute to the data and its interpretation. Furthermore, all findings were stepped back through the audit trail to the original data, a process facilitated by the small sample size (Crouch & McKenzie, 2006).

Finally, the transferability of the theory was sought by presenting as much detail as possible about the context in which the research was conducted for readers to be able judge the appropriate contexts for which to transfer the findings (Guba & Lincoln, 1982).

Charmaz suggested three criteria for evaluating the substantive theory: originality, resonance, and usefulness (2006). How does the theory challenge or refine current ideas about widowhood and diet? Does the theory make sense to individuals that share circumstances with the participants? How does my work contribute to knowledge? These
questions helped me to refine a theory that does not only fit the data, but also offers new and relevant insights into the experience of widowhood and diet among older women.

The theory is original as it is the first theoretical framework to my knowledge to explain changes that occur in eating behaviour among older women in widowhood. Prior work has observed stabilized eating behaviours in women widowed after some time, but this is the first to describe the process of stabilization. Loss of commensality is conceptualized as the catalyst to the process of change. This conceptualization broadens the understanding that behaviours change with a spouse’s illness or death.

It is still premature to determine the resonance of the theory. A preliminary model was presented to an interdisciplinary group of colleagues and was found to resonate, however the final model has not yet been presented to large audiences. The theory’s resonance will depend on how it is received by a more general scholarly audience and individuals who either share the experience, or who have intimate familiarity with the experience from their social network.

Finally, I believe the theory to be useful as it contributes to research and practice concerning the food behaviours of older widowed women. The next section elaborates on the implications that can be drawn from this study.

Conclusions and Implications

Conclusions

Grounded theory was used to elucidate the process of change in eating behaviours and in widowed women. Two overarching questions guided the inquiry:
(a) What is a substantive theory that explains the process of described change in the experience of eating behaviours and food-related activities among older widowed community living women who live alone?

(b) How do women understand their eating behaviours to have changed since the death of their spouse and how do women experience these changes?

The Aligning process. The aligning process was constructed to explain the process of change in the experience of food behaviour among older widowed women living alone in the community. It is my interpretation of the process underlying the shifts in food behaviour expressed by the fifteen participants who shared their experiences with me. Further research is needed to test the theory within its current scope and broaden or delimit its relevance by testing it in more diverse populations. The theory suggests the following propositions:

1- Widowed women experience a change in diet trajectory as a result of their perception of loss of commensality, not solely the loss of a spouse, occurring during caregiving or at the time of the spouse’s death.

2- An initial change in food behaviour is passive, related to the change in social context of the personal food system, stressors related to caregiving and widowhood, depressed feelings, and/or individual priorities.

3- Discordance between a woman’s dominant values and her behaviours prompts a second shift in food behaviour.

4- A second change in food behaviour is mindful and may include the way a woman thinks about food (preferences, values, identities) and/or her food
behaviours. This change does not necessarily include a change in food choice or diet. This change progresses towards a stable personal food system.

5- The resultant stable system is aligned with the individual’s current preferences, dominant values, and identity.

6- Increased social contact during both changes may have a social regulatory effect on food behaviours.

7- An individual’s values, gendered experience with nutrition care, resources, and social integration impact how she moves through these sub-processes.

**Shifts in food behaviours.** In widowhood, women no longer had regular commensality; widowhood meant eating alone. Eating alone underscored their loss; any behaviour that pre-widowhood had included their spouse, now when undertaken, reminded them of their solitude. Mealtimes were also experienced as less enjoyable than they had been when they were shared with their spouses. But women still ate either for survival or because they still enjoyed food. The enjoyment of eating pleasurable food was unaltered in widowhood. There were two common types of shifts in behaviours among participants: simplification of foodwork and food behaviours that were unrestrained by prior commensal patterns. These shifts were attributed to the loss of commensality they experienced. These shifts were understood differently depending in which part of the aligning process they occurred. They were experienced as temporary in the first stage of falling into new patterns. Therefore, evaluation of these shifts was suspended through the initial acclimatization to their new social context. If the shifts occurred or were maintained through the re-establishment of the personal food system, they were
experienced as doing something for the self, and they were usually happy and satisfied with the shifts. However, the very need for a revised food system further highlighted their new life stage of widowhood eliciting strong and complex emotions.

**Implications for health professionals**

In an effort to ensure a useful theory, it is essential to re-engage with older widowed women as well as practitioners working to support this population to assess how the theory resonates with their experiences and identify areas needing further development. The next phases of this work will include presenting the theory to interdisciplinary groups of researchers and practitioners at conferences. Focus groups with widowed women is another avenue to obtain necessary feedback on my conceptualization of their experience. Although it is premature to suggest recommendations to health professionals before completing this next step, I offer implications should the propositions of the theory hold after further research.

Mealtimes in widowhood were generally described as less enjoyable than shared mealtimes with their spouses. The description of this experience in widowhood ranged from simply an unfavorable comparison to meals pre-widowhood, to unpleasant in its own right. However, the experience of the enjoyment of food, of taste and other gustatory sensations, did not appear to change in widowhood. Although more research is needed to understand the experience of meals in widowhood when not specifically contrasted with commensal meals, the findings that the enjoyment of food and taste is unaltered is significant. Focusing the language on the consumption of food rather than meals may help widowed women to experience food behaviours more positively.

Loss of appetite is frequently documented as a symptom of grief. However, there
are other changes to food behaviours that are experienced with the loss of commensality typical of widowhood. These changes often occur prior to the death of the spouse. The period surrounding a spouse’s illness is usually characterized by high levels of contact with health professionals. There is an opportunity to intervene in advance with information and resources. Resources to guide food choices that are healthful but prioritize convenience may help shape the new patterns women fall into and support women during the initial transition. Although new patterns are considered temporary, behaviours are sometimes learned in this stage and carried into the re-established personal food system.

Women that hold dominant values of nutrition or health may be receptive to nutrition education efforts when they are evaluating their alignment and re-establishing their personal food system. Expression of incongruence between behaviours and dominant values may indicate evaluation of alignment, and thus opportunity for intervention. Counselling strategies such as motivational interviewing may help practitioners to understand women’s dominant values (Spahn et al., 2010). Strategies can then be developed collaboratively to behaviourally match the women’s values.

Developing opportunities for social contact particularly during meals may help to offset the loss of social regulation experienced with loss of commensality. Many participants knew of support programs that were offered by local hospices but these were often discounted due to the emotional difficulty they anticipated experiencing. Less formal dining clubs might be less emotionally intimidating and offer opportunities to build networks with other widowed adults while providing reminders of ‘normal’ food behaviours.
Dietary behaviours may once again shift as women re-establish their personal food system. Although women felt more satisfied with their behaviours at this stage, this was not related to healthfulness. Nor do behaviours shift back to what they were prior to widowhood. Behaviours may not shift at all from the temporary patterns with the re-establishment process, as women may resolve the incongruence with their preferences and values by modifying their preferences and/or dominant values. For example, this meant demoting the importance of home-cooked foods for some because of their newfound preference for minimal meal preparation efforts. As pre-prepared foods are often less healthful than ones prepared at home, helping women navigate their options for these products is essential to minimize the effect of this shift on health outcomes.

**Implications for the study of widowhood and food behaviours**

The main shifts in food behaviours were a decrease in complexity of meals and an altering of meal patterns; neither type of shift necessitates a poor diet. Dietary measurement studies might examine the food choices and patterns of widows that have shifted to simpler meals and snacks but are still meeting their nutritional requirements, thus elucidating possible strategies for eating well within these new patterns.

Diet in widowhood is not static and therefore widowhood examined as a static variable masks the underlying process. Further research is needed to identify measureable markers of the aligning process to assist with the creation of meaningful widowhood variables to be used in food and nutrition research. The proposed process suggests a path of food behaviour change, however what the path looks like is largely dictated by the set of intersecting influences (couple’s food system, gendered experience of nutrition care, physical and financial resources, and social integration). The present work was focused
on elucidating process and not outcomes. Development of each influence and examining how it affects outcomes related the individual’s food system, health, and bereavement process would expand the utility of the model.

The category broken scripts relates to the effects on the household food system due to a change in social context and may be useful to consider when studying other changes in social context. The concept may be most relevant for changes that involve the reduction of members in the household such as separation, divorce, and children leaving home.

This model of food behaviour shift in widowhood can serve as a conceptual framework in future research focusing of food behaviours among older widowed women. Such research would likely elucidate concepts not included in this model leading to a fuller understanding of the complexities of this transition period.

References


Vesnaver, E., Keller, H.H., Payette, H., & Shatenstein, B. (2012). Dietary resilience as described by community-dwelling older adults from the NuAge study- "If there is a will-there is a way!" *Appetite, 58*(2),730-738.


APPENDIX A

Sample Recruitment Poster

UNIVERSITY OF GUELPH

INVITATION TO PARTICIPATE IN RESEARCH

Eating Behaviours Among Older Widowed Women

We are interested in speaking with older widowed women about their experiences with eating, appetite, cooking and shopping.

Potential participants must be 65 years and over, widowed for 5 years or less, live alone, responsible for the majority of their cooking and shopping, and be able to complete the interview in English.

Participation would include a one-on-one interview in your home or another location of your choice that will require approximately 45-90min of your time.

The research is being conducted by Elisabeth Vesnaver, a PhD candidate working under the supervision of Professor Heather Keller, Department of Family Relations and Applied Nutrition at the University of Guelph. This project has been reviewed by, and received clearance through the University of Guelph Research Ethics Board.

If you are interested in participating, please contact Elisabeth at 647.504.8474.
INFORMATION LETTER

Eating Behaviours of Older Widowed Women

My name is Elisabeth Vesnaver and I am a PhD candidate working under the supervision of Professor Heather Keller, Department of Family Relations and Applied Nutrition at the University of Guelph. I am interested in learning more about the eating behaviours of older widowed women. In particular, if there are changes that occur with widowhood, why and how these occur. The purpose of this study is to explore the experience of eating, appetite and food related activities of older widowed women in relation to their experience of widowhood. My aim is to recruit 30 individuals to talk to about their experience with eating, appetite, cooking and shopping and how this experience changes over time with widowhood. The study is intended to help me and the research community understand how and why the eating behaviours of older women change with widowhood. It will also help to identify areas to support the nutritional health of older widowed women.

Participation in the study is completely voluntary. I would like to ask you about your eating habits, appetite and experience with cooking and shopping. This conversation will take between 45 and 90 minutes of your time. The questions will be quite general, for example “Can you tell me about your eating habits? Have these changed since your husband has passed away?” Some people feel discomfort when speaking about their experience of loss. If desired, you will be provided with contact information for community services that will be able to address some of your concerns. You may decline to answer any questions and you may withdraw from the study at any time. The conversation will be audio recorded and then transcribed into a document.

All information you provide is considered completely confidential. The recording and the transcript of the conversation will be kept in a locked cabinet in Elisabeth Vesnaver’s office. During transcription, the recording and transcript will be kept in a secure research lab at the University of Guelph. Results from your participation may be used in scientific publications but it will not be possible to identify you. You will receive a $20 Tim Horton’s gift card as a token of my appreciation for your participation in this research.

This project has been reviewed by, and received clearance through the University of Guelph Research Ethics Board. If you have any questions or concerns resulting from your participation in this study, you may contact the research coordinator at the University of Guelph, Sandra Auld at 519.824.4120, x56606. You may also contact me, Elisabeth Vesnaver at 647.504.8474 or Heather Keller at 519.824.4120, x52544. Thank you for your assistance with this project.

Sincerely,

Elisabeth Vesnaver
PhD candidate
CONSENT TO PARTICIPATE IN RESEARCH

Eating Behaviours of Older Widowed Women

You are asked to participate in a research study conducted by Elisabeth Vesnaver, PhD candidate and Dr. Heather Keller, Professor, Department of Family Relations and Applied Human Nutrition at the University of Guelph.

If you have any questions or concerns about the research, please feel free to contact Elisabeth Vesnaver at (647) 504-8474.

PURPOSE OF THE STUDY

The purpose of this study is to explore the experience of eating, appetite and food related activities of older widowed women in relation to their experience of widowhood.

PROCEDURES

Elisabeth Vesnaver will come to your home to ask you some questions about your food behaviours and how your experience with widowhood has or has not influenced them. Participation involves at least one interview that will take 45-90 minutes to complete. The conversation will be audio-recorded and then transcribed. Participants may be contacted for a follow-up telephone conversation or in-person interview if clarification is needed.

POTENTIAL RISKS AND DISCOMFORTS

You may experience some discomfort speaking about your loss. However, the questions will focus primarily on your eating behaviours. If necessary you will be provided with contact information for a support service that can address your concerns.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

You may benefit from the experience of talking about your dietary habits. The results from this research will contribute to our knowledge about widowhood and how it affects eating behaviours and will be used to develop programs or services to support food intake during widowhood.
PAYMENT FOR PARTICIPATION

You will be given a gift card to Tim Horton’s at the completion of the interview.

CONFIDENTIALITY

Every effort will be made to ensure confidentiality of your information. In the event that you identify that you are being abused, including but not limited to physical, emotional, financial abuse or neglect, or if we believe you are in imminent danger of bodily harm, we are required to report such information to the appropriate authorities.

Your name will not be associated in any way with the research. You will be assigned a participant ID code. Any personal information such as your name or contact information will be kept in a research file identified by this code and be kept separate from your interview information. Your contact information will be destroyed at the end of the study. Your interview data will be kept for five years and may be used for further analyses on food intake in older adults.

Your data may be used to publish results in scientific journals but it will not be possible to identify you. Quotes from interviews will be used in these publications, but you will not be identifiable.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may exercise the option of removing your data from the study. You may also refuse to answer any questions you don’t want to answer and still remain in the study.

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board.

If you have questions regarding the ethics of the research, contact:
Sandra Auld
Research Ethics Coordinator
University of Guelph
437 University Centre, Guelph, ON, N1G 2W1
519. 824.4120, x56606
SIGNATURE OF RESEARCH PARTICIPANT/LEGAL REPRESENTATIVE

I have read the information provided for the study “Eating Behaviours of Older Widowed Women” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

____________________________________
Name of Participant (please print)

____________________________________
Signature of Participant

Date

SIGNATURE OF WITNESS

____________________________________
Name of Witness (please print)

____________________________________
Signature of Witness

Date
APPENDIX B

Telephone 1st contact guide:

1- Remind of purpose of study
2- Screen for eligibility
3- Explain nature of participation
4- Check understanding of purpose and what participation involves
5- Explain scheduling
   e.g., I’d like to interview people in a certain order based on certain characteristics. For example, I’d like to interview women that are more recently widowed closer together so that I can more fully understand that experience. Do you mind if I ask you a few more questions to help me determine the best point in my research to interview you?
6- Questions to guide theoretical sampling
7- Schedule interview if appropriate. Otherwise collect contact information.

Telephone eligibility screening:

Gender:
Age:
Widowed: Y/N
Age when widowed:
Living situation:
Who is responsible for:
   • Shopping?
   • Cooking?
Understands purpose?

Information to guide theoretical sampling:

Years since widowhood:
Years married:
Children:
Would you say your health is: Excellent? Very good? Good? Fair? Poor?
Contact information:

Full name:

Phone number:

Best time to call:

Upcoming availability (going on any holidays?):

Notes:
Interview Guide

1- Can you tell me about your eating habits?
   How many meals do you eat a day?
   Can you tell me about those meals?
   Do you snack? When and why?
   Do you enjoy eating? Why or why not?
   Do you ever eat with others? What is that like for you? How is it different from eating alone?

2- How have your habits changed since your husband passed away?
   What do you think contributed to these changes?
   Was anyone else involved?
   What helps you to manage these changes?
   How do you feel about these changes?

3- Can you tell me what eating was like with your husband?
   Can you tell me about what your appetite was like?
   Did food taste the same?
   How did you plan for meals?
   What kind of meals did you eat?
   Who prepared meals? What was that like for you?
   Who did the shopping? What was that like for you?
   What were mealtimes like?
   Can you tell me if there were any differences in how it felt to eat alone, with your husband or with others?
   If you could describe eating with your husband in one word what would it be?

4- Can you tell me what eating was like when your husband first passed away?
   Can you tell me about what your appetite was like?
   Did food taste the same?
   How did you plan for meals?
   What kind of meals did you eat?
   Who prepared meals? What was that like for you?
   Who did the shopping? What was that like for you?
   If you could describe that period in one word, what would it be?
   After having these experiences, what advice concerning eating behaviours would you give someone who just lost their husband?
Brief demographic questionnaire:

1. When we first spoke on the phone, you described your health as ____________, has there been much change in this since your husband passed away?

2. Do you have sufficient income to meet your needs? ______________

3. How many years of education did you complete? ____________

4. What ethnicity or cultural group do you identify with? ______________
A Guide to Healthy Eating for Older Adults

Good nutrition is important at any age. Eating well will help you feel your best each day. You may even help to prevent or manage heart disease, diabetes and some cancers.

This guide is designed for older adults. The content will help guide you in making healthy eating choices. You will find many ideas that will make healthy eating easy and enjoyable!

Remember, it is never too early to start eating a healthy, balanced diet!