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Ageing and food
The effects of home caring

Home caring for disabled elderly people by (family or professional) caregivers modifies the food diet of households, but these modifications vary with the attendant's status. The intervention of a home help leads to transformations with the integration of nutritional and dietetic norms but these changes differ with the interaction between the home help (according to age and qualification level) and the elderly person and are not necessarily efficient. Conversely, in cases of family caring, the household tries to keep up the food diet but we observe transformations that depend on the re-organization of food activities. They vary with the help's status and age (spouse, son/daughter), and the elderly person's sex and types of disabilities (physical or psychological). The preventive policy aimed at elderly people implemented within the French National Nutrition and Health programme (PNNS) and based upon the up-keep of food diversity should take these social interaction effects into account.

The transformation of elderly people's everyday life combined with individual biological and physiological ageing effects (mastication problems, loss of appetite, change in tastes, and so on) have an impact on their diet. These modifications are such that they may lead to undernourishment characterised by major nutritional deficiencies, physical and psychological weakness aggravating their health, and accelerated ageing. This is why the diet of the elderly is the subject of a public preventive policy within the National Nutrition and Health programme (frame 1): the objective is to fight elderly undernourishment by relying on people to take care of them.

We study the impacts of third party intervention (spouse, child or social and care attendant) on the household's food supply and diet, focusing on people with physical or psychological disabilities (frame 2). Disability means a total or partial reduction in capacity to perform a physical activity (to go out and do the shopping, do the cooking) or psychological activity (speak, think) related to deficiencies (physical diseases such as osteoarthritis, poly-arthritis, slipped disc, partial paralysis, and so on, or psychological such as Alzheimer's disease) and requiring the implementation of adaptation strategies (Ennuyer, 2002).

A qualitative approach of the role of social interactions in food diet

Caring for the elderly does not go without saying and raises the question of the nature of the relationship between the elderly person and the carer (particularly according to his/her status). For instance, we know that delegating the shopping to a third party leads to a reduction in the shopping basket (Gojard, lhuissier, 2003), but this reduction depends on the help's domestic status (cohabiting or non cohabiting people) (Cardon, Gojard, 2008).

The qualitative survey developed here (frame 2) goes further. First of all, it questions the type of social relationship between the disabled elderly person and the carer (home help, child or spouse).

The assumption is that diet transformations depend on the type of social interaction between the help and the elderly person. These social interactions vary in accordance with the attendant's status (spouse, son/daughter/home help), the elderly person's sex, disability type (physical or psychological) and socioprofessional category.

Furthermore, the quantitative survey enables us to simultaneously study food supply and meal contents. The transformations observed are food integration or rejection, ways of cooking and sequence of meals leading to meal diversification or, on the contrary, simplification. The changes in generations' cooking habits characterized by the overconsumption of fresh produce, the low consumption of processed products and cooking involving a lot of preparation are at stake.

Changing the diet of elderly people via the intervention of home helps?

In 2006, 93% people benefiting from home attendance called on a home help who comes alone (25%) or in addition to a member of the family circle (68%). In 35% of the cases, the help is assigned the task of food shopping and in 40% of the cases, the meal preparation (Petite, Weber, 2006). We raise the question here of how the delegation of food activities to home helps modifies or not the food diet of the elderly person's household. This is a

crucial question, as the National, Nutritional and Health programme referring to home helps acting as "go-betweens" for public food prevention policies: they must ensure food diversity ("eat a little of everything") and meal diversity ("keep up meal regularity). For this purpose, they are asked to play a diagnosis role (watch on food habits and food preferences, check food supply, meal content) and a prevention role, (enhance and apply a healthy and balanced diet). Ideally, the action of home helps should be to bring the diet into line with the French National, Nutritional and Health programme.

Even so, home helps integrate the expectations of this prevention programme on diet differently. It depends on the home helps' generation and level of education. The oldest (who generally have a lower education level) put effort into the shopping content and even the meal content and play the expected diagnosis and prevention roles: they suggest new produce (some new vegetables, for instance), keep a watch on the meal content and suggest modifications to the menu, trying to follow the National, Nutritional and Health programme's suggestions. Conversely, the youngest home helps (with a higher education level) put less effort into the shopping content, or even into the meal preparation and prefer to do what they are asked by the elderly person. For instance, they only "prepare" the food (peel vegetables, cut the meat, and so on.) or prepare meals themselves when the elderly person is physically unable to do it. But they take no initiative, considering that they are not qualified enough in cooking to meet the demands of the elderly person or of the home help service employing them. They keep their distance from the institutional recommendations and as a priority play a supervisory role. Some are very critical towards the institutional suggestions, which they consider as "excessive" or even "improper" and not adapted to an at-end-of-life person.

Moreover, the handling of food activities by helps depends on the management of their intervention time between professional time and family time: they also have to manage their own home food activities. They often express how difficult it is to simultaneously think about menus for the elderly and their own family. Furthermore, in that time management, they also have a spatial constraint linked to the distance between the elderly person's home and the shopping centre. The shopping time has an influence on the preparation time and meal content, with the home help limiting the time of preparation. For example, in one hour the helper of Mrs Gentrix (who lives in the town centre) does the shopping and cooks varied dishes, all through the week. On the other hand, this same home help drives to do Mrs Vendroux's shopping who lives in the outskirts, far from shops. She has less time left to prepare meals, which will be quickly fixed and less varied. She prepares for several days and uses ready-cooked meals. We see here the social category effects, with well-off elderly people more often living in the centre close to shops.

Observing interactions between the home help and the elderly person shows three types of delegation of food activities, the effects of which vary according to the elderly person's expectations (irrespective of the household position: couple or person alone).

- In positions of *subordination* ("work for"), the elderly person's word is authoritative, the home help carrying out their requests. The elderly person refuses to take the helps' recommendations into account. For instance, although the help suggests reducing pork meat (thought to be too fatty) or eat tuna instead of salmon (also thought to be too fatty), the elderly person refuses to integrate those suggestions into her food diet. The home help's competencies will be judged on the sole ability to meet the expectations of the elderly person who enhances her own cooking competencies. This implies few transformations in the food consumed and cooking done. This type of social interaction is more marked when the elderly person is a woman from the middle or upper social classes.

- *Conversely*, in situations of *complementarity* ("do with"), the relationship is one of skills sharing, enhancing the integration of new food and new cooking methods. Here, the elderly people are more concerned about their diet and pay more attention to the home help's food advice when the latter is involved. Here, changes are as much about the produce consumed as the cooking methods: for instance, eating poultry instead of cooked pork meats; learning new cooking (steam cooking instead of cooking with butter). The relationship of complementarity is more frequent when there is social proximity between the home help and the elderly person, that is to say, in working-class groups.
- Last, some elderly people lose interest in their diet and integrate the help's prescriptions. They no longer worry about their meal content. In this case, more than the profession, what counts is the gender (the characteristic situation of a man living alone) or the convalescence experiment. In such situations of *substitution* ("act in place of"), the home help takes on the food activities, but losing or keeping food habits depends on the home help's involvement. This is the case of Mrs Renaud who lost her appetite and did not cook anymore after convalescence. The intervention of her care-attendant, who was very much involved, helped her to get back her appetite and transform her food habits.

"Keeping up the food diet" in spite of family reorganization: the effects on food diet in cases of family caring

Relaying public preventive policies is less visible in cases of family caring. In these circumstances, *the elderly person (alone or in a couple) ideally attempts to maintain the family food diet.* However, we observe food changes that are not linked to dietary and nutritional recommendations but to the types of family re-organization of the food activities linked to disability attendance.

In this way, when, in a couple, the disabled spouse is taken care of by the other spouse, diet transformations are linked to daily time management, *between the time dedicated to the disabled spouse* (wash, dress), *the time dedicated to the*

couple (food) and *the time for oneself* (activities, leisure). They also depend on potential taste changes, medical prescriptions and even on physiological problems linked to the illness (mastication). But they chiefly vary according to *the carer's status and sex* (spouse; daughter/son), *and the ill spouse's sex and disability type* (physical or psychological) *and the household's socioprofessional category*. Each person's cooking skills also come into play. When the husband is physically or psychologically disabled, *the spouse keeps on preparing meals and attempts to maintain the couple's food diet and food diversity* (irrespective of the profession). However, we observe changes in the shopping modes, cooking and in the produce and dishes consumed. Some women delegate the shopping (but they all prepare meals), others take care of everything. Some prepare different dishes for their husband and themselves, others adapt their diet to their husband's. Whatever the situation, they mobilize a whole set of cooking skills to vary the meals. For example, Mrs Leroi, 76 years old, whose husband has Alzheimer's, delegates her shopping to a minimarket. She keeps on cooking a variety of dishes (vegetable casserole, beef coked in wine, fillet of beef in brioche, filet mignon of veal, fish with sauce) but she has changed her ways of cooking (fresh produce is replaced by frozen products (vegetables, chips, fish and so on.), 4th category vacuum-packed products (potatoes, beetroot, bacon, cheese, short crust, and so on.) and products in tubes (sauce, mayonnaise and so on.) which allow her to cook quicker (while keeping to the couple's diet) and free time for her.

Conversely, if the wife is psychologically disabled, the changes are due to the way the husband takes over. For these generations, men had no or few cooking skills. So their methods of cooking are much more simplified, the dishes less varied and they resort to ready-made dishes more frequently. Food diversity is lower. This is the case of Mr Lecorre whose wife suffers from Alzheimer's disease. Instead of the dishes cooked by his wife (stuffed tomatoes, squid with spicy tomato sauce, rice pudding, beef casserole with red wine, and so on), he cooks fried beef steaks with potatoes and a ready-cooked sauce, for instance. He often prepares frozen and ready-made meals. Furthermore, he has made a weekly menu and repeats it every week.

On the other hand, when the wife suffers from physical disabilities, she keeps "control over" the meal content, but maintaining the couple's diet depends on the husband's acceptance to be monitored when doing what his wife used to do. Sometimes, the husband does the shopping and does all or part of the cooking activities. He usually reproduces his wife's ways of cooking (who, for instance, directs him), keeping the household's cooking habits. In other situations, the husband's participation is limited to supply tasks, the wife providing the cooking with difficulty: she modifies her cooking methods and simplifies dishes, or even gives up a dish (starter or dessert). For instance, Mrs Sildrat is overweight, which limits her ability to get around. Her husband, a retired fisherman deeply involved in an association, only takes care of the shopping. She is the one who prepares the meals but limits the preparations that require a lot of kitchen utensils. She prefers to give up sophisticated cooking for simplified dishes (boiled fish and potatoes instead of fish with homemade spicy tomato sauce) and gave up starters. Usually, in the salaried categories, husbands involve themselves more frequently than in classes where the sexual distribution of tasks is important (craftsmen, shopkeepers, farmers) (Zarka, 1990). When husbands are not involved in any task, the supply is often delegated to a child whose involvement type depends on their sex. As a rule, sons perform tasks and do not interfere in their parents' food diet. They usually limit themselves to doing the shopping (Petite, Weber, 2006). Conversely, besides doing the shopping, daughters interfere more in their parents' meal content, making suggestions or even challenging their food habits. This leads to conflicts between mother and daughter on cooking skills and particularly on dietary knowledge. Here again, we witness a generation effect, daughters being more sensitive to dietary matters than their mother is. Their involvement modifies cooking methods (replacing butter by olive oil), or even meal contents (giving up desserts considered too "sweet"). These crossed effects of gender and generation are more marked in the working classes (where the use of family members is more frequent than in the other categories) and become more pronounced when, in her parents' eyes, the daughter enjoys upward social mobility. We also find this asymmetry daughter/son type in the cases of widowed women delegating the shopping to children.

In conclusion

The (familial or professional) care of the disabled elderly therefore changes the household's food diet. These changes consist in an integration or rejection of cooking ways and meal sequences leading to either diversity or simplification of meals. They vary according to the type of participants and according to profession, sex and (physical or psychological) disability of the household's members.

Carried out as part of the French National Nutrition and Health programme and based on the maintenance of food diversity, the preventive policy targeted towards the elderly must take into account these effects of social interactions: the issue of elderly undernourishment does not only pertain to food and nutrition problematics but concerns the whole set of social adaptative conditions of preventive policies, which particularly depend on the relationships between the elderly and the people who attend them and are responsible for implementing the policy.

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Frame 1: The French National, Nutritional and Health programme (PNNS)

Started in January 2001, the main objective of the French National, Nutritional and Health programme is education as regards French population's food. It now gives a large place to the elderly, an "at risk" population because of health changes due to ageing and occurrence of physiological and biological problems. One of the PNNS nutritional objectives regards prevention, screening and preventing of ageing people undernourishment.

Frame 2: The survey

The methodology relies on a qualitative survey carried out between 2005 and 2006 with some fifty households aged between 70 and 85 years old and from various professions, living alone or in couple, in rural or urban areas. We met them through home help services and most of them benefit from a disability living allowance. The survey is based on semi-directive interviews and observation survey (observation of domestic places - stocking, place of food preparation - and district area - shopkeepers, markets). We also analyze *the list of meals*: each household writes down the content of daily meals during a fortnight and later on is interviewed on the basis of this list in order to give an account of the *methods and places of supply, cooking ways and meal content.* Moreover, interviews were carried out with home helps (either at the elderly home, or at the employing association, or at their own home).

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