Family influences on eating behaviour in low income households with pre-school children

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Abstract

Healthy eating advice aimed at families has traditionally been targeted at women in the belief that it is they who make the decisions about food consumption within the family. The overall aim of this study was to explore the family influences on eating behaviour in low income households with pre-school children. It focused on both the man and the woman in the family. It was considered particularly important to include men since the literature showed that little relevant research had been conducted with men on low incomes.

The study consisted of four phases. The first involved interviewing 10 couples in their home. The second phase comprised of two single sex focus groups. The third phase provided a negative case analysis of women who were not prepared to be interviewed with their partners but were willing to be interviewed on their own. The final phase involved 22 couples interviewed in their home to ensure the trustworthiness of the results of the previous phases. The study was conducted from an interpretivist perspective and the findings were analysed, drawing on the principles of Grounded Theory.

The male partner and the children were found to be particularly influential on eating behaviour, as was the cost of food and the time available for preparing meals. Families changed their eating behaviour over time and this was especially true once the couple began to co-habit and again when their children were old enough to make choices about what they ate. During the process of the research, the concept of the 'life course' emerged as a major theme and was explored in greater depth using the nutrition career as a theoretical framework.

Following on from this, different family cultures were mapped out alongside the life course. These two themes were found to relate dynamically and a 'Life Course and Family Culture' (LCFC) model was developed. It is suggested that this model could be used as a basis for developing health promotion needs assessment tools and a questionnaire developed in the study is suggested as a means of facilitating this.

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Author's Declaration

The findings of the study have been presented in a number of settings:

Mackereth, C. J., Milner, S. J. and Watson, D. (1999) Food consumption in low income families with pre-school children. *British Journal of Community Nursing*, **l4**, (7), p. 332 - 337. A copy is included at the end of the thesis.

Two poster presentations: Research Training Fellowship Conference, Northern and Yorkshire NHS Executive 1996; Annual Presentation Day, NoReN 1996.

Conference presentation: *Gender influences on eating behaviour in families on low-incomes*. Community Practitioners' and Health Visitors' Conference, Bournemouth, 2001.

Presentations of the findings were shared with the following groups within Low Teams: Women's Health Group; Family Centre Management Committee; Teams Support Group.

Chapter One

Rationale, design and structure for the study

Introduction

This chapter sets out the rationale for the study. The background to the study is described in order to provide the context within which the research took place. A profile of the study area is provided. The aim and objectives of the research are then presented. Finally, the study design is described and an outline of the structure of the thesis is provided.

Rationale for the research

The researcher was working as a community development worker in a Family Centre in Low Teams at the beginning of the research and was employed to work with the community using a community development approach. This required starting from the perspective of local people, exploring their agenda and working with them to address some of the health issues which concerned them. Food and eating was a perennial topic in both group sessions and in conversation with local residents. There were frequent discussions about what they should cook for tea, where they had seen some cheap food product, what they had eaten the night before and whether they had enjoyed it, what new foods they had tried and what their partner or children would eat or not. It was decided therefore that exploring what influences affected eating behaviour in families would be an appropriate area for research. It was a topic which could possibly provide the information necessary to influence a health promotion strategy about eating, particularly from a community development perspective.

Over the past decade, community development has been increasingly seen by health and local authorities as a way of addressing the problems which are rife in many deprived communities. Current government policies reflect this growing interest and recognise that community development can impact on policies across all departments, including the Department of Health, the Department of Environment, Food and Rural Affairs,

Department for Education and Employment, The Department of Environment, Transport and the Regions and the Home Office (Federation of Community Work Training Groups 2001). A 'joined up', strategic thinking way of developing policy is recognised as the way to bring about neighbourhood renewal (Social Exclusion Unit 2001). This national strategy encourages the delivery of learning opportunities locally and supports the regional co-ordination and development of standards and policies which are nationally agreed.

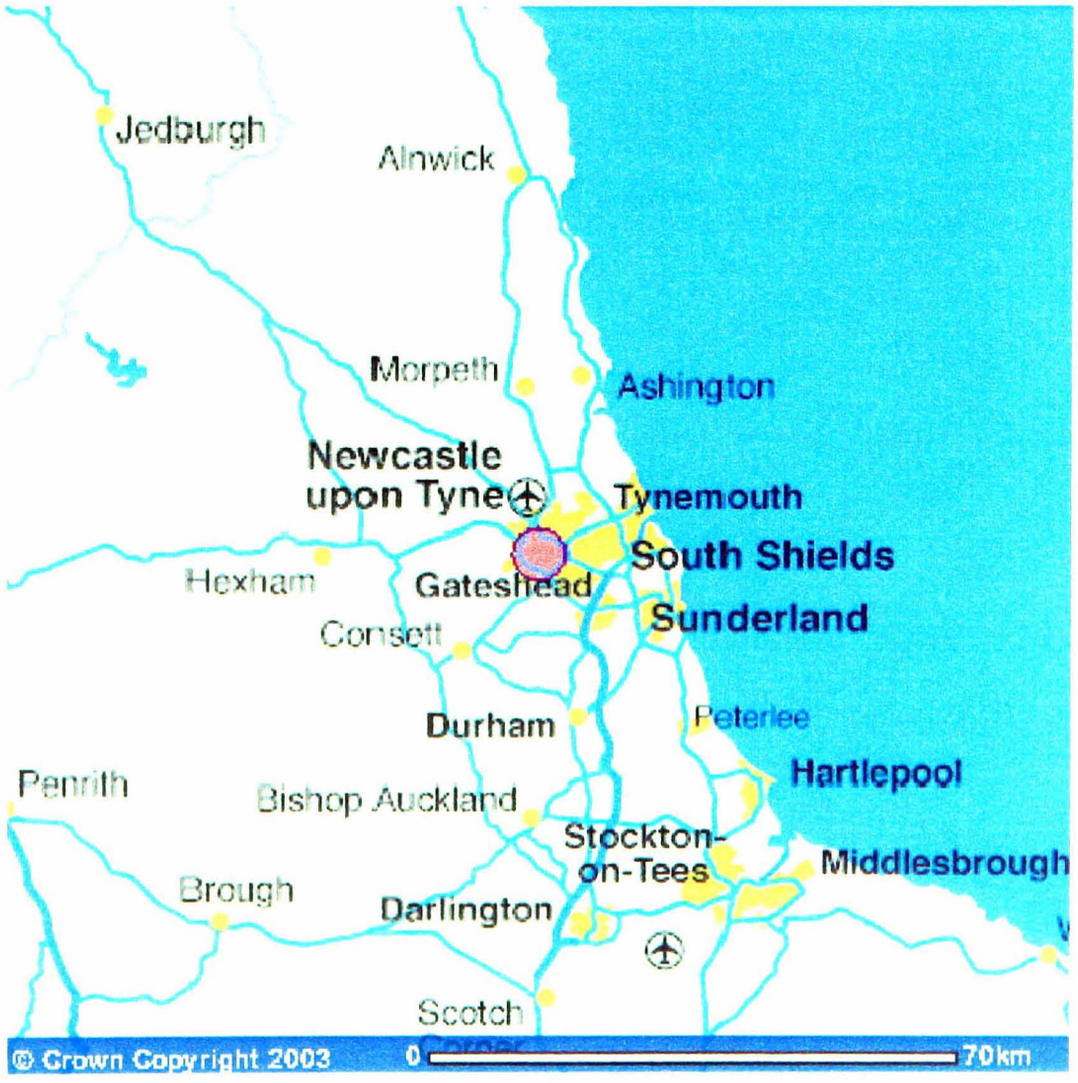
There has been a plethora of initiatives aimed at reviving local economies and developing communities, such as Health Action Zones (Department of Health (DoH) 1998a) and Sure Start (DoH 1998b), many of which have developed food related activities. All these are based on local communities participating not only in the programmes, but often in the process of developing the programmes and sometimes in the delivery. However, many of these initiatives have been criticised for being imposed from above, with little participation or consultation (Foley and Martin 2000). It seems that a commitment to community development on paper is not enough to translate it into practice.

The setting for the research study was Low Teams, an area of high deprivation. It has the usual accompanying high rates of unemployment, low education attainment, poor housing and poor health. Various local initiatives were in place when the researcher worked there, including a community development health project, a community centre, a community business, a volunteer project and a Family Centre. The latter was where the researcher was based and worked closely with, predominantly, local women.

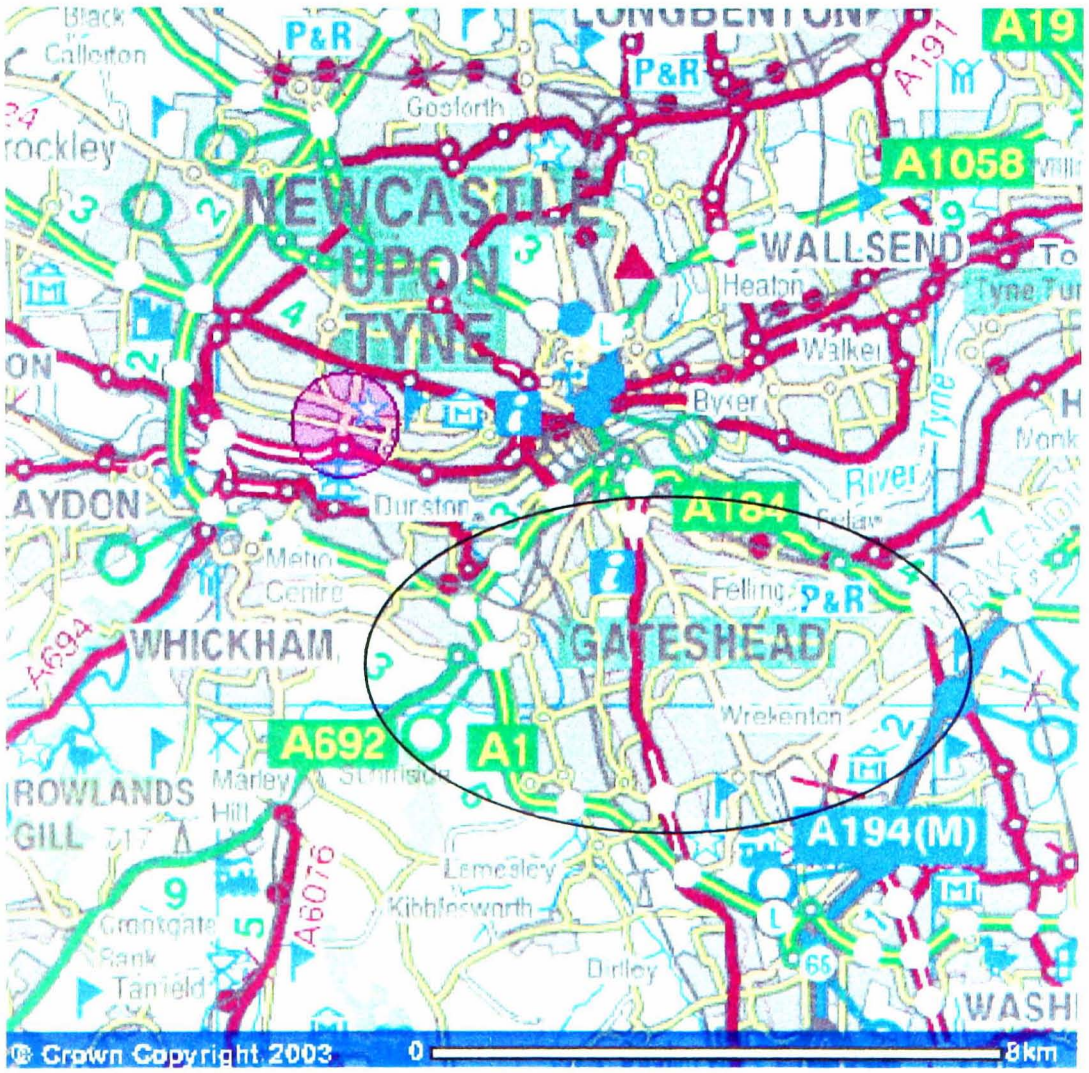
The setting of the research study

Gateshead is a town in the North East of England, on the south side of the river Tyne (see Maps One and Two). The Ward is divided into two areas - High Teams, which includes the Team Valley Trading Estate and the more affluent Lobley Hill, and Low Teams which lies close to the river and is bounded on the south, east and north by a dual carriageway and on the west by gas works and industrial waste land (see Map Three).

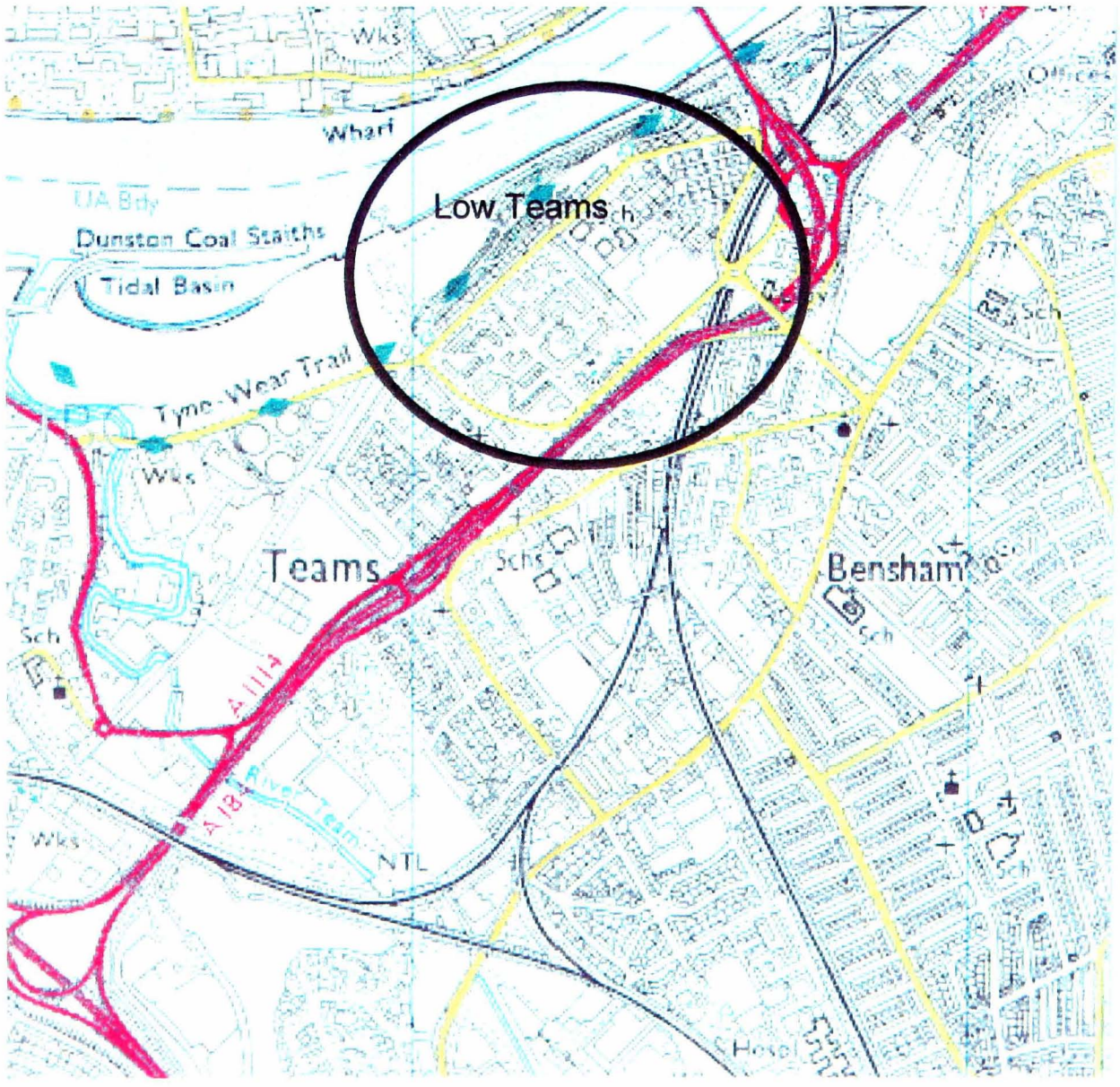
Map One. United Kingdom and Tyne and Wear



Map Two. Around Gateshead



Map Three. Low Teams



The social characteristics of High and Low Teams are quite different and so the Ward statistics do not accurately reflect the situation in either area. This is highlighted when figures for Low Teams are examined, which is an area of much greater deprivation than High Teams. The research was conducted in Low Teams, part of Teams Ward in the north of Gateshead, approximately two miles from the town centre, because this was recognised as an area of particular poverty.

The population of Teams Ward is 9,444 (all statistics from Gateshead Metropolitan Borough 1991). Low Teams has a population of 2,304. The age distribution of Low Teams, Teams Ward and Gateshead are shown below (see Table One).The population of Gateshead is gradually declining, with young people moving away from the North East to find work and families moving to new, out of town housing developments. This has implications for the provision of services in Low Teams. Generally this demographic shift leads to an increasingly elderly population. However, Low Teams has a high proportion of under fives when compared with Gateshead as a whole. This subsequently affects health services and health promotion provision for families with pre-school children (statistics for 1981 were unavailable for Low Teams and for some areas for Teams Ward).

Over 60% of the population of Teams Ward lives in rented accommodation, the vast majority being local authority owned (see Table Two). This figure rises to over 85% in Low Teams. Some of the housing stock is of reasonable quality, built in the traditional post-war style, and has benefited from modernisation. The most unpopular housing is the maisonettes, built in the late sixties, which have suffered major problems with water penetration and damp associated with flat roofs. These are well identified health hazards (Olson 2001). Young families placed there face problems with lack of play areas, flights of stairs and the accompanying safety problems, vandalism and waste disposal. Clasper Village, situated at the east end of Low Teams, is another area of sixties low rise housing which has been identified as having associated health risks, such as safety and a lack of play areas. There is a small recently developed private housing estate, which partly

accounts for the increase in owner occupied housing, along with people buying council houses following the 1980 Housing Act. Many of these houses are on the market.

Table One. Population structure

Population structure	Low Teams	Teams Ward		Gateshead	
Date	1991	1981	1991	1981	1991
Total population	2,304	9,807	9,444	210,934	199,588
Number of males	1,109	4,769	4,451	102,916	96,357
Number of females	1,195	5,038	4,993	108,018	103,231
% aged under 5	10.6%	5%	6.9%	6%	6.1%
% aged 5 – 15	14.3%	15%	16%	12.7%	13%
% aged 16 – 24	16.0%		12.6%		12.5%
% aged 75 and over	5.2%	8%	9%	6%	8%
% ethnic minority	1%		0.4%		0.8%
% with a long term limiting illness	21.0%		21.1%		17.3%

A great deal has been written about the effects of housing on health (e.g. Lowry 1991). Townsend et al. (1986) cited non-ownership as an indicator of deprivation which is associated with ill-health and the Black Report (Townsend and Davidson 1982) showed that mortality is higher amongst local authority tenants than amongst owner-occupiers, even after allowing for differences in social class. This has obvious bearing on services in an area of high council tenancy. Low Teams has a substantially higher level of council tenants than the Ward as a whole and will therefore not have experienced the health benefits of home ownership that other areas in the Ward have.

Table Two. Housing

Household type	Low Teams	Teams	Teams	Gateshead	Gateshead
Date	1991	1981	1991	1981	1991
Number of households	972	3,869	4,196	78,971	82,903
% with dependant children	36.5	27	27.1	33	28.6
% of lone parents	31.3		24.2		15.8
% with only elderly people	21.8	28	28.6	24	25.9
% with only 1 elderly person	17.1	19	20.9	15	17
% council tenants	85	72	59.2	48	35.9
% owner occupier	12	17	30.3	39	52.7
% privately rented	2.1	7	6.2	9	7.2
% housing association	1.9	2	4.2	3	4.2

Phillimore and Beattie (1994) identified Gateshead as having one of the highest rates of unemployment in Britain. Teams has one of the highest rates in the Borough, and Low Teams can be seen to be particularly affected. (see Table Three). Furthermore, the Index of Multiple Deprivation (Department of the Environment, Transport and the Region 2000) ranks Teams at number 327 out of England's 8,414 wards in the index of multiple deprivation, that is in the five percent of the most deprived wards in the whole country (figures based on income, employment, health deprivation and disability education, skills and training, housing and geographical access to services).

Unemployment has been repeatedly linked to poor health (Philimore and Beattie 1994, Harrington et al. 1993, DoH 1998c). There is a clear correlation between deprivation and heart disease and circulatory problems, cancer, cirrhosis of the liver, asthma and mental health problems (DoH 1998c). Many of these diseases are also linked to diet and eating habits (DoH 2003), which was a major reason for addressing food consumption within the present study. Both deprivation and nutrition are implicated in mortality and morbidity (DoH 1998c). It was therefore considered appropriate to study the diet and

eating behaviour of families living in poverty, given that both these variables have such a significant effect on health.

The implications for health services are enormous. There is a major role for health workers: providing practical advice on benefits and budgeting, counselling, providing support, monitoring family health, stimulating an awareness of needs, initiating innovative ways of working and influencing policies affecting health.

Table Three. Employment

Employment status	Low Teams	Teams	Teams	Gateshead	Gateshead
Date	1991	1981	1991	1981	1991
Full time employment	47.7%	64%	56.6%	67%	61.5%
Part time employment	15.5%	14%	16.9%	14%	17.2.%
Unemployed	29.4%	18%	19.9%	12%	12.6%

Pre-school provision is provided by a Family Centre, which is grant aided by social services and is organised by a local management committee. The aim is to improve the health and social well being of families and to prevent family breakdown, with a clear remit to encourage community participation using the principles of community development (Price 1994). This was where the researcher worked and how she knew many local people.

There are two parent and toddler groups, one based at a local church, the other at the Community Centre. Low Teams has one primary school within the area. A further one is situated outside the area and is attended by some children from Low Teams. Both have nurseries which cater for over three year olds. There is no secondary school in the area

and young people travel approximately two miles to the nearest. There is a College of Further Education situated about four miles away.

Mortality figures are available for Gateshead and the causes are generally similar to those of the UK. Given that the mortality rates are much greater for the lower social classes (Phillimore and Beattie 1994), Teams has consequently a greater incidence of disease, that is morbidity, and higher death, that is mortality, rates. This is indicated by the standardised mortality ratios (SMR). This is a technique of comparing mortality rates with different sectors of the population, maintaining other variables constant. The UK figure is 100, whereas Team's is much higher, at 173.7 (1989-1991), despite holding age, gender and occupation constant. This is the highest in Gateshead and has risen from 136.2 (1981-1983). The standardised illness ratio is 184.4. The other indicator of poor health is low birth weight (18.4% in Teams). Teams is the fifth most deprived Ward in Gateshead, ranking 39th in the whole of the Northern Region. Indicators used are unemployment, overcrowded households, households without a car and non-owner occupied housing, all of which are high in Teams.

Aim and objectives of the research

The aim and objectives of the research were developed in consultation with the local community. This was mainly women who attended the Family Centre who all had an interest in food and eating. The principles of community development were used in developing the aim and objectives, as described in the next chapter.

The aim of the research was:

> *To explore family influences on eating behaviour in low income households with pre-school children*

The objectives of the research were:

1. To investigate gender and family influences on eating behaviour in low income households with pre-school children

2. To explore parents' knowledge, attitudes and beliefs about the relationship between diet and health
3. To identify a practical framework for the promotion of healthy eating in low income families with pre-school children, based on a sound theoretical model

Study design

In order to achieve the overall aim and objectives, the study developed in four phases. Phase One consisted of ten semi-structured interviews, conducted with mixed sex couples, in their own homes. All the couples were on a low income, defined for the purposes of the study as claiming benefit, and had at least one pre-school child. The couple were not necessarily both biological parents of the child or children, but they all lived together as a family in a single household. Each couple was interviewed together, in order to obtain views from both the man and woman within the couple.

Arising from the results in Phase One, it was decided to use a different research method for the next stage. Consequently, in Phase Two, focus groups, one comprising men, the other women, were facilitated at Teams Family Centre. These were all new recruits to the study who had not been interviewed in the first phase. The focus groups offered an opportunity to confirm the findings of Phase One and to gain an insight into living in the study area. They also provided further information about attitudes to eating behaviour, particularly around gender issues.

Phase Three consisted of a group of women who were prepared to be interviewed themselves, but were not prepared to allow the researcher to interview their partner. The six women who were interviewed were, again, all new recruits to the research.

In Phase Four, which followed analysis of the three earlier phases, a different technique, termed 'snowballing', was used to recruit twenty two couples who were interviewed in their home.

The Structure of the thesis

Chapter One. Design, structure and rationale for the study.

This chapter provides the background and context of the study. It then presents the aim and objectives of the study.

Chapter Two. Literature review

This chapter initially examines definitions of health. It recognises that it is a multi-dimensional concept, with no clear definition. Medical and social theories of health are explored, whilst inequalities in health are also discussed with particular reference to socio-economic status and gender.

Definitions of health promotion are subsequently discussed centred around the Preventive, Educational, Social change and Empowerment models. Empowerment is identified as a fundamental concept in health promotion. Individual and community empowerment are explored. Healthy public policy is identified as a major component of health promotion. Community development is defined and a brief history is included.

The relationship between health and diet is considered, with reference to the effects of poverty on diet. Influences on food choices, including men, children, social aspects, dieting, media and income are discussed.

Chapter Three. Methodology and methods

Theoretical issues around research methodology and design of this study are discussed and the interpretivist research paradigm is proposed as the most appropriate approach to the study. The traditional concepts of validity and reliability are critically discussed and it is argued these are inappropriate tools to measure the effectiveness of interpretivist research. 'Trustworthiness' is suggested as an alternative approach to assessing the effectiveness of the research. Triangulation, thick description and reflexivity are explored as methods of promoting trustworthiness.

Analysis is based on the principles of grounded theory, as expounded by Glaser and Strauss (1967), but modified along the ideas of Charmaz (2000), who proposes a less didactic mode of enquiry, allowing for more creative exploration of the data. Use of the interpretivist paradigm, as an over arching theory, the use of grounded theory as a sound basis for analysing data and the principles of community development provided the practical basis for developing a framework which could be useful for community practitioners are explored. Ethical considerations are explored, including issues of informed consent and satisfying the Local NHS Ethics Committee's requirements.

Chapter Four. Phase One: Semi-structured interviews with ten couples

This chapter describes the first phase of the research, which entailed recruiting ten couples. The couples were identified through the Health Authority's Child Health Records. This proved difficult, with many couples refusing to participate. However, once the required number of couples had been interviewed, several categories emerged, described as:-

- *routines: eating meals and snacks*
- *decisions: factors affecting food choice*
- *sharing: cooking and shopping*
- *health and diet: the link*
- *sources of information: about food and health.*

A potential core category, the *life course: influences on eating behaviour over time*, emerged from the data and is explored in more detail in subsequent phases, using the nutrition career as an exploratory framework.

Chapter Five. Phase Two: Focus groups

Two single sex focus groups were conducted in order to confirm the findings from Phase One. Further questions were asked about living in the area, which became another category described as *'Typical' Teams*. The two groups showed some differences, indicating gender dissimilarities within the area.

Chapter Six. Phase Three: women only interviews

Six women whose partners would or could not be contacted were also interviewed in Phase Three. This provided negative case analysis, wherein unusual cases are examined in order to confirm the original findings or not. This group provided a different perspective on family life in the area. Reasons for male refusal were also sought and obtained.

Chapter Seven. Phase Four: Interviews with couples

Given the difficulties in recruiting couples in Phase One, a snowballing technique was employed in Phase Four, wherein people known to the researcher were asked if they knew of couples who would be prepared to be interviewed for the study. The potential core category of the life course was confirmed, by using the nutrition career as a framework for exploring the areas of growing up, adolescence, leaving home, co-habiting and having children.

The differing family influences were explored, particularly that of men and children. Cost and time were recognised as relevant issues, as were the social aspects, including social exclusion as a specific problem. Couple's views about the relationship between health and food was explored, as well as about sources of information about food. Finally, variations across the different phases were examined.

Chapter Eight. Discussion

The findings are explored in greater detail in this chapter. Initially the first core category of the life course is discussed in relationship to the nutrition career which was used as the framework within which to explore the concept in greater detail. A second core category, the family culture is then discussed in its different manifestations: *quick and easy, rushed and organised*. From these two core themes a 'Life Course and Family Culture' (LCFC) model is identified as a potentially useful tool in assessing families by developing and using a questionnaire. The implications of the use of this model for health promotion practice is then explored.

Chapter Nine. Reflections on the research

Initially, the chapter returns to the aim and objectives of the research to assess to what extent they have been fulfilled. The importance of establishing trustworthiness is then discussed and the limitations of the research are explored.

Recommendations for improving health promotion opportunities for low income families are suggested, which include understanding the importance of recognising diversity within communities, improving information available to families, improving the provision of health promotion for young people, children, men and women and promoting healthy public policies.

Suggestions for further research are made, including issues about researching men on low incomes and accessing children living in families on low income. Action research is suggested as a useful tool to explore healthy eating with families on low incomes, particularly from a community development approach.

Summary

This chapter has described the background and rationale to the research. It outlined the researcher's post as a community development worker and expressed the reason for focussing on food and eating behaviour. The chapter then provided an account of the setting of the research, with statistical evidence of the deprivation of the study area. The aim and objectives of the study were expressed. Finally, the study design was described, phase by phase and the structure of the thesis was outlined.

The next chapter is a literature review of the area under study. It examines different concepts of health and explores health promotion as a way of improving health. It then explores the literature on food and eating behaviour.

Chapter Two

Literature review

Introduction

This chapter provides a review of the literature relevant to the research study. It starts with a discussion of definitions of health, with particular reference to medical and social models. The range of determinants of health are identified and inequalities in health are discussed in relation to the link between poverty and poor health. Differences in men's and women's experience of health are explored. The promotion of the public health is discussed and empowerment as a key aspect of health promotion is explored in detail. Community development, as a particular approach to promoting health, is examined. Despite criticisms which can be directed at community development, it is an approach which explicitly addresses inequalities. Following an examination of the literature on the effect of diet on health, influences, particularly the effect of the male, on food choice is reviewed, including the influence of children, advertising, income, and the lack of food policies.

Definitions of health

Health is a difficult concept to define because it is multi-faceted. There have been numerous attempts to define health. One of the most commonly quoted definitions of health was introduced by the World Health Organisation (WHO) in 1948:

> 'Health is a state of complete physical, mental and social well-being, not merely the absence of disease'

This definition draws on two models of health which the literature identifies: the 'medical' model and the 'social' model.

The 'medical' model of health has a long history (Seedhouse 1986, Naidoo and Wills 1994, Nettleton 1995). This approach to health has been used predominantly within the tradition of western scientific medicine, which is based in the positivist tradition of

scientific enquiry (Hughes 1990). Positivism implies a deterministic view of the world, in which there is an objective reality that can be discovered through experimentation. This is the foundation of scientific research and is based on the idea that there is always a cause for any event, for example, night and day are caused by the earth rotating round the sun.

Five basic assumptions can be identified as fundamental to the 'medical' model of health (Nettleton 1995). The first of these derives from the Cartesian philosophical doctrine of mind-body dualism and argues that all human beings have a mind and a body, and these are two separate entities. Bodies are in external space and subject to the mechanistic laws of nature, as are other objects in space. They exist in objective reality and can therefore be inspected by external observers. Minds, however, are not subject to inspection by others and mechanistic laws do not apply (Ryle 1949). The second assumption conceptualises the body as a machine, as an object which can be repaired when it breaks down, with doctors and other health workers acting as mechanics who restore utility when the body is dysfunctional. Following on from this, a third supposition assumes that the physical body requires physical cures. The primacy of technological interventions is accepted, wherein surgery, physical treatments and drug therapy are considered the appropriate methods of managing medical problems. A fourth assumption of the 'medical' model is that a biological cause of disease is more important than psychological and social factors. Finally, it is suggested that all diseases have specific physical causes, for example, distinct agents, such as bacteria or viruses, particular deficiencies, such as vitamins or minerals, or physical trauma, such as fractures. Diseases, once diagnosed, can then be physically cured by mechanistic or pharmaceutical means.

Over the past 150 years disease patterns have changed considerably. There has been a considerable reduction in mortality, that is death rates, and morbidity, that is rates of illness. However, despite the predominance of the 'medical' model of health within western industrialised countries, these improvements in health have not been due to medicine alone (Ashton and Seymour 1988). In the second half of the nineteenth century, the main causes of death in the western world were infectious diseases, such as tuberculosis, whooping cough, measles, scarlet fever, small pox and diphtheria. Poor

housing and sanitation were recognised as significant factors in the spread of these diseases (McKeown,1976). Massive programmes of environmental improvement were introduced, such as improved sanitation, ventilation and hygiene, which led to considerable reductions in mortality from infectious diseases over the ensuing 100 years (Baggott 2000). Medical interventions, such as BCG vaccination, immunisation for whooping cough and measles and the introduction of sulphonamides and antibiotics, were all introduced when mortality rate for those diseases had already been substantially reduced (McKeown and Lowe 1974).

The 'medical' model, in its most conventional form, is criticised for the encroaching medicalisation of all areas of human experience (Tones and Tilford, 1994). Many areas of social life have become regulated by medicine. For example, sickness leading to time off work and access to benefit has to be sanctioned by a doctor, via a sick note (Thorogood 1992). Another example is pregnancy and birth. Instead of treating the event as a normal and natural occurrence, childbirth has come to be defined as a medical problem and consequently women are expected to have their babies in hospital, even though there is no evidence of increased safety (Nettleton 1995). As Thorogood (1992) states

> 'There are few areas of social life on which medicine doesn't have an 'expert' opinion' (p. 47).

Thus, as the medical profession claims expertise in increasing spheres of life, the 'lay' population becomes increasingly dependent on medicine (Tones and Tilford 1994). This dependency leads to de-skilling of lay people and consequently increased dependency on the very agency (medicine) which is disenabling them (Thorogood 1992). They become the passive recipients of medical treatment, and are increasingly disempowered.

Empowerment is considered a key aspect of a more holistic view of health and is generally considered to be the process by which a person gains control of his or her life (Rissel 1994). Empowerment is a difficult concept to define, but it involves the development of a positive self-esteem and having autonomy within one's life. The concept of empowerment will be explored more fully in relation to health promotion,

later in this chapter. This alternative approach to defining health comes from a humanist perspective.

Humanists accept that human beings are complex and live in an ever changing world, within which there are interconnections between other humans and the physical, spiritual and intellectual worlds (Seedhouse 1986). A humanist perspective of health emphasises the importance of the concepts of autonomy and empowerment (Illich 1976, Tones 1998). It is a viewpoint that is less about disease or illness and rejects the medicalisation of people's lives. Instead, humanists are concerned with personal and lay perspectives (Naidoo and Wills 1994).

This humanist approach to health is acknowledged as the 'social' model of health. Within this model, health is determined by a broad range of factors. Social and environmental determinants have been identified as major elements affecting the changing patterns of disease. The 'medical' model, with its focus on the treatment of illness, fails to address these issues (Macdonald and Bunton 1992). A large body of research has shown that morbidity and mortality are consistently related to levels of poverty (defined by the European Union as income below half of the national average income), unemployment and poor housing (Townsend and Davidson 1982, Whitehead 1987, Phillimore and Beattie 1994, Department of Health 1998c). Other key determinants of health include gender, race and age (Department of Health, 1998a). The present study had an explicit interest in poverty and gender, and these are examined in greater detail later.

The widely quoted WHO (1948) definition attempts to introduce a humanist element, by including 'psychological and mental well-being'. It has, however, been criticised as being too idealistic (Downie et al. 1990, Seedhouse 1997). In the WHO definition, an individual can not be healthy if there is any kind of illness, disease or disability. Nor can they have any social problems. Indeed they must feel absolutely well in all respects, which seems somewhat utopian. It would be rare for anybody to be in such an ideal state of 'physical, psychological and mental well-being' for long, and that is assuming they could ever reach such a state. Furthermore, having such an ideal to aspire to may be

disempowering if people strive for the impossible and realise they will never attain such an ideal status. They must then conclude they are unhealthy, with all the negative connotations involved.

Seedhouse (1995) challenges the concept of well-being. He argues that no definition of 'well-being' is offered. One person's view of well-being might be very different to another's. For example, one person's notion of well-being could be going out to a bar drinking every night, whereas another's might be going out for a run, eating a healthy meal and getting to bed early. The notion of well-being becomes such a wide concept that it may include anything, and as such becomes meaningless. Indeed, 'well-being' becomes synonymous with 'health' because it does not add anything to the meaning.

In 1986, in the Ottowa Charter for Health Promotion (1986), WHO expanded their definition of health.

> 'To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities.'

This definition is subject to the same criticisms as the earlier one. 'Complete' well-being is again a utopian ideal, which if aspired to would inevitably lead to failure. It does not identify what aspirations or needs should health be a resource for. Furthermore, if health refers to any resources for everyday life, it could include anything. For example, if an alcoholic required alcohol every evening to continue with living, it could be argued that alcohol is a health resource for that person, but this is not most people's understanding of health.

The definition is so broad, it provides no boundaries to provide an understanding of what 'health' means in practice (Naidoo and Wills 1994). This vagueness means that anyone wanting to work for health has nothing to base that work on, that there are no limits to what could be included as 'health work', nor can any targets be set to ascertain any

achievement. However, whilst many would agree that health is a difficult concept to define, there is a general consensus of the basic appropriate areas to work within the health service (Seedhouse 1986, Simnett 1995).

Seedhouse (1986) has sought to combine medical and social theories of health. His theory states that health is the foundation for achievement of an individual's potential, that is, the extent that a person can reach his or her chosen level of autonomy.

> 'A person's optimum state of health is equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance for all people. Others are variable dependent upon individual abilities and circumstances' (p. 61)

The conditions are similar to building bricks, or the foundation stones of a building. They are what creates a basis from which to develop one's potential. Such core conditions include basic needs such as food and warmth, access to information, skills, confidence and companionship. Health workers should put their efforts into strengthening these fundamental priorities and allow individuals then to autonomously develop their potential as they see fit. Within this theory everybody has their own potential for achievement. However, everyone will have a different potential and therefore a different meaning of 'health'. The flexibility of the theory, of course, means that it is just as vague as some of the other theories that Seedhouse criticises (Naidoo and Wills 1994).

To define 'health' or to create one unified theory of health may be impossible. It could be argued that all the theories and models discussed above have something to offer health workers and no-one should claim to have the answer to these debates. Health is a multifaceted concept and no simplistic answers can be expected. As Williams states:

> 'Of course, the way in which society views health is a reflection of the values it holds at that particular time.' (1992, p. 48)

Health is also experienced in different ways within society, depending on a host of determinants, which lead to inequalities in health.

Inequalities in health

Not all social groups experience the same levels of health. There are a broad range of determinants of health, such as socio-economic group, gender, race and age (DoH 1998c). The present study has an explicit interest in social class and gender and this review focuses on those two determinants of health.

Inequalities in health and socio-economic group

There has been knowledge of the link between poverty and poor health for many years. Poor recruits for the Boer War were found to be so unhealthy that many were unfit for duty (Smith 1996). Statistics showing the correlation between health and wealth are usually expressed in terms of socio-economic group. This is a classification system derived from the Registrar General's scale of occupational class. Thus, Social Class I includes those working in professional occupations and ranges down to Social Class V, which is made up of unskilled manual workers.

In 1979, the government commissioned a report on health inequalities. This was the Black Report, which identified striking differences in the mortality and morbidity statistics between the social classes. Social Classes IV and V were found to experience considerably poorer health at all stages of life when compared with Social Classes I and II. The report concluded with a wide ranging list of recommendations to counteract poverty and so improve health (Townsend and Davidson 1982). This was succeeded by the publication of The Health Divide in 1987 by Whitehead who found that class differentials were getting wider. In 1994, Philimore and Beattie found that in the Northern Region, inequalities were increasing, with the gap between the health of the wealthy and that of the poor widening.

A more recent report, the Acheson Report (DoH 1998c), confirmed this trend. For example, in the 1970s the mortality rate among men of working age in social class I was half that of social class V. By the early 1990s, it was three times lower. This differential can be identified across all social classes, so that between the 1970s and 1990s, rates fell

by approximately 40% for the professional classes, by 30% for the skilled and partially skilled workers and by only 10% for the unskilled. These growing differences are also evident in morbidity rates, including cardiovascular diseases, respiratory diseases, most cancers and male suicides. Social Classes IV and V were found to be more likely to be obese (a risk factor for many diseases), be prone to accidents and suffer poor mental health. Acheson (DoH 1998c) found that the proportion of people living in poverty had increased from 10% in 1961 to 20% in 1996. In 1998, overall unemployment was three times higher than it had been in the late 1960s, with rates being four times higher in social classes IV and V than I and II. The Acheson Report established that poverty affected maternal nutrition, which has repercussions on a child's later health and the class differential in infant mortality remained wide.

The Acheson Report (DoH 1998c) identified that any improvements in health must take account of the structural factors of social class, which lead to those in poverty living in sub-standard housing in a poor environment, having limited educational opportunities, and restricted access to services. The poor were also found to be more likely to suffer further social problems such as violence, crime and truancy. They were more likely to smoke, due to the stress of living in poverty (Blackburn 1991), not exercise and eat unhealthily, usually because of lack of access to facilities and lack of money (Leather 1995). These are factors outside the scope of medicine but have profound effects on health (Thorogood 1992).

There is an abundance of evidence showing inequalities in health across the social classes. However, there are strong indicators that it is not just absolute poverty, but relative inequality which affects health (Wilkinson 1996).

> 'Part of the association between people's material circumstances and their health appears to be not so much a direct relationship between exposure to unhealthy material circumstances as a relationship between relative income, or social position and health' (Wilkinson 1999, p. 256).

Thus, increasing income per se will not be likely to improve health generally in developed countries, whereas reducing inequalities between social groups is likely to. In more egalitarian societies, health is improved overall, and seems to be related to the lack

of major differences in social status. Consequently, although in the USA more than twice the gross domestic product per capita is spent on health compared to Greece, the population of the former has a lower life expectancy (Wilkinson 1999).

The Acheson Report (DoH 1998c) concluded that persisting inequalities were unacceptable. Three areas were considered of fundamental importance:

> 'all policies likely to have an impact on health should be evaluated in terms of their impact on health inequalities; a high priority should be given to the health of families with children; further steps should be taken to reduce income inequalities and improve the living standards of poor households' (Synopsis).

Other wide ranging recommendations were made, including improving levels of and access to benefits, promoting education, improving social housing and transport systems, more day-care, better food and equitable access to health services. In the preface, Acheson says:

> 'it has become clear that the range of factors influencing inequalities in health extends far beyond the remit of the Department of Health and that a response by the Government as a whole will be needed to deal with them'.

The Government has responded to the Acheson Report (DoH 1998c) by recognising that the Department of Health alone cannot tackle inequalities in health. All Government departments have a role to play in reducing health variations. Professions concerned with these issues, such as health workers, generally greeted the report and Prime Minister Blair's vision of health care positively, with the proviso that resources would be needed (Allen 1999, Eaton 1999). It was clear that if health were to be truly promoted, many other Departments beyond the Department of Health would need to be involved in policy making to reduce inequalities.

Inequalities in health and gender

Inequalities in health are expressed through gender, as well as social class. Male mortality is greater than female mortality at all ages. Between the years 1982 – 1992, the only group with increasing mortality rates was young males, aged 26-38 years . This can

be explained by the increasing rates of violent death, suicide, and deaths from AIDS (Tickle 1996).

Morbidity is much more difficult to quantify than mortality. Sources of data for disease and illness are varied and information is not always collated in the same way. There are registers compiled for some diseases, such as cancers and infectious diseases. Other information is obtained from the General Household Survey, which depends on self-reported incidents of ill health (Naidoo and Wills 1994). It has been found that men visit the GP far less often than women, though the latter's number of visits is inflated by pregnancy, childbirth, children and family planning (Office for Personal Census and Surveys 1991). However, the same survey found that between 0-16 years and over 65 years, there were more men as both in and out patients to hospital than women. Blaxter (1990) found that women were more prepared to describe and discuss ill health. It could be that by seeking help earlier, they ward off the development of more serious illness.

Discussion has focused on epidemiological data, but is of limited help in understanding men's and women's differing outlooks on their lives and their health. Robertson and Williams (1997) identify different and important perspectives from which to approach an understanding of masculinity. One such perspective argues that men are genetically programmed to have certain traits such as aggressiveness, independence, strength, competitiveness and to have power over women. This is the stereotype that many men and women expect any individual man to live up to (Mathews 1988). It is men's 'nature' to behave as such and cannot be changed: it is innate and intrinsic. In contrast, women are programmed to be nurturing, caring and dependent (Bilton et al. 1981). However, such biological determinism would entail that sex-specific behaviour is universal amongst men and women, and this is not the case. For most activities and attitudes, exceptions can be found, with women behaving in stereotypically male ways and vice versa.

From a different perspective, gender specific behaviour is considered learned. Sex differences, that is the physical differences between men and women, are biologically determined by genetics. Gender, that is male and female roles, are due to attitudes shaped

by individual learning through the family's and society's culture (Fareed 1994). From birth, carers have different attitudes to male and female infants, and this is reinforced throughout childhood (Sabo and Gordon 1993). Such behaviour includes rough, aggressive and competitive games and increased risk taking by boys when compared to girls.

As children grow up, their social constructs are further shaped by society's stereotypes of men and women. Men are expected to be the breadwinners for the family and engage in paid work outside the family and women to be focused on the home and motherhood, despite more women entering paid employment and more men becoming unemployed (Williams and Robertson 1999). These changes can lead to 'role strain' for both men and women. For men, there can be a contradiction between the stereotype of a man and how a man feels, the difference between the role a man puts on in public and the private man (Holroyd 1997, Robertson 1998) . This can lead to stress which can then lead on to numerous health problems and illness (Matthews 1988). Being a 'good provider' in financial terms is still considered to be one of the most important aspects of masculinity. Unsurprisingly, unemployment provides a contradiction between the ideal man and his reality, and affects mental health negatively (Skelton 1988, Waldron 1995).

For women, their employment, frequently in low paid, part-time work, coupled with men's unemployment, entails a double burden of caring for the household and working (Henwood et al. 1987). Often there is a shared myth within British society that couples share all tasks, but the reality is that housework and childcare is still done predominantly by women (Brandth and Kvande 1998). Dignan (1999) suggests

> 'A new man is one who does not see his role defined by history or culture. The new man is more sensitive and caring and shows his emotional side' (p. 100).

However, he goes on to comment that reality is very different. When men become unemployed, they rarely involve themselves in housework or childcare (Morris 1987, Skelton 1988). Possibly this is due to having lost what is perceived as the 'man's' job, they do not want to lose any more status by doing 'women's' work.

Ideas about the importance of companionable partnerships need to be explored more closely in the context of domestic life. The post-war ideal was to consolidate family life, with new housing being erected to provide homes for a new type of family: one that was optimistic and cosy (Finch and Summerfield 1991).Working class families were traditionally considered to have men earning, women homemaking and the focus was outwards to the extended family and community. Young and Wilmot (1975) found that younger working class couples were forming more companionable relationships, which were home focused, as the middles classes had already done. They saw this as the mores of the middle classes percolating down to the working classes - progress marching onwards. This view of marriage and co-habitation has been challenged by many (e.g. Finch and Morgan 1991, Finch and Summerfield 1991). In most households women still do the majority of household and childcare activities (Oakley 1974, Graham, 1984, Blackburn 1991, Brandthe and Kvande 1998).

This lack of male involvement in childcare and housework may be compounded by health professionals, many of whom are female, by excluding men and working predominantly with women (Barna 1995). Most images of childcare involve mothers rather than fathers, so reinforcing the sex stereotypes (Trevelyan 1996). Chalmers (1992) found on observing health visitors in the home, that they did not tend to include men in the conversation, despite calling themselves 'family visitors'. In the present study, the researcher was working as a community development worker and also was a health visitor. This had the potential for a conflict of interests, between professional roles and research roles. The researcher recognised these different roles and was explicit in describing her role, that is, that she was predominantly a researcher, but would be prepared to negotiate with and refer to other workers, according to the families wishes.

The data obtained by Chalmers (1992) in her interviews with women was assumed to apply to the whole family, but rarely was there any mention of men in the health visitor`s records. In this study some men refused contact with the health visitor, or the health

visitor found access difficult and had problems engaging them in conversation, as did health visitors in William's study.

> 'He [father] always seems to be at the back somehow' (1997, p. 242).

Furthermore, any negotiation around roles and activities within a partnership can reveal problems in communication. This can involve

> 'inattentiveness, vagueness, lack of clarity, over-generalisation, early anticipation of what is about to be said, negative reactions and coercion... Strategies for conflict avoidance included ignoring the issues, refusing to discuss them, competitiveness or co-operation' (Sharpe et al. 1996, p. 23).

Many studies in the 1960s and 1970s were conducted on white middle class men (e.g. Sharpe et al. 1996), thus ignoring working class, unemployed and minority ethnic men. Most research with men is conducted in the public sphere, such as at work, whereas much research with women is conducted in the private domain of the home, wherein domestic tasks are completed (Gamarnikow and Purvis 1983). Many studies have identified that men tend to have less social support than women, are less likely to self-disclose and are more comfortable talking about non-personal issues such as work or leisure (McKee and O'Brien 1983, Balswick 1988). Men are generally more comfortable in the public arena, discussing areas of their lives which are less personal and emotional. McKee and O'Brien (1983) found that when they interviewed men about their roles as fathers, that is, in the private sphere, they

> 'almost uniformly had less to say and took less time to say it' (p. 151)

compared to women.

Given the difficulties in researching men on low incomes, it is perhaps not as unexpected that there is a dearth of health information, as some commentators have suggested.

> 'it is surprising, given the UK's current inequalities in health, that the health issues of ...working-class men are...almost absent from the literature' (Williams 1997, p. 238)

As a way of circumventing this problem, research has often focused on men's beliefs and behaviour *as perceived by women.* Thus low socio-economic class men have, generally speaking, not been studied from their own perspective (Thorogood and Coulter 1992). The difficulties in accessing men living on low incomes (Clarke and Watson 1991) have

meant that women have been asked what *they* think their partner's views were. This research project, therefore, focused on men, as well as women, on low incomes, with the aim of hearing from men themselves about their knowledge, attitudes, beliefs and practice regarding choices in food and eating. This information will contribute to promoting healthy eating amongst this group.

The promotion of public health

Just as 'health' was found to be a multi-faceted and complex term to define, so is the term 'health promotion'. Health promotion is sometimes equated with public health and vice-versa (Tones 2001). However, the term health promotion will be used throughout this thesis. WHO (1985) defines the term 'health promotion' as

> 'the process of enabling people to increase control over and improve their health'

This is a very broad definition and there have been numerous attempts to refine and develop it (Downie et al. 1990, Kendall 1998, Tones and Tilford 2001). Most emphasise a positive sense of health promotion and start from the premise that it is worthwhile improving people's health and that it should aim to improve participation and enhance equity (Jones 1997a). Simnett (1995) expands the WHO definition.

> 'Health promotion empowers people through supporting personal and social development...it increases the options available to people to exercise more control over their own health and over their environment, and to make choices conducive to health...it improves the quality of relationships ...It is based on the principle that people need to learn throughout life, to prepare themselves for all of its stages and to cope with stress and illness' (p. 16)

This definition refers to the broad scope of health promotion and emphasises the importance of empowerment. Models of health promotion are described and the concept of empowerment is then explored in detail because it is central to an understanding of health promotion (WHO 1986, Delaney 1994, Jones 1997b, Tones 1998, 2001).

Models of health promotion

The wider agenda of health promotion shows a shift from the more individual focus of health education to a wider agenda and can be expressed by conceptualising health promotion as a formula:

'Health Promotion = Health Education x Healthy Public Policy'

(Tones and Tilford 1994, p.7)

Both these aspects of health promotion interact with each other. Health education can lead to changes in policy and policy affects how individuals and communities make health choices.

Health education has a range of purposes, including providing information, supporting individual decisions, promoting appropriate use of health services and consciousness raising. Different approaches to health education are useful for these differing functions. They include the medical or preventive model, the behavioural model, the education model, the radical or social change model and the empowerment model. These are not necessarily exclusive and different approaches may be appropriate to achieve certain results.

The preventive model

The preventive model has much in common with the medical model, which has been explored in terms of health earlier. It is an approach which is concerned with preventing mortality and morbidity. It focuses on medical interventions which will do this, such as immunisation and screening. It is expert led from the top-down and based on epidemiological evidence. In some areas it has been successful, as in the eradication of smallpox (Naidoo and Wills 1994). Associated with the medical model is the behaviour change model, which can be placed under the heading of the preventive model. This approach to health promotion is concerned with changing people's behaviour by altering their attitudes (Ewles and Simlett 1985). It is concerned with encouraging people to adopt 'healthy' lifestyles, such as stopping smoking, exercising and eating the 'right' food. However, as identified when the medical model of health was discussed, it ignores the

social and environmental aspects of health. It is often criticised of victim blaming, wherein individuals are held responsible for their own health without addressing factors that may be out of the control of the individual concerned (Tones and Tilford 1994).

The educational model

This approach is concerned with providing knowledge and information from which people can make informed choices. At a very basic level, it is based on the premise that when individuals are provided with knowledge, they will rationally change their attitudes and subsequently their behaviour will change accordingly (Downie et al. 1990). However, although communication in terms of providing information is part of the educational process, teaching involves helping people move through the different psychological aspects of learning. This involves the cognitive component, where information is provided and understanding is promoted, the affective factor, which involves exploring attitudes and feelings, and the behavioural element, concerned with providing the opportunity to develop skills (Naidoo and Wills 1994).

This approach differs from the previous model in that it does not aim to impose an expert view on people or persuade them to change. Although there is an intended outcome, the result may not be the one the educator intends (Ewles and Simnett 1985). An essential element of education is that it aims to develop autonomy, rather than persuading a person to believe in or do what the educator wants them to (Keane 1997). It is different from training, which is about helping people acquire a range of pre-set values, beliefs and skills. Training is necessary for many tasks, but is closer to the concept of indoctrination than education (Seedhouse 1986). A moral element is therefore implicit in the educational model. An ethical continuum can be drawn from, on the one hand the positive, ethically acceptable end, which is where education lies, to the opposite, negative end, where propaganda and brainwashing is consigned (Tones and Tilford 2001). Health promotion from this perspective is concerned with encouraging an understanding of and exploring a person's value system, in order to ensure any choices made are voluntary and informed. Consequently strategies to develop decision making skills are encouraged.

One criticism of the educational model is that its proponents promote it as value-free, and that as long as learners make their own decisions, in full awareness of the facts and with an understanding of their own belief system, it does not matter what choice it is they make. However, no educational process can be said to be value-free. The educator makes value judgements about what topics are discussed and what methods are used (Eweles and Simnett 1985). Health promotion is based on values and is rooted in an ethical system which includes the principles of equity and participation and is based on the premise that health is valued (WHO 1985).

A further criticism that can be made is that there can be substantial barriers which no amount of informed decision making may surmount. Barriers may be found on an individual basis. For example, a person may not be able to exercise due to some physical disability, or be unable to make choices due to an addiction. Barriers may be environmental, for example socio-economic circumstances may prevent a person acting on the rational choices they may have made. Poverty can have an overwhelming effect on people's behaviour, from not being able to afford healthy food to not accessing health services (DoH 1998c). Factors in the environment, such as pollution, are not under an individuals control. Consequently it can be seen that there are many areas of life which can not be controlled by making an informed choice.

The social change model

The social change model is also known as the radical model. It arose from the criticisms of the two earlier models, neither of which address the structural determinants of health in terms of the socio-economic environment (Tones 2001, Naidoo and Wills 1994). As discussed earlier, the literature informing the debate around inequalities in health show the dramatic differences of health experienced by different groups of the population. Poverty, with its associated health determinants such as poor housing, low educational attainment and restricted access to health services, is a major cause of ill health. To address these issues, changes in the physical, economic and social environment are required. This approach involves social and political action and is aimed predominantly

at policy makers, as well as local communities and the general public. It aims to promote change 'to make the healthy choice the easy choice'.

A method used by proponents of the social change model is critical consciousness raising, which was a term developed by Freire in the 1970s (e.g. 1972). He proposed that when activists and local people meet equally, dialogue can develop from trust. This leads to critical consciousness raising, which helps people break false consciousness by a four-fold process. This process comprises of reflection on aspects of personal reality, developing a collective identification of the root causes of that reality, examination of the implications and finally, the development of a plan of action to alter reality (Tones and Tilford 1994). This can occur on different levels. A small group of local parents may meet at school and discuss a child being injured in a car accident. This may lead to concern about road safety within their community generally and provide the impetus to get together to campaign for traffic calming measures. At another level it may involve someone recognising the links between ill health and poverty and lead them to join a political pressure group to reduce unemployment or improve benefits.

Another aspect of this action may include lobbying, which involves bringing pressure to bear on the appropriate organisation or institution to bring about change. Groups may also use advocates, who are individuals or organisations who are more powerful than themselves to lobby on their behalf (Tones and Tilford 2001). Agenda setting is also part of the social change model. It is a less specific activity than lobbying, which tends to focus on particular changes. It is concerned with creating an atmosphere which will encourage change. For example, a community group may increase local awareness of an environmental hazard by leafleting residents, calling public meetings and talking to local groups. They would be setting the agenda, wherein other local people would begin to perceive a problem which would need acting on.

One criticism of this approach to health promotion is that it is tends to address issues which are politically sensitive and those involved may well come across insuperable barriers created by those in power (Ewles and Simnett 1985). The social change model

tends to ignore the fact that powerful vested interests actively campaign to counteract and, if possible, neutralise any activity which does not fit in with their agenda. For example, a community may campaign vigorously against the closure of local health services, but be completely ignored because of the financial limitations of the Primary Care Trust or because the latter has a different agenda, with finances being siphoned into other projects.

A further criticism of the social change model is that it reifies social systems. This has been described as 'the ecological fallacy' (1997a), wherein social systems are deemed to cause disease, in a deterministic way, as in the medical model, where germs are perceived as causing disease. There is a strong correlation between unemployment and ill health, but it would be an error to conclude that there is a causal link - not all people living in poverty are in poor health. Furthermore, it ignores the place of the individual, focusing on a deterministic view of society in which all choices are the inevitable consequences of social circumstances.

> 'The individual is relegated to being nothing more that a system outcome, not a thinking and acting human. The person is the victim of a system'
> (Kelly and Charlton 1997, p. 83).

The empowerment model

The educational model was criticised for focusing only on the individual and the social change model was criticised for focusing purely on the social systems. The empowerment model, however has both an individual and a social element. There are two aspects of empowerment - self-empowerment and community empowerment, which are related and often interact with each other. Both concepts are concerned with encouraging people to identify their own needs, promote positive self-esteem and develop the skills needed to effect change and take control over their lives.

Empowerment is a concept considered essential to health promotion: most theories of health promotion tend to identify empowerment as it's '*raison d'etre*' (Rissel 1994). It is a popular word, which is filled with positive psychological, political, social and ethical

connotations (Rissel 1994, Robertson and Minkler 1994) and yet it is another term in the field of health and health promotion of which the meaning is disputed.

A criticism of the term 'empowerment' has been the lack of definition or theoretical underpinning of the concept (Rissel 1994, Sheilds 1995). Most discussions on the subject, however, do suggest a range of associated concepts: self-esteem, autonomy, positive well-being, personal control, power, support systems, community organization, participation (Gibson 1991, Rissel 1994, Brown and Piper 1995).

Empowerment is usually perceived as a process. It implies development, either personal or communal (Gibson 1991). As a process, it could be the way in which individuals and communities attain control over their own lives. Four stages in the empowerment process have been identified:

- initial awareness of the potential for change
- critical consciousness raising, usually in relationship with others
- development of a positive self-concept, along with skills and competencies
- integration of all these stages into everyday life (Rissel 1994).

Distinctions can be made between individual, self-empowerment and community empowerment. Individual or psychological empowerment is when people feel as though they have control over their lives. This may be a consequence of membership of a local group, attendance at a local college or one-to-one counselling, but may well occur without participation in collective action. For example a woman may find the confidence to leave an abusive relationship following counselling, but may subsequently leave the area and so be uninvolved in community activity. Community empowerment is about local individuals being involved in activities within the local community and includes a politically active element. This may follow on from a group's psychological empowerment (Rissel 1994). The two concepts are distinct, but related (Rissel 1994). Sheilds (1995) conducted a qualitative study exploring the meaning of empowerment for individual women. She identified three major themes:

1. Internal sense of self, which comprised four elements:

'claiming pieces of their identity (that is, as separate from the family and other relationships), the development of self-value, the development of self-acceptance, and the development of trust in terms of self-knowledge' (p. 23)

2. Ability to act with own control or choice. This is similar to the concept of the internal locus of control over life events, wherein an individual has control, or believes him or her self to have control.
3. Connectedness:
   'the tie between all parts of the internal sense of self as well as the ability to take congruent action' (p. 29)

Lifeskills teaching, such as assertiveness training, can be used to encourage such individual empowerment, as can one-to-one counselling. One way of developing a person's own psychological empowerment is to become involved in the local community (Zimmerman and Rappaport 1988). At this point, the relationship between individual and community empowerment becomes more apparent.

An important link between psychological and community empowerment is a sense of 'community' (Rissel 1994). For example, a parent may initially visit a Family Centre to get personal support with child rearing and subsequently recognise the importance of such provision in the area and become involved in managing the Centre. Conversely, an individual may be personally empowered, but with no feeling of connectedness to the community, in which case there will be no reason for involvement in collective action, as in the previously cited case of the woman suffering domestic abuse. A sense of community or connectedness can be characterised as the social space which involves family, friends, neighbours, local associations and groups, religious groups, local authority and local workers (Robertson and Minkle 1994). It represents the tie between an individual and all the significant social structures around.

Community empowerment can be described as a group coming together to seek power over their lives (Gibson 1991). This could involve active community participation, which may involve groups meeting together, identification of need, political action and critical

consciousness raising. These methods of working are significant elements of community development work, which has empowerment as the cornerstone of its theory and practice.

Although individual and community empowerment are described separately, they have a dialectical relationship (Robertson and Minkler 1994):

> 'an empowered person is more likely to engage in active community participation than someone who is helplessly apathetic. On the other hand, participation may contribute to empowerment.'
>
> (Tones and Tilford 1994, p. 268)

Rissel (1994) suggests that the sense of community enhances individual empowerment and, with collective action and some power over resources, can lead to community empowerment.

Empowerment is fundamentally about gaining power and control. In this context, power is not conceived of as 'power over' rather than 'power to' and as such refers to a partnership between professionals and communities or individuals. However, professionals tend to have greater access to resources and information and may not be prepared to change their own agenda to allow local people to take control (Zutshi 1991). A community may become empowered and decide to challenge existing provision or demand further resources. Professionals may then choose to withdraw resources and/or support if the community's criticisms are not deemed politically appropriate (Robertson and Minkler 1994). In consequence, funding has been withdrawn from numerous community development projects because the outcomes have been considered detrimental to the funders aims, regardless of the community's wants or needs (Alcock and Christensen 1995).

It has been argued that empowerment takes place when communities take power, rather than remain passive recipients. Power cannot be given to a group. Empowerment must be taken by a group (Rissel 1994). This enables it to set its own goals and agendas. A danger with this is that there may be powerful local factions or individuals who claim to speak on behalf of the community, but have their own interests at heart either explicitly or implicitly (Rissel 1994). Robertson and Minkle (1994) describe conflict occurring in low

income communities where needle exchange schemes have been introduced to reduce the health risks for intravenous drug users. For drug users, exchange schemes can be a matter of life and death, whereas other community members are deeply opposed because such schemes are deemed to condone drug use which is illegal and the source of many social problems. In consequence, the introduction of needle exchange schemes have faced enormous difficulties within the community.

Empowerment was considered an essentially radical approach to health promotion in the late 1970s and early 1980s (Beattie 1991, Gibson 1991). On the surface, there could appear to be a shared agenda with conservative ideology and its concern with giving the consumer a voice. However, the latter is concerned with the market, with buying and selling to those with the most resources, unlike the former, which is concerned with a collective approach to empowerment. The conservative agenda, moreover, may have an ulterior motive of reducing services, arguing that the community can provide for itself (Robertson and Minkle 1994, Tones and Tilford 1994).

There have been criticisms of empowerment being a key concept to health promotion. For example, Seedhouse (1997) challenges definitions of health promotion on grounds similar to those he challenges definitions of health (as discussed earlier). He considers that all definitions of health promotion are inadequate. The words used are vague, like 'empowerment' or 'well-being', and this provides

> 'the illusion of shared meaning' (p. 31).

It gives the impression that everyone understands what is being said, whereas many of the definitions given are unhelpful. He argues that the WHO definition is meaningless. It is almost reducible to 'health promotion is about promoting health'. He reasons that health promotion can not be explained without recourse to ethics. Without being explicit about the health workers own political and moral outlook, any work undertaken could be accused of being unethical. For example, as a health worker, one could not be seen to be actively encouraging smoking, as this is not part of the health agenda. However, many health promotion activities are explicit about their ethical background. In particular, community development projects are completely open in their agenda of tackling

inequalities in health. It therefore seems entirely in the character of such models of health promotion to be clear and open about the background, moral or political, they are coming from. Consequently, a definition of health promotion that includes empowerment is used, with the ethical caveat of being specifically concerned with reducing inequalities.

Individual and community empowerment is ultimately concerned with power and control, but, as has been shown, all these concepts are multi-faceted and complex. This is hardly surprising since the concept of health itself has been seen to be a contested issue. Perhaps at present, vigilance is required in continually challenging the meanings of these terms and how they interrelate, until any clearer understanding is reached. This may, of course, prove in time to be a chimera but this would not deny the validity of the process.

The educational model was discussed earlier in terms of autonomy (Weare 1992). Given that self-empowerment is concerned with gaining control and autonomy as an individual, there are common elements between the two. In a similar way, community empowerment shares many elements of the strategies that the social change model encompasses, such as critical consciousness raising. The empowerment model therefore can be seen as potentially an overarching model, wherein the self-empowerment aspect is amalgamated with the educational model and the community empowerment aspect is amalgamated with the social change model.

Healthy public policy

Health education, which encompassed a number of health promotion models, represented one strand of Tones and Tilford's health promotion equation (1994). The second strand was healthy public policy. The Concise Oxford Dictionary defines policy as

> 'a course or principle of action adopted or proposed by a government, party, business or individual etc.'

Policies can be developed and implemented at all levels of society. Policy can be seen as the result of interaction between organisations, be they political, business or welfare groups (Baggott 2000). They can be beneficial or detrimental to health. For example,

health and safety policies are aimed at protecting the worker, whereas policies which reduce benefits, such as student grants are likely to lead to increased poverty and consequent ill health (Delaney 1994).

Discussion around health inequalities and critiques of individualised conceptions of health and health promotion has shown that socio-economic and environmental factors are major determinants of health. The social change model of health promotion endorses political action to address this through putting pressure on organisations to change practices to be health enhancing. A major way of addressing this is to promote healthy policies. This has happened since the 18th century, when various reformers put pressure on the government of the time to introduce public health policies. During the 19th century numerous Acts of Parliament were passed which embodied policies for sanitary reform (Baggott 2000). The use of such regulatory frameworks continues and there are countless Acts which address the public's health, from laws around drugs and smoking to health service provision.

Building healthy public policy is one of the five areas identified by WHO (1986) as a means to promote health. It produced the following definition:

> 'Healthy Public Policy is characterised by an explicit concern for health and equity in all areas of policy and by an accountability for health impact' (WHO 1988)

It goes beyond just the health care systems to incorporate a much wider sphere of influence. It is concerned with creating a 'healthy society' and acknowledges that social, political, economic and environmental factors influence health. Healthy public policy therefore incorporates a wide range of disciplines under its auspices.

> 'Healthy public policy refers to multi-sectoral and collaborative processes involving the participation of all groups and populations affected'
>
> (Bunton 1992, p. 131)

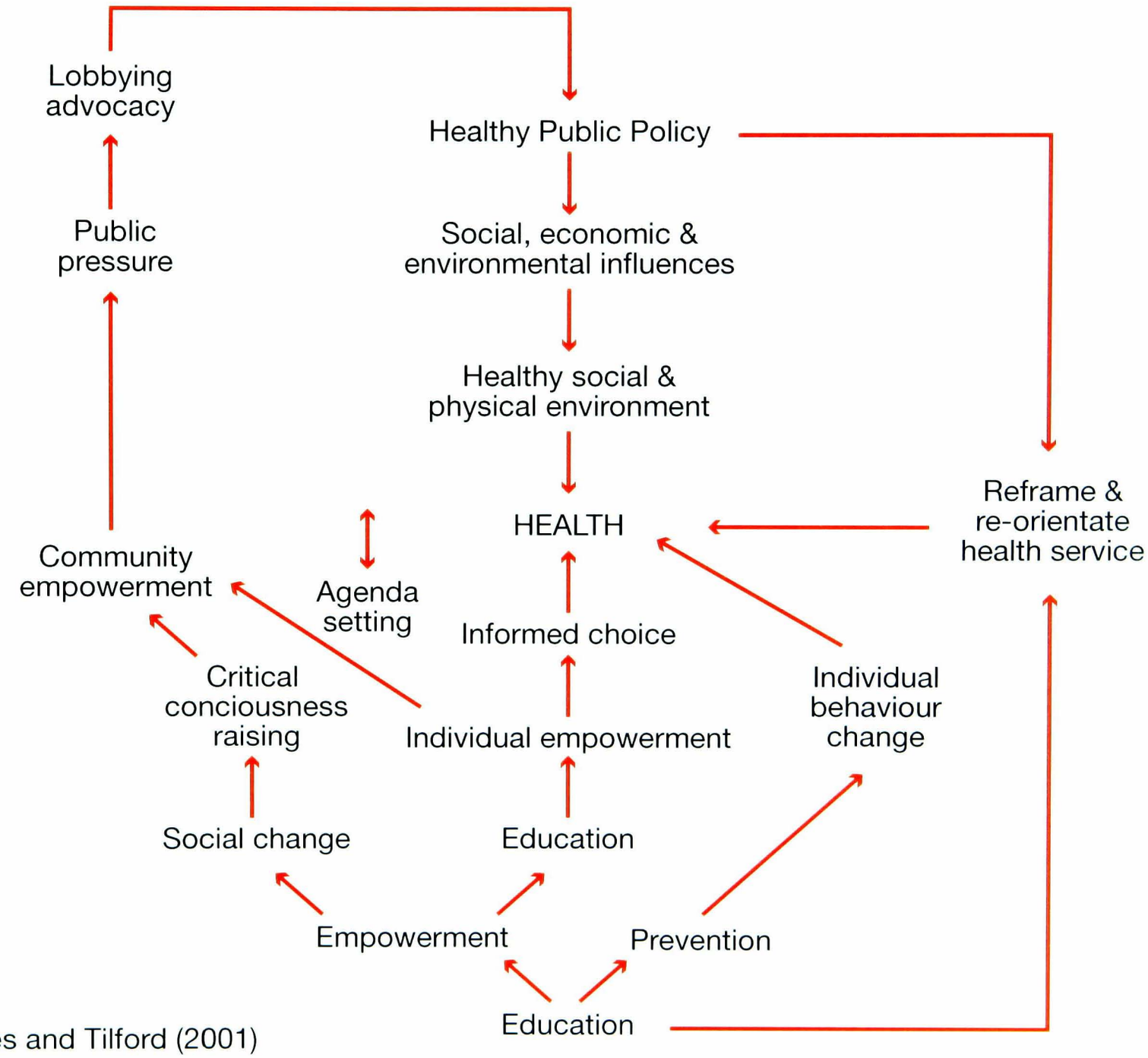
In the UK, government departments have functioned virtually autonomously. Health has been considered the concern of the Department of Health. Housing, education, employment and the environment all impact on health, but in terms of policy, this effect

has generally been overlooked (Hunter 1999). Building healthy public policy entails addressing this by linking policies so that all public policies will be involved in promoting health.

The link between health education and public policy can be put together to provide a model of health promotion, which draws on the theories identified, which could be described as a model for health promotion (see Figure One). The preventive model has a place to play, in terms of promoting individual behaviour change around issues such as immunisation and vaccination. However, the emphasis more about on encouraging the 'proper' use of services rather than re-orientating health services towards health promotion rather than just preventing disease (WHO 1986).

As discussed earlier, the empowerment model encompasses the educational model, in terms of individual empowerment and the social change model in terms of collective empowerment. The two strands interact, with individual empowerment leading to collective empowerment and vice-versa. Education provides the information, explores value systems and supports the acquisition of skills in order for people to make informed choices. Alongside this, the social change model seeks to raise consciousness within communities to empower them collectively, which will then lead to public pressure being put on organisations to implement policies which improve health. Healthy public policy affects the health of both individuals and communities through bringing about social, economic and environmental change. At the same time agenda setting takes place, which again is a two way process aimed at creating an environment within which change becomes more acceptable (see Figure One). One practical approach to working with the empowerment model is community development. It is concerned with both empowerment and affecting policy change.

Figure One: A model of health promotion



Adapted from Tones and Tilford (2001)

Health promotion and community development

Empowerment, as discussed earlier, is a key element to health promotion and a strategy to promote empowerment in practice is community development work. Jones (1991) suggested a definition of community development. Community development

> 'aims to set up a process by which the community defines its own health needs, considers how those needs can be met and decides collectively on priorities for action.' (p. 12)

It is very much a 'bottom-up' approach rather than 'top-down'. The former refers to work arising from the concerns of local people, whereas the latter refers to that arising from higher authorities, who impose their views on the community. However, this definition does not include any reference to poverty or inequalities. The Healthy Sheffield project suggests that:

> 'Community development is best described as a way of working informed by certain principles, which encourages people to identify common concerns and which supports them in taking action related to them.
> Community development practice is based on two core values:
> - a commitment to tackle inequality and discrimination
> - a recognition of the need to give people more power over their lives and thus enable them to control the factors which affect their well-being'
>
> (Healthy Sheffield 1993, p. 13-14)

The first official use of the term 'community development' by the Government was in 1948, though had its origins at the end of the Nineteenth Century in the United States. Black self-help groups were organised by the Republican Party to improve agricultural productivity, but were essentially about social control, not ownership by the local people (Dixon 1989). Up until the 1950s, community development was used as a method of teaching so-called 'uneducated natives' better ways to manage land, health and education, under a colonial government. These were 'top-down', authority led projects. It is ironic, when compared with recent formulations of community development, that although self-help was considered a fundamental element of the process, any form of autonomy or empowerment was not on the agenda, so dependency on the ruling body was an outcome. Our present understanding of community development is particularly

based on a 'bottom up' approach, that is, actively starting where people are at, not from a 'top down' professional agenda. Within the field of accident prevention, an example of the former would be a community led initiative which sought to lobby the local council for traffic calming measures on a busy local road. The emphasis is not just on self-help, but on ownership and local people speaking for themselves. An example of the latter would be legislation requiring that seatbelts should be worn when driving.

By the early 1970s, the work of Freire (e.g. 1972) became available and proved to be greatly influential to the community development movement. Working to liberate people from the oppressive Brazilian State, he contended that education and development is not neutral. Pupils/students are not empty vessels to be filled with knowledge, but arrive with an abundance of experience, from which learning can arise from reflection, and hence action. This is the process, noted earlier, of critical consciousness raising. The Freirean education process is based on group work, with a number of steps, starting with finding out what makes group members tick, moving on to identifying a problem, discussing it in order to draw up an action plan. The next stage is carrying out the plan and finally, bringing the consequences of the action back to the group. A major focus of this work is that it uses a 'grassroots' approach and the community itself has ownership of any action.

The Women's Liberation Movement provided a further impetus to the expansion of community development approaches to health promotion. Within this movement of the 1960s and early 1970s, health issues became a central concern. Women began to take ownership of their own health by redefining and challenging the patriarchal and professional medical agendas as oppressive (Daykin and Naidoo 1995). They considered conventional medical views about women and their health were jargon ridden and medical interventions and the use of technology predominated in health care provision. The Women's Movement sought to construct new ways of thinking about health which were more appropriate to women (Orr 1987). Ways of de-mystifying medical knowledge and taking control of their own bodies were sought.

The methods of working which developed from feminism stress the importance of personal and collective experience and the use of non-stigmatising and non-hierarchical structures. Emphasis was given to working in small groups which would provide support and offer an opportunity to share experiences. From the outset, women's health issues were central, partly because of the common experience of women at the hands of mostly male medical experts around childbirth, gynaecology and mental health. In consequence, a plethora of self-help groups developed, concerned with both specific and holistic issues (Orr 1987).

Considering the last three decades, with the developments described above, it will be of little surprise that community development and health work came together. Many of the principles behind the Alma Ata Declaration (1978), Health for All (1985), the Ottawa Charter (1986), community development (Tones and Tilford 1994), the Women's Health Movement, black, minority and ethnic groups (Naidoo and Wills 1994) and the New Public Health (Ashton and Seymour 1988) overlap or are complementary. The recognition of the potential for combining an alternative approach to health with community development led to the development of numerous community health projects (Kenner 1986).

Since the 1960s, community development has been used to foster participation in health service provision. This has entailed obtaining the views and involvement of local community leaders through consultation and encouraging self-help. Many projects, however, have involved the implementation of governmental agendas and Peterson (1994) comments that most community development projects have failed to provide lasting evidence of change. It has been argued

> 'that urban problems could not be tackled at local level but were the result of national and international economic trends. They require more radical structural solutions' (Taylor 1997, p. 60).

A further, inter-linked problem was found when the Thatcher Government of the 1980s argued for promoting local management of policies by reducing welfare provision. However, this soon showed the sort of problems that local management could lead to. In

housing, for example, the Right to Buy Housing Act 1980 led to the purchase by sitting tenants of much of the better public housing, with the poorer quality housing being left to those who could not afford to buy or move on. Linked with the cessation of any new building by Councils, and little investment in maintenance, this policy resulted in many of the most disadvantaged people being concentrated in the least desirable council housing:

> 'the introduction of choice for the majority pushed those without choice further to the margins' (Taylor 1997, p. 63)

This stigmatised some housing estates, with high crime rates and welfare dependency, leading to them being described as 'post-code discrimination' areas.

Criticisms of community development, however, can often be a result of short-term funding. Most projects complain about lack of resources and that long term investment in regeneration is required (Naidoo and Wills 1994, Taylor 1997). Good community development work should ensure that the key participants are informed by and are accountable to their wider community. The rules and procedures that the usually dominant partnerships employ need to become more democratic, so that communities are not excluded from decision-making. Community development can then develop the capacity of partner institutions to work effectively, as well as offer local representation. This latter must be in the knowledge that

> 'It is easy for groups within the community to turn against each other or for those who do gain influence to exclude less powerful groups'
> (Taylor 1997, p. 66)

Some projects have problems when communities become dependent on the health workers. Workers may inspire local residents' views of what is possible to do within the community, without the resources to back up such ideas. Alternatively, workers may manipulate the agenda to their own ends, or the ends of their organisation (Tones 1998). There is always the potential for paid workers to become caught up in their organisation`s agenda, or to be faced with expectations of the project, which conflict with local people's expectations (Bray and Craig 1990).

Despite some of the difficulties experienced using a community development approach, there are a multitude of successful projects that have addressed health and inequalities using this method. Some of these have a wide community remit, such as the Primary Care and Community Initiative in Glasgow and the Health Perceptions Project in Belfast (Mackereth 1999). Others are theme led, such as men's health (McMillan 1996), parenting as in Teams Health Project (Mackereth 1999) and women asylum seekers as in Riverside Community Health Project's work (Riverside Community Health Project 2001). The researcher in this study recognised that food was an important aspect of local people's lives, in that it was an issue that was frequently referred to. The topic of 'food' was defined by the researcher, rather than identified by local people as an area for research., but the researcher was constrained by time and cost. Issues around community development research or participatory action research are discussed later, in Chapter Nine. However, given that the determinants of eating behaviour are related to socio-economic issues, it became a major focus of the research study.

Food and health

The major causes of death in the UK for both men and women are coronary heart disease, stroke and cancers (DoH 1992). Dietary intake is an associated risk factor in these diseases (WHO 1990) and is therefore of considerable interest to those concerned with health promotion. One of the present study's objectives was to explore parents' knowledge, attitudes and beliefs about the relationship between diet and health and to investigate gender influences on eating behaviour in low income families.

Nutrition of the mother affects the health of unborn babies, both health at birth and health in later life. Babies who are growth retarded in utero or are born prematurely are more at risk of coronary heart disease, hypertension and diabetes in later life, and this is related to the weight of the mother before pregnancy, as well as her own birthweight (Barker 1998). Mothers with dietary deficiency of folic acid are at risk of bearing a child with neural tube defects (Stockley 1993). Breast feeding for the first 13 weeks of a baby's life

protects against gastrointestinal illness (Howie et al. 1990), as well as conferring immunological protection (Robinson-Walsh 1999).

As children grow up, the higher their level of educational attainment, the healthier dietary behaviour they report (Wadsworth 1997). Martell (2000) reports on the National Diet and Nutrition survey of four to 18-year-olds, as yet unpublished. The researchers have found that children's diet is mostly too high in fat, sugar, salt, with not enough fruit and vegetables. Children often arrive at school without breakfast and consequently suffer poor short-term memory and reduced ability to concentrate. Welford (1999) describes the difference a food policy made at one school, which included providing a breakfast club and fruit, with children being more calm and controlled, and exam results improved. The Acheson Report (Department of Health 1998c) recommended that all schools should have a food policy, which may include the provision of free fresh fruit for children and the exclusion of confectionery vending machines.

Poorer families eat less fruit and vegetables, which are rich in fibre and antioxidants, which seem to be protective against chronic diseases such as coronary heart disease and cancers (Leather 1995). Obesity is related to many diseases, and it is considerably more common in those on low income compared to those on high incomes (Prescott-Clarke and Primatesta 1998). As Lang (1999) points out:

> 'Poverty, in particular, has always been the ultimate discriminator of health. Diet is a key factor in this relationship. The better a population's diet the longer it tends to live, and the higher an individual's income, the better his or her diet is and the longer he or she tends to live' (p. 49).

He goes on to criticise the lack of food policy in the UK, as does Caraher (2000), amongst others. Indeed, The Acheson Report (Department of Health 1998c) identified these issues and noted that although the Common Agricultural Policy has ensured adequate food supply within Europe, it has increased the cost of food, which will affect low income families most. The report goes on to comment that reductions in inequalities will reduce the prevalence of diseases with risk factors associated with diet:

> 'These include some types of cancer, cardiovascular disease,

> osteoporosis, anaemia, dental disease, and obesity and hypertension, and their complications' (Benefit for recommendation number 20).

Influences on food choices

There are a wide range of influences which affect food choice, from cost and availability to personal taste. Several studies have been conducted, drawing on sociological and social psychology theory. Those most relevant to the present study are those which identified the importance of cooking within the family and the gender division of labour within the household. Murcott (1983a, b) conducted semi-structured interviews with 37 pregnant women attending an antenatal clinic in a South Wales valley. Charles and Kerr (1988) conducted a far larger study. They conducted two interviews with 200 women with a pre-school child. There was an interval of a fortnight between each interview and women were asked to keep a diary in this time of all family food consumption. The interviewees from both these studies came from all social classes and worked, unpaid, at home, carrying out domestic tasks, whereas all their partners were in full time, paid work.

These two studies have been influential in understanding family power relationships and the meaning of food and eating within families. The findings indicated that women predominantly do the cooking and they cook for men and children, often not eating, or snacking when alone. Men had a strong influence on what is eaten and if a meal was not to his liking he would make this clear to the woman. There was an emphasis on 'proper', home cooked meals, which comprised of meat, potatoes, vegetables and gravy. Charles and Kerr (1988) found social class differences in eating habits. Social classes I and II were more likely to eat three meals a day, eat at a table and consume much more fresh fruit and vegetables and wholemeal bread than social classes IV and V.

Two further influential studies were undertaken and are of particular interest because they focused their research on working class women. Pill and Parry (1989) based their research on part of a longitudinal study. This involved interviewing women at an interval of five years. The interviewees were aged between 25 and 40, were in social classes IV and V and had at least one child. Many of the conclusions reached in this study were confirmed by a further study, which obtained data from nine discussion groups held with

working class women in the North East of England (McKie et al. 1993). Both studies found that gender was a significant factor in food choice, with men exerting considerable influence on the family diet, particularly in less educated and lower paid families. Women recognised that there was some relationship between diet and health, but were constrained from making changes to their eating habits because of men.

The research studies discussed focused on women. Men were not consulted about their eating habits directly. Instead these studies asked women what their partners' views and beliefs about food and eating were. Men did not corroborate the data collected. Thorogood and Coulter (1992) note

> 'that there is a dearth of studies of men's attitudes and beliefs about the relationship between diet and health' (p. 59).

The present study sought to begin to redress this dearth and interview both men and women about their perceptions, attitudes and beliefs about food and eating.

The above studies examined the knowledge that individuals had about diet and this was one area where somewhat differing results were discovered. Charles and Kerr (1988) found that

> 'women appear vague on the specific links between food and health, their attitudes and practices reveal that *social* definitions of the relation between food and health often affect a family's diet' (p. 155)

Other studies suggest that people, especially women are much more aware of the relationship between health and diet. McKie and Wood (1991) found that women perceived a close relationship between diet and health; Pill and Parry (1989) found in their survey that half the sample explicitly recognised that diet was important in maintaining health; Anderson et al.(1995) found that 95% of the general public were aware of the need to eat more fibre and 93% were aware of the need to eat less sugar and fat. However, people found it more difficult to translate this information into practice and only 25% could identify sources of starch. To improve diet, people do need to understand the broad health outcomes of eating certain foods (Contento et al. 1993).

People *are* changing their diet to a healthier diet, albeit predominantly social classes I and II. Of over 1000 responses to a survey conducted in 1989 by Gillespie and Achterberg, half consumed a healthy diet (according to the criteria of Greater Glasgow Health Board), half of these having changed in the last 10 years. As could be predicted, the less healthy eaters were more likely to be male, from lower income families and to be smokers. Many researchers have suggested that providing leaflets and focusing on women as the gatekeepers to the family's health is not appropriate. Structural changes need to be addressed (Caraher 2000) and men need to be approached at appropriate venues with appropriate messages to promote healthy eating (Wilson 1989, Charles and Kerr 1986).

A key point that all the above studies identified was the importance of the family sitting down to a 'proper meal', which symbolised the harmony of the family unit, with food used as a demonstration of care and affection. Keane and Willets (1994) found an

> 'identity through meal-sharing is seen as important to family oneness' (p. 15).

The 'proper dinner' has been described repeatedly as a home cooked meal consisting of meat, potatoes, vegetables and gravy and demonstrates the symbolic and ritual use of food (Murcott 1983b, Charles and Kerr 1988). Sunday dinner was the proper meal par excellence, a meal that almost all families had. Proper meals, home cooked meals and cooked dinners were terms used interchangeably by respondents and considered healthy and nutritious (Calnan 1990). Such a meal was perceived as particularly good for you and had a symbolic significance of a meal about family coherence. However, despite the importance conferred on proper home cooking, Wilson (1989) found that such meals were not actually cooked very often, and then it was provided for men. When women and children were eating without men, they rarely ate a 'proper meal'.

Some families put greater emphasis on the harmony of the family unit, by, for example, eating together than others. Differing family approaches to issues such as eating, behaviour etc, have been described as differing 'family cultures'. Families develop their own approaches to aspects of life which fit in with their view of the world (Pahl 1990, Roll 1991, Henson et al. 1998). This is affected by the structure of the family (two biological parents, single-parent, step-parent), the history and background, including

social class and ethnicity of the family, the gender and ages of the family, the stage in the life course, and individual personalities (Holland et al.1996).

A common finding from the research was that food that men eat is of higher status, that is, more desirable and more expensive, such as red meat, than that of women or children (Charles and Kerr 1988, Calnan and Cant 1990, Gofton 1992). This is particularly the case for men on low incomes or unemployed (McKie et al. 1993). Thus men are more likely to be offered red meat, whereas children are often given fast foods like fish fingers or burgers. Also, most women would eat differently if alone (Charles and Kerr 1988). They tended to have a bar of chocolate or crisps or a 'snack' or even not eat at all (Murcott 1983). On the other hand, women were more likely to eat brown bread, fruit and salads than men (Wilson 1989). However, they would cut down on their own intake if necessary, to meet the needs of the family (Dowler 1996). Men were seen as requiring greater amounts of food, regardless of the type of work they do. Most men now do sedentary work, so the need for large helpings is not necessary from a physiological perspective, but the size of helpings remain 'man-sized' (Wilson 1989). Women's needs are subordinated to men's and, to a lesser extent children (Calnan and Cant 1990). The influence of men on the family diet is often immense, as part of their overall influence on family culture.

The opposite of proper food was 'junk' food or convenience food. There seemed to be an increase in 'snacking', which is associated with convenience foods, but women often felt guilty about using such products (Atkinson 1983, Warde and Heatherington 1994). As such,

> 'convenience is a moral issue' (Gofton 1995, p. 156).

The consumption of such food is seen as morally reprehensible. However, the availability of a wide variety of pre-prepared food drastically reduces the time needed for preparation and cooking (Mennell et al. 1992). Gofton (1992) suggests that convenience foods can be seen as a way of freeing time, rather than the sign of a 'lazy housewife'. The increase in snacking (accounting for 19% of eating) may be justified by the 'time scarce' nature of

modern society (1995). However, in terms of health, convenience and junk foods are high in fat and sugar and therefore detrimental to health in the long term (Caraher 2000).

As shown above, eating habits are far from being tied solely to the biological needs of the individual. Symbolism is apparent in the moral and cultural attitude to many foods (Atkinson 1983). Milk is considered as strength giving and pure, whereas red meat is masculine and fish and salads are feminine. In many cultures, food is divided into binary categories:

> 'good or bad, masculine or feminine, powerful or weak, alive or dead, healthy or non-healthy, a comfort or a punishment, sophisticated or gauche, a sin or a virtue, animal or vegetable, raw or cooked, self or other' (Lupton 1996, p. 1)

Good foods can be problematical, because often these are considered healthy, the foods one ought to eat, whereas bad, or unhealthy foods are desired as an indulgence. Different food types are eaten at different times, which distinguish different rituals or festivals, and mark boundaries between different nationalities, cultures and religions. Meaning becomes attached to every food substance and many preparation processes, which starts in infancy and continues through to adulthood, thus marking different stages of the life course.

Eating together as a family also provides the opportunity to teach children the social forms and manners as well as the social relations within the family (Calnan 1990).

> 'Food practices can be regarded as one of the ways in which important social relations and divisions are symbolised, reinforced and reproduced on a daily basis' (Charles and Kerr 1988, p. 2)

Despite the heavy symbolism of eating, in everyday life

> 'eating is, in large part, a mundane and unreflective activity'
>
> (Warde and Hetherington 1994, p. 759).

In consequence, any suggestion of changing eating habits can be a challenge to many firmly held assumptions (Graham 1984). An exception to this passive and habitual approach to food choice may occur when people come across new or uncertain situations. An example of this could be making decisions about infant feeding. These decisions are

likely to be conscious, overt and reflected upon (Murphy et al. 1998). These are situations where it may be possible to have some impact in steering people towards healthy food, and, again, are often linked to the individual or family's life course.

The way food is chosen and prepared reflects the social divisions within society, particularly with regard to gender, class and age. Despite the widely held belief that couples today are more equal in their input into domestic arrangements, than in the past, many studies have shown this notion of sharing to be exaggerated (Oakley 1974, Murcott 1983a, Charles and Kerr 1988). Women are still predominantly responsible for domestic chores, especially for food and its preparation.

Food shopping and cooking

Shopping is primarily done by women (Calnan and Cant 1990, Calnan 1990, Warde and Hetherington 1994). Sometimes this is a task shared with men, though the input from men is variable, with some only there to push the trolley. Most use the supermarket for their main shopping, which is most likely to be weekly for lower socio-economic classes. The higher the social class, the more likely were they to do a main shop less often (Charles and Kerr 1988).

Women predominantly do the cooking, but there are occasions when men do cook. This tends to be at weekends, for example, they may prepare the Sunday lunch, manage the barbeque, cook snacks such as bacon sandwiches, cook curries or other specialist dishes (Murcott 1983b, Calnan and Cant 1990). It is the routine preparation and cooking of food which is almost inevitably women's work. The man is more likely to cook if the woman is in full time employment (Warde and Hetherington 1994). When men cook, the woman is likely to feel grateful for his 'help' and even though women talked about bringing their boys up differently, Charles and Kerr found that

> 'the majority are bringing up their children in conformity with the dominant gender division of labour' (1988, p. 53).

Women do the shopping and the cooking, but do not have total control over the content of meals. They cook according to men's preferences. Labour is gender divided, so that

men are perceived as the bread winner and women are the home makers, regardless of the actual work status of the couple. Within this latter role women serve and provide food for the family and within this process, men's preferences are deferred to, whereas women's preferences are subordinated. Women will provide food that they know their partners will like and appreciate (Charles and Kerr 1988, Calnan and Cant 1990, Warde and Hetherington 1994). Murcott (1983b) states that:

> 'A non-committal reply however did not necessarily settle the matter [of what to cook], for some discovered that being presented with a meal she had then decided on could provoke adverse and discouraging remarks' (p. 86).

A woman would often consult her partner about the meal he would like, but also would prepare food within boundaries that were acceptable to him.

As 'gatekeepers' to the family diet, health education has been focused on women. However, men are particularly influential in what food is chosen to eat. If this is the case, women may be doubly burdened with guilt, because although they are aware of what foods are healthy, they are unable to change the family diet because of the man's preferences (Charles and Kerr 1986, 1988, Pill and Parry 1989, McKie and Wood 1991, McKie et al. 1993). It should be noted that Kemmer et al. (1998) found in their study of 22 couples, women had some autonomy and would both encourage her partner to eat what she preferred and avoid cooking what he liked if she didn't. The sample had a middle class bias and this seems likely to account for the difference, as they tended to share more household activities in general.

Influence of children on family eating behaviour

The strong male influence on family eating habits was identified in the literature, but other powerful influences were noted. Children were found to have influence in food purchase, particularly when compared with earlier this century (Gofton 1992). This may create a dilemma for the mother, who wants to provide healthy food for the family. Most healthy foods lack 'child appeal' and this could undermine mothers' attempts to improve children's diets (Gelperowic and Beharrell 1994). Millar (1996) suggested that this could be due to advertising. He found that adverts were three times more effective on children

compared to adults. This is born out by research completed by Kortzinger et al. (1994). They found that German school children were much more likely than English children to pick fruit as a snack than chocolate. It was suggested that this could be due to food advertising, which is much more tightly controlled in Germany. This has important implications for health promotion and government legislation.

Developing appropriate food tastes is part of child development and is important not only in the immediate physiological health effects, but also because childhood food habits are likely to continue into adulthood (Kortzinger et al. 1994). In low income families, children ate more convenience foods (Wilson, 1989). This was due to lack of resources and access, and the inability to experiment with different foods because of the fear of waste (Dowler 1996). Often tensions arose around food, with children wanting to be independent and rebelling against adult authority (Charles and Kerr 1988, Lupton 1994). Children may refuse food specifically as a rejection of maternal authority, she being the producer of food (Lupton 1996). Further conflict arose between giving children what they want, such as sweets, and ensuring the children eat food that is 'good for them'. Sweets are often used to appease, comfort, bribe or control children (Charles and Kerr 1988).

Influence of weight loss diets on family eating behaviour

Another influence on changing food habits is in order to lose weight. Predominantly, it is women who diet, and they rarely diet for health reasons, according to Charles and Kerr's study (1988). It is to control body size and this may be linked to the reality that they have no other control within their lives. There are strong social pressures to diet and maintain a particular body shape, but Lupton (1996) argues that dieting women should not necessarily be considered victims. This links to women feeling positive about taking control. However, it is in contrast with McKie et al.'s finding in their study of women-only focus groups (1993). They found a powerful and explicit relationship between body image and food. Many women in the focus groups were resentful of the pressure to maintain an ideal body image. This was often made difficult by men demanding food types that were incompatible with weight loss. For most women on low incomes, it is not feasible to provide different meals to suit different family member's requirements (Calnan

and Williams 1991). It also goes against the strong pressures for the family to eat together as a social occasion and have a proper meal. French et al. (1994) found that losing weight often becomes

> 'a lifelong emotional struggle with food' (p. 27).

The problem is psychological and includes lack of confidence in ability to lose weight and the use of food as a comfort and to lift mood. Thus, there are many contradictions in women's attitudes to dieting.

Influence of personal preferences on family eating behaviour

Many research studies have found that personal preferences, which often develop early in life, are the main reason for families to eat in certain ways (Wilson 1989, Calnan and Cant 1990, Goode et al. 1996). Taste was found to be the most important influence on food choice, with cost coming next and health after that. Indeed, the major obstacles to changing to a more healthy diet were tastes and preferences (Calnan and Williams 1991). Children will often respond negatively to a new food. Repeated exposure is required for acceptance (Birch 1992). If families are on low incomes, they cannot afford the waste that occurs if food is rejected. Contento et al. (1993) found that mothers' beliefs about food strongly influence the foods they offer to their children. However, somewhat in contradiction, Borah-Giddens and Falciglia (1993) found that children's food preferences are not significantly related to their parent's preferences. They suggest that siblings, peers and the media have a stronger influence. Perhaps in early childhood outside influences are not evident and children tend to eat what is given them. As they get older those outside influences become more effective. Lowe et al. (1998) certainly found that video intervention, using peer modeling increased uptake of foods previously rejected, which has potential relevance to health promotion interventions.

Influence of the media on family eating behaviour

The effect of the media on shaping individual's preferences can be great. Food advertising is ubiquitous in Western society. An image is created round a particular food product, which is used to differentiate the food from others on the market. This image

may not be related to the taste, form or nutritional properties of the food (Lupton 1996). This is particularly the case with highly processed foods, which tend to be high in fat and salt, such as fizzy drinks, sweets, snacks and fast food. These items are advertised in packaging, on television or in magazines, as products related to youth, vigour and attractiveness. Anderson et al. (1995) quote the 1992 MORI survey, which found that 43% of respondents gained information from television adverts, 32% from women's magazines and 28% from adverts in newspapers or magazines.

Women are major recipients of advertising and health promotion information and there are often conflicts between the messages being conveyed. Many women are resentful of the media as being victim blaming and objected to their use of emotional blackmail (McKie and Wood 1991). McKie et al. (1993) state that:

> 'Women's recognition of the manipulative and exploitative qualities of advertising media has often been underplayed in studies of attitudes to diet' (p. 38)

It has already been noted that children are very susceptible to advertising, being three times more responsive than adults (Millar 1996). Of the adverts focused at children, 75% are for food or drink products (Keane and Willetts 1994). Bright colours, catchy tunes and cartoon characters are all used to attract children. There is a close relationship between the adverts seen by children and requests for those foods (Donkin et al.1992). Parents often find it difficult to refuse children's insistent demands for a particular food seen advertised on television when in the supermarket (Keane and Willetts 1994). Sweets being displayed at the cash-point is another aspect of the cynical marketing tactics of supermarkets.

Influence of available resources on family eating behaviour

Resources are vital to food choice, and may include income, access, availability, price, transport and skills (Lang and Caraher 1998). The treasury defines poverty as anything below half the average income. Based on 1998 prices, the poverty level is recognised as £129.50 a week after rent or mortgage costs are deducted for a couple with no children. For a couple with three children, the level of poverty is below £216 (Eaton 1999). However, the family income does not express the distribution of money within the

household. Pahl (1983, 1990) and Volger and Pahl (1994) investigated the control of household finances. In their studies, households tend to be treated as units, but this does not express what could be considerable inequalities of the distribution of money within the family, which can lead to 'hidden poverty'. Taxation policy assumes husband and wife as one unit and social security policy assumes the man is the chief earner and that he will share the money received.

Low income families were limited in the type of food purchased by cost (Murcott 1983b, Wilson 1989, Caraher et al. 1998). Despite poverty, families considered it important to try and continue eating in the accustomed way (Murcott 1983b). Wilson (1989) found that there were certain foods that those on low incomes considered to be markers to show they were not living in abject poverty, such as butter and a Sunday roast. She likens this to the purchase of children's clothes at jumble sales: those on the lowest incomes were least likely to buy second hand clothes, whereas middle class families were more than happy to do so. Despite this desire to maintain certain standards, if the bills, for example, electricity and gas were high, food was the most flexible financial outgoing. If there was not enough money, food could be cut back on (Graham 1984, Dowler 1996).

There are price disincentives to healthy eating in poor areas (Sooman et al. 1993). Healthy food was perceived as more expensive and, if income was limited, people would not experiment because of the risk of waste (Wilson 1989). The range of food available to low income families was limited. The more frequently a child eats a particular food, the more they like the taste of it, as noted earlier (Contento et al. 1993). Thus, if their diet is restricted, their taste will similarly become more restricted, meaning experimentation is even less likely to be successful. Birch (1992) suggests that eight to ten exposures to a new food are needed for acceptance, with 12 to 15 exposures for full acceptance. Families on low incomes cannot afford such waste.

Income is obviously a major barrier to obtaining healthy food, so low income families have less variety of foods and eat less fruit, wholemeal products, lean meat, oily fish and more white bread, chips and cheap meat (Dowler 1996). They also eat food which will

satisfy their hunger rather than what is healthy (Caraher et al. 1998). However, cost is not the only factor. There are other structural reasons which prevent low incomes obtaining healthy food. Changes in the structure of society has lead to the development of hyper-markets in remote locations (Hallsworth 1991, Caraher 2000). Lack of car ownership and/or driving license means that access is difficult and women and older people are those least likely to have access to transport. Nor do they have the opportunity to buy more cheaply in bulk. At the same time local shops are being driven out of business because of the competition from the large stores. This has lead to poorer areas becoming 'food deserts', where nutritious and cheap food is almost unobtainable. Whitehead (1998) has summarised recent contemporary ideas about such places: residents tend to be without transport and have great difficulty reaching out-of-town supermarkets and local shops contain expensive, highly processed food with little or no fresh fruit and vegetables.

Low income families are often accused of not budgeting properly, or of wasting money on things like cigarettes. However, these families, although they spend less in total on food than higher income families, do spend a much higher proportion of their income on food and are most efficient in obtaining the most calories at the least cost (Malseed 1989, Dowler 1996).

The school curriculum no longer includes cookery and this has been seen to result in a lack of cooking skills within families (Lang and Caraher 1998). This is undoubtedly the case, but Caraher (2000) points out that at present there is no evidence that poor people lack cooking skills. The problem is that they do not have the resources necessary to put those skills into practice. Focusing on individual ability can end up victim blaming and so increase the burden on women who are struggling to make ends meet as it is and can thus be counter-productive to health promotion initiatives.

Low income has a profound effect on all aspects of family life, but especially on eating habits. It is not just about not having enough money for food, but the added problems of no transport, no adequate local shops and the effects on the family's morale when they

have to go without food or are unable to try different foods. All these factors have vital relevance for the present study to explore and on health promotion provision. It also needs to be addressed through food policy (Department of Health 1998c, Lang 1999, Caraher 2000).

The need for a coordinated food policy

There is a need for a cohesive and coordinated food policy, which has been lacking for many decades, which will take account of the problems that families on low incomes face (Lang 1999). The focus of government policy and the food industry has been on individual consumption, rather than on food poverty and the health effects of food long-term (Caraher 2000). The ability to change diet is dependent on what is available in the shops and what is affordable and structural changes are needed for this to be addressed (Wilson 1989). In 1990, the five top retailers controlled 60% of the grocery market in the UK and they alter accessibility to food (Wrigley 1998). Given that most people have enough to eat, the food industry needs to sell more expensive and therefore more processed products in order to increase profits. New technology is being used to improve the child appeal of packaging and these products are often unhealthy (Gelperowic and Beharrell 1994). Some people are aware that food today is over-processed and over-priced, but feel ignorant and powerless,

> 'at the mercy of an uncaring government and avaricious industry'
>
> (Lupton 1996, p. 11).

Thus women felt impotent when faced with the power of the food industry, ending up feeling guilty and trying to ignore the problem. Many women were concerned about additives but felt unable to do anything about it (Charles and Kerr 1988, 1986).

There is an upsurge of consumer interest in food, which has the potential to affect the food market. In the 1990s there were numerous food scares, such as salmonella in eggs, BSE and more recently genetically modified food. In consequence, there has been an increasing scepticism about the safety of foods (Caraher 2000). However, it is predominantly among the middle classes. Families on low income generally do not have

the choice about what foods to eat and what not to eat. They are concerned with satisfying hunger at the lowest cost and the cheapest food is often the most unhealthy. However, despite the emphasis on the importance of consumer choice, the food industry plays the largest role in food availability (Lang 1999).

Governments have supported a free market and depended on self-regulation of the food industry, with regards to safety. This has encouraged the production of cheap food, but at a cost. Quantity has become paramount, with quality a poor second. Relaxed standards have led to many of the food scares such as BSE and salmonella. Profit has been the driving force behind the food industry and this has led to many other problems within the food industry (Baggott 2000).

Profit being the motivation behind farming has led to practices which jeopardise the environment. For example, increased use of pesticides means higher yield crops. However, the residue of these chemicals is washed into the water supply. The expense of cleaning water then is passed on to the water companies and ultimately to the public (Lang 1999). Cheap meat is provided by using land in Third World Countries for grain to make into animal food, so depriving those countries of land to grow their own food (Lang 1999). Cod is likely to become a food of the past because of over-fishing (Kurlansky 1998). Genetically modified food has been promoted by the food industry as a way of making a still greater profit, regardless of public anxiety (Sadler 1999). Despite the need to improve diet by increasing the intake of fruit and vegetables, Lang (1999) describes how the European Union destroyed fruit and vegetables at a cost of £230 million in 1993/4. This represents 980 million kg of apples or 312 million kg of oranges, which could have been distributed to school children.

Despite the importance of food production, the final cost of food is mainly processing, packaging, transport and retailing. The more food is processed, the more can be charged for it. Hence the preponderance of highly processed food found on sale (Tansey 1994). The food industry is ever finding different ways of producing a market, for example, slimming foods, which claim to help reduce weight but are full of fat and sugar (Lang

1999). Supermarkets package most foods, offering symmetrical fruit and vegetables in plastic packaging at an added cost when compared to a local market.

The environmental costs of out of town supermarkets are twofold: the cost of transporting out of season foods from abroad and the cost of travel to and from the supermarket. Retailers encourage the use of cars by being situated on out-of-town sites (Lang 1999). They make an additional profit because they also sell petrol. The situation of supermarkets is producing food deserts, which particularly affect low income families (Whitehead 1998). Large stores are more profitable than small businesses and so can sell food cheaper, thus putting small shops out of business and increasing the problems of those living in 'food deserts'. Not only are bigger shops more profitable, but so are bigger retailers. In Britain, most food is supplied by a handful of major retailers, who consequently have substantial control of the food industry (Tansey 1994).

The stranglehold that the food industry has on the provision of food is enhanced by the work of the Ministry of Agriculture, Fisheries and Food (MAFF) (renamed the Department for Food, Farming and Rural Affairs (DEFRA) after the June 2001 General Election). It puts commercial interests in front of consumers' interests. The experts that DEFRA draws on for information are from food companies and its food advisory committee is made up largely of consultants and employees from the food industry itself (Lobstein 1996). This is unlikely to produce unbiased information, given the industry's prime concern is profit. Lang (1999) suggests that there are three core issues for a food policy to work effectively:

- 'institutions of food governance - to ensure that they work in the public interest, are flexible and are appropriate

- food policies - to ensure that health is a priority over industrial or sectoral interests

- food culture - to support the enjoyment of food and the popular understanding of what is needed to gain the maximum benefit from food, through education, advice and information' (p. 54)

Summary

The literature review initially explored definitions and models of health. The 'medical' model was described and criticised for being too narrow in its focus. The 'social' model of health was then discussed in terms of the definitions of health offered by WHO (1948, 1986) which aim to include wider social and environmental factors. This has been criticised as being too vague a term to be of use. Seedhouse (1986) proposed a model wherein health is the foundations of achievement. Again, though, the terms used are ambiguous. Defining health may be impossible as it is a multifaceted concept.

Inequalities in health were discussed. Although the link between poverty and poor health has been recognised for many years, morbidity and mortality rates continue to be considerably higher in lower social classes when compared with higher social classes. Inequalities arising from gender were explored in terms of men's and women's experience of health. Definitions of health promotion were then discussed and, as in the concept of health, found to be diverse. Empowerment was examined, as a concept which is considered central to health promotion, as are healthy policies. Community development, as a particular approach to promoting health, which is explicit about reducing inequalities and promoting empowerment was discussed.

Food was identified as having a profound influence on health. Studies researching the influences on food choice were examined and found that women shopped and cooked but were influenced by men in particular. However, the views of men were generally gained from asking their partners what their views were. 'Proper meals' were found to be important, particularly for their social relevance. Further influences on food choice were weight loss, personal preference, and the media. Limited resources, especially income, had a strong influence on family diet, as did the lack of a cohesive and coordinated national food policy, which was recognised as affecting dietary behaviour, with market forces predominating in producing processed food for profit rather than health.

Chapter Three will examine the methodology and methods used in the present study. It will examine ethical issues and discuss analysis of the data obtained from the fieldwork.

Chapter Three

Methodology and methods

Introduction

This chapter provides an overview of the methodology informing the study and the methods of data collection employed. Firstly, the theoretical interpretivist paradigm used in this study is discussed. Issues of validity and reliability are critically discussed with regard to the study. Trustworthiness is suggested as a more appropriate measure of the adequacy of the analysis. Triangulation, thick description and reflexivity are the tools used to promote trustworthiness. Ethical issues are explored in general as essential elements of the research process. The chosen research methods of semi-structured interviews are discussed in terms of their advantages and disadvantages, particularly in terms of recruiting men and researching in the home environment. Focus groups, are described and methods of analysis are clarified. Finally, ethical issues specific to the study are discussed.

The research paradigm informing the development of the study

A research paradigm offers a philosophical view of the concepts of knowledge and truth.

> 'A paradigm represents a patterned set of assumptions concerning reality (ontology), knowledge of that reality (epistemology) and the particular ways of knowing about that reality (methodology)'
>
> (Miller and Crabtree 1999, p. 8)

All research is based on a particular perspective, whether it is explicitly stated or not. One paradigm is a positivist philosophical approach. From this perspective, principles are based on a so-called objectivity that assumes reality is 'out there in the real world'. Positivists accept that the world is constructed of a single reality and that there are universal truths, which can be discovered by testing hypotheses in a deductive manner. They also advocate a belief in subject–object dualism, wherein the mind and body are

separate entities (Labonte and Robertson 1996). Positivist researchers assume that this reality can be measured and quantified. They use standardised instruments and results are expected to be replicable. They are likely to use large samples and statistical procedures which, when applied, will show the extent to which the results are generalisable to wider populations (Davison 1995). Researchers using a positivist approach endeavour to distance themselves from the respondents of the study and interact with them as little as possible, in order to maintain objectivity and reduce bias (Davison 1995).

The positivist perspective has been challenged by new paradigm researchers, who argue that

> 'there is no 'knowledge' of any kind that is not mediated by the experience of everyday life' (Oakley1992, p. 12).

Much new paradigm research is based on phenomenology, a philosophical perspective which is concerned with gaining an understanding of how individuals live in their worlds (Miller and Crabtree (1999). Phenomenology aims to

> 'view the constructs that people use in order to render the world meaningful and intelligible to them' (Bryman 1988, p. 51)

There are several research approaches that arise from this perspective, such as interpetivist, constructivist, participatory and action research (Lincoln and Guba 1985, Lewis 1996, Labonte and Robertson 1996). These have developed in order to help interpret data, rather than just describe events as in phenomenology.

These approaches differ in certain respects, but have similar basic assumptions. Researchers using a new paradigm perspective claim that human beings interpret all their experiences. They do not just experience events in the same way as everyone else, but interpret them according to their own subjectivity. Because everyone must, inevitably, experience events differently, there can be no truly shared reality. Instead there are multiple realities, based on our individual experiences. Such interpretations are based on the context within which they are experienced (Lincoln and Guba 1985, Lincoln 1995, Kvale 1995). As humans, we interpret everything observed or experienced and this has two implications: objective knowledge is impossible and theories are

> 'our own interpretations of research participants' understandings and not simply a reflection of them' (Secker et al. 1995, p. 75).

This perspective assumes there are no universal truths, just local and specific truths. Subject and object are considered interrelated, rather than being of a different nature to each other, as positivists claim. New paradigm researchers accept that the process of inquiry can never be value-free, because they always bring their own prejudices and interests to bear, from the framing of the research question to the choice of research methods and questions to be asked of respondents (Lincoln and Guba 1985, Addison1999). This has led to debate around what are the most appropriate methods to be used. Many authors have argued that quantitative approaches have relevance for new paradigm research, particularly when used in conjunction with qualitative methods (Pugh 1990, Epstein Jayrante 1997). However, qualitative research methods are predominantly used in an attempt to reach an in-depth understanding of the respondents' worlds.

There are a number of approaches which a qualitative researcher may adopt, but all have a common base

> 'more appropriate when research questions revolve around exploring meanings, beliefs, understandings or cultures, and when the aim is to illuminate and explain these rather than simply describe them'
>
> (Secker et al. 1995, p. 100)

It is an approach which is concerned with the meaning that people ascribe to the events they experience. This is somewhat different to other qualitative perspectives, such as participatory research, and collaborative inquiry of action science or experiential inquiry, which are concerned with involving respondents directly in the research process (Reason and Rowan 1981). Due to limitations of time and resources, the researcher was unable to employ these approaches. For the same reasons, action research, where data is collected and analysed, then recommendations are acted on, was not applied (Thesen and Kuzel 1999).

Some research approaches developing from the new paradigm have an explicit political content, such as feminist research, which is based on the unequal power base between men and women. This was considered an inappropriate approach, because the research

concerned both men and women, who were both in a deprived, powerless position. The researcher was interested in a wider perspective and so an interpretivist approach was considered appropriate.

Interpretivism is often equated with constructivism and both, again, arise from new paradigm research based on phenomenology. Both approaches are concerned with seeking to understanding the world as experienced by the individual being studied. There is no ultimate reality and we all interpret our experiences within our own world (Labonte and Robertson 1996; Charnaz 2000). However, some authors do separate the two terms.

> "Constructivists' claim that truth is the result of perspective; it is relative. There is no objective knowledge.....'Interpretivists' ....recognise the importance of the subjective human creation of meaning but doesn't reject outright some notion of objectivity. Pluralism, not relativism is stressed, with focus on the circular dynamic tension of subject and object' (Miller and Crabtree 2000, p. 10)

Accepting that there is some 'world out there', even if it is experienced differently by different individuals, seems to equate with a relative common sense view of reality (if only to the researcher). An interpretivist perspective was therefore applied. It should be noted that only a few of the many qualitative research approaches, such as symbolic interactionism, but a comprehensive review of perspectives was outside the scope of the present study.

The major criticism of new paradigm research is that the interviewer will influence the content of data collected and so the interview will obtain data which is contaminated by the subjective input from the researcher. From an interpretivist perspective, this is seen not only as inevitable, but in the very nature of any social interaction. Interpretation of data will be affected by the researcher's own subjectivity, as will the respondent's (Oakley 1992, Secker et al. 1995). Consequently, positivist criticisms have arisen from their insistence that objectivity is paramount and can be 'proved' by referring to the validity and reliability of any study.

Validity and reliability in research

To positivist researchers the concepts of validity and reliability are central to the proof of a theory. Validity is concerned with truth and can be divided into internal and external validity (Silverman 2000). Internal validity is concerned with ensuring that the research tool, such as a questionnaire, measures what it intends to measure. For example, does a self-esteem inventory actually measure self-esteem or is it identifying something else? This assumes there is an accurate measure of self-esteem, which could be uncovered by empirical testing. However, the process of researching a topic from an interpretivist approach is predicated on the researcher being a human being who will interact with the respondent and vice-versa. From this perspective, 'truth', as objectivity is not sought. It is inevitable that a different researcher will interpret different realities in different ways, because of their own subjectivity, as respondents will express different views at different times, according to the context of the data collection.

External validity is concerned with how the results of the study can be generalised from a sample to the population. A positivist study would include statistics based on how the results from a study can be used to make predictions about other populations. From an interpretivist standpoint, external validity is given low priority, because any study is viewed from a local and specific perspective and is inevitably not generalisable:

> 'The goal is *not* to produce a standardized set of results... it is to produce a coherent and illuminating description of a perspective on a situation that is based on and consistent with detailed study of that situation' (Ward Schofield 1993, p. 202).

What is important for a qualitative study is that the researcher is explicit about the extent to which, if at all, the findings of a study are transferable (Malterud 1999).

Reliability from a positivist tradition is concerned with replicability outside the study. Unlike internal validity, which is about consistency within the study, reliability is about whether the results would be similar if reproduced in a different situation or repeated by other researchers. Again, from an interpretivist perspective, this is of less concern. Replication would require in depth knowledge of both the previously studied group and

the group to be examined, in order to recognise the similarities and dissimilarities between the groups. The more similar the groups the more the initial findings are likely to be of use with the second group.

Trustworthiness in interpretivist research

As an alternative and more appropriate approach to the issues of validity and reliability, Lincoln and Guba (1985) suggest using different methods to achieve what they describe as 'trustworthy' results. This entails disengaging from the familiar terms of 'proof', 'validity' and 'causality', and focusing on the ever changing nature of human experience. From an interpretivist perspective, therefore, not only are different criteria required to address trustworthiness, but a different vocabulary. Trustworthiness is sought through 'credibility', 'applicability', 'transferability', 'consistency' and 'neutrality'.

'Credibility' is sought, rather than internal validity. For the conventional positivist researcher, a hypothesis is tested, in order to confirm the proposed theory. Internal validity requires a tool to measure what the researcher intends to measure in order to provide this confirmation. As noted above, it assumes a causal relationship between variables, which can potentially be proved. However, in human inquiry, there would be too many variables that would need to be accounted for in any human action. Respondents are never tested in isolation, so the effects of just one variable cannot be addressed. Instead, unlike inanimate objects, they live in a world of ever changing conditions with multiple variables affecting their beliefs, attitudes, knowledge and behaviour. A less compelling test must be used, in which there will be no provision of 'proof', as the positivist demands. Instead 'credibility' is sought, (Lincoln and Guba 1985, Heron 1996). Interpretive research examines the data first, before developing theory and openly seeks negative cases, which could potentially challenge the developing theory (Strauss and Corbin 1990). This allows the researcher to develop the 'best fit' and will allow for changes in interviewees' differing conditions, contexts and changes in responses at different times.

Although positivists stress the importance of both internal and external validity, the one can start to negate the other. For example, the more one refines the research population to, for example, gay men, under 25, with AIDS, who share hypodermic needles, the less generalisable it is to the general population. Within the qualitative dimension, this is acceptable as long as it is made specific and is known as 'applicability': the closer the studied group are to another group under consideration, the more likely that the results can be used appropriately. This is also known as 'transferability' (Lincoln and Guba 1985).

'Consistency' is a further criterion of building trustworthiness. Conventional inquiry relies on reliability, the key concepts of which are

> 'stability, consistency, and predictability' (Lincoln and Guba 1985, p. 298),

that is, replicability. This assumes that there is something 'out there' in the 'real' world. Interpretivist research is predicated on there being multiple realities, which are ever changing, so uses the term 'dependability'. The more often respondents confirm a developing theory, then the theory is strengthened and one can depend more on it. However, that is not to say those same respondents will reply in the same way when circumstances are different.

Lincoln and Guba (1985) identify 'neutrality' as the final criterion for trustworthiness. This is not the same as 'objectivity', a term of great significance to positivists, meaning that as scientists

> 'The methodological principle of a value-free, neutral, uninvolved approach, of an hierarchical, non-reciprocal relationship between research subject and research object' (Mies 1993, p. 67)

is paramount. Instead, from an interpretivist perspective, the researcher aims to avoid imposing his or her own views on the respondent but tries to understand the respondents own reality, in the knowledge of the possible effects of the researcher's own experience on the research process.

Rejection of the positivists' requirements of validity and reliability, requires alternative methods of generating 'trustworthiness' to support the work of qualitative researchers. Initially, Lincoln and Guba (1985) presume

> 'that the inquirer has made every effort to become thoroughly aquainted with field sites in which the study is to take place' (p. 251)

The skills of the inquirer/s are emphasised, given that they, as the researchers, are the research instruments and must develop and sustain trust with the respondents. Accurate data collection is essential, which may come from interviews, discussions, documents, diaries, records, etc. Other major tools for promoting trustworthiness are 'triangulation, thick description and reflexivity' (Brody 1992, p. 177).

Triangulation

Triangulation is of critical importance in increasing the trustworthiness of the interpretation of data to new paradigm research.

> 'As the study unfolds and particular pieces of information come to light, steps should be taken to validate each against at least one other source (for example, a second interview) and/or a second method (Lincoln and Guba 1985, p. 283).

It is concerned with always checking different sources of data against one another. This may include negative case analysis, which involves looking for cases which refute the emerging theory. This will not negate the theory, necessarily, but will help clarify who or what the theory relates to and increase understanding (Strauss and Corbin 1990). It is rarely adequate to accept a single source of information, unless it is coming from a unique source, wherein there is no other data to compare.

Triangulation may also involve using different methods of research to provide an 'all round' picture and can provide a check on findings. Different methods may include interviews, focus groups, observation etc. Different data sources may be accessed, such as different interviewees and secondary information, such as newspaper articles, epidemiological data and the like (Gilchrist and Williams 1999).

Denzin (1978) suggests using a team approach as a further method of triangulation. Several researchers may study the initial data and compare the categories that each member identifies. If there is close collaboration, then better trustworthiness is assumed. Use of a team also allows the possibility of de-briefing, wherein the data collector/analyser can discuss findings with others. In a more formal setting, developing an audit trail may be appropriate. This entails a retrospective analysis of the process of the research in order to ensure that appropriate techniques of research and analysis have been followed. This requires the researcher/s to keep a scrupulous record of each stage of the research.

Finally, checking the researcher's interpretation with the original sources can improve the trustworthiness of the analysis, sometimes known as 'member checks'.

> '*Member checks.* This refers to the process of recycling interpretations back to key informants' (Gilchrist and Williams 1999, p. 81).

This is a key element of naturalistic inquiry and participatory action research, but has use in all new paradigm research.

Thick Description

Thick description involves collecting rich data for analysis, such as collecting verbatim accounts with accurate notes about the encounter. This should take account of minutiae, as well as the basic information, and collecting a great deal of data in order to inform the research intimately (Brody 1992). Accurate transcription is necessary, in order to provide the adequate detail needed to ensure the rigor of the research (Poland 1995). Information should include how the respondents were identified, their relationship to the researcher and if and how that relationship develops. Personal details should be included, such as age and gender and previous experience should be noted, such as how long interviewees have lived in the area (Gilchrist and Williams 1999). Local knowledge of the area by the researcher is assumed in order for detailed descriptions to be reported to provide a context within which sense can be made of the data (Lincoln and Guba 1985). Taking field notes can encourage quality or 'thick' descriptions. This is a means of keeping a record of day-to-day activities, including where the research takes place, who is involved,

what people are doing, what events take place, the time sequence, people's goals and the physical setting (Bogdewic 1999).

Reflexivity

Reflexivity requires

'open disclosure of preconceptions and assumptions' (Brody 1992, p. 179).

It involves being explicit about the research question, how the research is to proceed and the theoretical perspective from which it arises (Miller and Crabtree 1999). Researchers need to focus on themselves and identify what influence they themselves have on the fieldwork and the interpretations (Borkan 1999). Field journals are, again, a way of capturing the feel of the interview or encounter. They can provide an account of how successful or otherwise the interaction felt, the mood of the researcher and the perceived mood of the respondent and most importantly, when interviews are tape recorded, the nuances of the respondent, for example, responses spoken in irony, in humour or in anger can be captured. This also includes 'mounting safeguards' (Brody 1992, p. 218) around time spent interviewing, personal involvement with respondents, personal safety and so on. However, this activity moves from being a purely reflective activity into reflexivity when information obtained at each interview or stage is used to inform the next stage of the research (Miller and Crabtree 1999).

Although grounded theory was not used in the present study in the purist way of Glaser and Straus (1967), the principles were drawn on (Chanaz 2000), in terms of category selection. This is further discussed later in this chapter.

Ethical Issues in Research

All research activity requires a consideration of a range of ethical issues which are about the moral principles adhered to during the conduct of the research. Such issues include being fair and just to the individual concerned and to society as a whole. Primarily this is to protect respondents from harm, but also to ensure that research is trustworthy and not fraudulent. Researchers have obligations to their subjects, to society, to their funders and

employers and to their colleagues (Peace, 1993). Naidoo and Wills (1994) suggest that there are certain generally accepted ethical principles. These include respect for individuals and their rights. Doing no harm is a fundamental principle, though doing good is more problematical: the research may not be doing the individual respondent any good. However, as long as it can be considered that the research is potentially of good to society and no harm to the individual, it is usually deemed acceptable. Within this study, the researcher acted within her professional code of conduct, which covers the range of ethical issues discussed above (United Kingdom Central Council 1992). The two supervisors, with wide experience of research, scrutinised the study throughout the research process.

An initial concern was asking potential respondents early in the interview if they were on benefit. It could be a sensitive issue, particularly with those couples unknown to the researcher. However, this highlighted the need to be absolutely open about what the research is about with respondents. Walmsley, for example, (1993) researched people with learning difficulties. People tend to have low expectations of this groups capacity to give or withhold consent or provide useful information. Walmsley met a respondent who appeared not to have learning difficulties and was uncomfortable asking whether she (the respondent) considered herself in this category of disability. The researcher was concerned that she may be offended. Consequently, she took this as a positive way of assessing the ethics of further research.

> 'In principle I see it as an ethical litmus test of the research question, if it can be explained to the research population without too many uncomfortable euphemisms. How can you justify asking people to reveal details of their lives without telling them what you are trying to find out?' (p. 40).

The above quote highlights several ethical issues. Not telling respondents what the research is about denies any respect for them as individuals by withholding information. With regard to doing good, research is often very one sided, with the researcher obtaining data, and the respondents gaining nothing for themselves. At most, the process may be neutral for the respondents or it could waste their time. It could certainly do harm, in that interviewees may disclose information about themselves which they would not do had

they known the true purpose of the research. Withholding information is certainly not just and emphasises the power that the researcher often has over the researched (Peace 1993). Any research study should be open and honest about the aims of the research in order to fulfil the ethical principles fundamental to any research project.

The same difficulty of self-disclosure can be encountered from a very different perspective, when the respondents enjoy the research encounter. This runs the risk of creating a compliance, wherein respondents give the answers they believe the researchers want or which are socially desirable. Finch (1993) found, when interviewing the wives of clergymen and women attending playgroups, that she was welcomed into their homes as a guest. The women were extremely confiding, often talking about very private areas of their lives. There is the potential for respondents to reveal more about themselves than they would otherwise choose, because of the comfortable, friendly atmosphere the researcher has encouraged (Gilchrist and Williams 1999). The privacy of the home may allow improved self-disclosure but the researcher has to accept that other people may be in the household when the interviews took place. In this study, the couple were always asked if they were happy to proceed with others around. The few cases when this occurred, the couple were comfortable in participating in the research, with two interviews when the 'outsider' joined in the discussion.

Most couples interviewed had children playing around throughout, which sometimes was quite disruptive. However, as the researcher was a practitioner, she was familiar with such difficulties and, generally speaking, could manage these problems by using distraction techniques or enlisting one member of the couple to care for the child whilst she spoke to the other partner and vice versa. The couples appeared to accept the dual role of researcher and practitioner, so they spoke about their experiences openly when asked. Some respondents did respond to the researcher as a practitioner and asked questions about practice, particularly about the woman's mental health. This dual role can create difficulties unless boundaries have already been set. The researcher listened to respondents and then offered to provide appropriate care from other workers.

Assurances of confidentiality are given, but guarantees are not provided, other than the professional status of the researcher. The present study was concerned with couples on low income and therefore data collected was of a particularly confidential nature. It is therefore important that care is taken where data is labelled in an appropriate way, using different initials in transcription and stored, such as in a locked filing cabinet and when it is destroyed, it is done so appropriately, such as by shredding transcripts and wiping tapes clean. It is also vital that when the study is published, no respondent can be personally or organisationally identified, unless previously agreed (Oppenheim 1992).

Information may be elicited by the researcher, who the respondent trusts, but this data may be handled and analysed by others, which has the potential to break confidentiality. In the present study, the researcher transcribed the tapes from Phase One and Phase Two. This was to ensure that a deep understanding of the data was achieved. A transcriber was enlisted to help with the findings from Phase Three and Four. All transcriptions were checked against the tape recording to ensure accuracy. The transcriber was not from the same area as the research area and she knew none of the participants, which enhanced confidentiality issues. An aspect of transcription that the researcher had not anticipated was that the transcriber was initially shocked by the language used by the respondents. The research therefore spent time talking about this issue and added the expletives that had been 'censured'. Others having access to the data were the research supervisors, who were confident about anonymity, given that they did not know the area and false initials were used. In the same way, external examiners or higher research bodies may wish to verify the findings would not be able to identify the individuals.

Furthermore, the findings could be used to undermine the group under study. Finch (1993) found in her study from a feminist perspective of the wives of clergymen, that they were generally happy to lead lives centred round their husbands. She was concerned that this finding could be used to argue that all women would be happier if they were subservient and subordinate to men.

> "[B]etrayal' in an indirect and collective sense, that is, undermining the interests of women in general by my use of the material given to me by my interviewees' (p. 177).

A major method used to address some of these issues is obtaining informed consent (see Appendix One). This is the responsibility of the researcher to explain the research study fully, including information about why it is being done, who is doing it and for whom (Barnard 1992). Once the respondent is clearly informed about the study, they can then make a free choice as to whether to participate or not. An information sheet is usually provided for the respondent for future reference and a 'get out' clause is included, so it is clear that the research can be terminated at any point (see Appendix Two). This process is described in the next chapter.

One safeguard for respondents of NHS research is the Local Research Ethics Committee. This is a body of people of varying backgrounds, such as doctors, nurses, clergy, solicitors and lay people, who are brought together on a regular basis. Their purpose is to scrutinise research proposals, to ensure respondents are not being exploited, that adequate explanation of the research is to be provided and that informed consent will be obtained in an appropriate manner. Although these committees are not statutory bodies and do not have any legal powers,

> 'Ethics committee approval is effectively mandatory before funding or publication is possible and it is unlikely that a researcher's colleagues would quietly stand by if an unscrutinised project were to be undertaken, (McLean 1995, p. 243).

Approval for the research was obtained from Gateshead Local Research Ethics Committee.

Overview of the Chosen Research Methods

The two research methods chosen were semi-structured interviews and focus group discussions. The major advantage of qualitative research methods is that they allow rich data to be collected. The data is rich in the sense that it is complex and varied when compared with quantitative methods, which predominantly use closed questions that do not allow the respondent to expand on their views. Qualitative data offers the opportunity of attempting to understand the respondents' own realities. When using qualitative

methods for investigating issues around the social and cultural contexts of choice of food, Milburn (1995) found that, on analysis of the data, four important aspects of increased understanding of food choice were complexity, method, context and dynamics. For example, the complexity of family relationships was revealed by allowing flexibility in interviewing in Charles and Kerr's study (1988). The method of using semi-structured interviews allows the interviewer to ask questions that seem appropriate at the time, with further probing as necessary, so that complex detail of the phenomena can be obtained (Ackroyd and Hughes 1992). The specific context of the respondents' lives can be explored, to gain greater insight into the relevance of their biological details, social setting, cultural aspects and the like. This richness of data can be confirmed by paying attention to how people respond verbally and non-verbally and can enable an exploration of the dynamics of the relationship involved (Bryman 1988).

When considering research methods, observation of shopping and cooking behaviour was considered. However, on reflection, this was deemed to be inappropriate partly because of the intrusive nature of that process, but also because the study was concerned with respondent's perception of their eating behaviour rather than just their actual eating behaviour. The study was interested in how people view their own lives and how they act with reference to such views. For the same reason conducting a survey of people's views about food and eating behaviour was considered inappropriate because it would be unlikely to uncover the complex reasons as to why people eat as they do or perceive that they do.

To gain the richest data, the researcher requires communication and listening skills. Perhaps the most significant one is the ability to reflect. Self-awareness of the effect the researcher may have on subjects is important (Atkinson and Shakespeare 1993). Ackroyd and Hughes (1992) maintain that the interviewer should be as similar as possible to the respondent. This is often not possible. However, attempts can be made to use appropriate and understandable language and a venue respondents feel comfortable in, which also requires the researcher to be aware of the subject's cultural background, environment and social circumstances. The researcher must also be aware of the researcher-subject

interaction and how status, confidence and the unconscious reinforcement of responses may influence those responses (Miller and Crabtree 1999).

As in all social interactions, first impressions are relevant, as are the experience and status of both interviewer and respondent. Any interview or discussion requires the researcher to show empathy and be non-judgmental (Jones 1985). Understanding is gained through listening and so the researcher should avoid interrupting where possible, and should be curious without imposing their own views on the group or individual. However, there may be situations when it is appropriate to disagree, but this depends on the relationship between those involved. Robson (1989) suggests that being challenging, when fitting, can prevent the interview or discussion turning into an easy chat, when no useful information concerning the understanding of the phenomena under study is revealed. Also, a lack of self-awareness in an interviewer can lead to inappropriate technique being used. Fielding (1994) describes the problems of:

> 'misdirected probing and prompting, ignoring the effects of interviewer characteristics and behaviour, neglecting the cultural background of the researched and with question wording' (p. 11).

Semi-structured interviews

These are essentially conversations in which researchers elicit responses from subjects about their views, feelings, attitudes, experiences and/or behaviour in relation to the phenomena under investigation (Walker 1985, Ackroyd and Hughes 1992). It is a social process, an interaction between two or more people, which needs to be regarded and interpreted as such (Walker 1985). As in all qualitative research, the aim is to 'see through the eyes of those whom one studies'. The researcher is attempting to understand and interpret the world from the subject's own perspectives.

In general, guidelines are used to provide some structure to the interview (Rose, 1994) (see Appendix Three). However, how much structure is appropriate depends on issues like the nature of the study and the research question to be answered. A completely

unstructured interview is unlikely to elicit information useful for the research and would purely be a conversation, the content being random. But, as Jones (1985) states:

> 'there is no such thing as presuppositionless research' (p. 47).

Research has a purpose and so some guidance is required in order to obtain meaningful data. This allows the researcher to guide the discussion, but, in a semi-structured interview, the subject also has some freedom to steer the interview (Hakim 1987).

Massarik (1981) suggests a hierarchy of interviews. The most positivist interview would be predetermined and similar to a survey with closed questions. In contrast, the most qualitative interview would be the phenomenological interview in which there is maximum trust between interviewer and respondent, with a fundamental equality between them (Brazier 1994). This type of interview is mostly found in participative research or action research, wherein the subjects become researchers themselves and shape the research question and are therefore directly involved in the research. Semi-structured interviews do not have this complete equality, in that the researcher has a research question, but does still aim to explore the views and feelings, values and behaviour of the subject from their own perspective.

Within the present study semi-structured interviews were used in Phases One, Three and Four. This was because of the advantages suggested previously. Perceptions of eating behaviour were being sought and this is sometimes a difficult area to explore. For example, the findings showed that as interviews progressed, some couples seemed to contradict themselves. This apparently related to how they would like the situation to be, but, as the interview progressed, they talked more about the actualities of home life and diet and eating behaviour. Using guidelines can provide some structure, but still allow individuals to develop their views in order to provide a deeper understanding of the concepts being discussed. This is an approach which is consistent with an interpretivist perspective.

Researching men on low incomes

A limitation of the research was the difficulty of recruiting men. In the study, women acted as gatekeepers, being the ones to decide if their male partners could be interviewed. Some of the women seemed to block access to their male partners for their own reasons, rather than because of objections from their partner. Whether this was to do with protecting their own role, as mothers and housekeepers, and their status as such within the household or pre-empting any possibly embarrassing response by the partner, such as contradicting the woman, is unclear. Other women's refusal in the study was on the grounds that 'he wouldn't speak to you', according to the women. In some cases they said that their partners were shy or would not be interested.

So, why are men on low incomes difficult to interview? Sometimes there was an obvious reason. For example, one woman, who was keen to be involved in the research, repeatedly arranged an interview, but cancelled it each time because her partner had been drinking. McKee and O'Brien (1983) suggest that, because, in their study, wives gave 'permission' for their partners to be interviewed, the sample would be weighted to

> 'those with 'good' marriages or highly involved or committed husbands' (p.148).

It is likely that women who declined to allow their partners' to be interviewed in the study have different characteristics to those who agreed, such as having very traditional working class relationships, with gender roles clearly defined (Clarke and Watson, 1991). The findings from the women's focus group and the Phase Three interviews appeared to confirm this, in that they seemed to reveal less sharing relationships.

Another reason for non-participation of men in the study may be that the researcher was a female professional worker and therefore, in many respects very different from the potential male interviewees. Some researchers have found that responses from interviewees differ if the interviewer is male or female. There are conflicting reports as to whether the gender of the researcher and researched make a difference to responses: McKee and O'Brien (1983) found that the more similar the interviewer is to the respondents, the greater the compliance; Lee (1993) suggested that women tend to prefer

women; Brown and Lunt (1992) showed that only 25% of men using a well man clinic valued male staff providing the service. However, most studies suggest that the personal and social characteristics of the interviewer was of most relevance in obtaining trustworthy data (O'Connell Davidson and Layder 1994, Lee 1993).

A further issue concerns a female researcher interviewing men, as she is potentially vulnerable because of her status as a woman (O'Connell Davidson and Layder 1994). McKee and O'Brien (1983) found that when they interviewed widowed fathers, some of the men treated the researchers as if they were on a date, by offering food and wine. It is possible that men could misconstrue the motives of the researcher. This was an issue of concern when the study was being scrutinised by the Local NHS Research Ethics Committee. When it was explained that women visiting men, as general practitioners, health visitors or district nurses, is a normal part of practice, this was accepted. However, it did raise questions about what practice is safe and what precautions should be taken. In the event, the researcher left a note at the Family Centre which was used as a base when visiting, saying where the interview was taking place and what time she would return. In a practical sense, to a large extent the researcher was protected from feeling vulnerable, because in all cases, the woman in the household was present.

Gender issues were relevant when the format of the interviews was addressed. In the research, the man was given the first opportunity to speak. From a pragmatic approach to the research, this was because of the difficulties in interviewing men. It was considered expedient to ensure the interview was secured with the man, who was less likely to agree to be interviewed than the woman . However, speaking to the man first could be seen as giving the man 'a voice' which could be perceived as being more important than the woman's (O'Connell Davidson and Layder 1994). Researchers need to be reminded of the impact that the process of doing research can have on the respondents (McKee and O'Brien 1983).

Interviewing in the home environment

The interviews were conducted in the respondents own homes. Although it is common practice in the UK for mothers of young children to have professional workers visiting them at home, such as the health visitor and the doctor, this is not often the case for fathers (Finch 1993). If the father is around when the health professional calls, it is commonplace for him to leave the room (Williams 1997). Whether this is due to the man's personal discomfort or that professionals are guilty of erecting barriers to communication with fathers is unclear (Trevelyan 1996).

The room within the house which was appropriate to conduct the interview presented difficulties. Initially, the intention was to interview men and women separately in their home. It was thought that couples may be less open in each other's company or that they may be more likely to confirm each other's views. However, most of the families visited had either only one 'public' room, that is the living room, or were open plan. It was deemed inappropriate to ask to interview men in, for example, the bedroom or kitchen. Other researchers have got round this issue by negotiating the use of a different room on the basis of potential interruption or noise, or using two researchers to interview members of the couple at the same time (Lee 1993). In this study it was neither physically possible to use different rooms and nor were two researchers available.

In several interviews children and/or babies were present, which limited the research further, in that there were frequent interruptions. Some families had asked a relative to care for the children, but the researcher could not expect this and some families did not have close family nearby. If there had been funding available, it may have been possible to offer to pay for childcare or provide a play worker to entertain the children.

Focus groups

Semi-structured interviewing, as used in Phase One, is a useful technique for gaining insight into the thoughts of individuals, but it is sometimes appropriate to use group discussions as a method of gaining a different understanding of the phenomena under study. Discussion groups using a pre-determined stimulus are known as focus groups

(Pickin and St Leger 1993). In the present study, a prompt sheet (see Appendix Four) was used and so it was decided to use the term 'focus' groups. Group dynamics are used to elicit responses which may not be forthcoming with individual interviews (Pickin and St Ledger 1993). This is because group members respond to each others views and may gain insight from others and then produce new ideas (Hedges 1985). Brown (1999) has used focus groups regularly and has found them

> 'dynamic, spontaneous, synergistic, and fun...both flexible and diverse' (p. 112).

Focus groups have been considered particularly useful for exploring controversial and/or complex phenomena (Morgan 1988), though others feel that individual interviews are more appropriate for difficult issues (Burns 1989). The decision of which method to use must depend on the nature of the research question and the personal and social characteristics of the respondents. For example, McKie et al. (1993) found discussion groups with women allowed them to

> 'draw strength and confidence from one another to talk' (p. 37).

Alternative suggestions may be made about how to deal with a particular problem (McKie et al. 1993). A further advantage of using focus groups in that it is a useful way of eliciting insights, but also a disadvantage, in that members wish to remain an acceptable member of the group and so acquiesce to the majority view (Kitzinger, 1994).

A major disadvantage can arise from an imbalance of power, with an opinionated individual dominating the discussion. Lack of respect for those with alternative views can lead to people not being open about their own opinions. Side conversations, with all participants talking at once, or the discussion veering away from the topic being researched, can be problems (Brown 1999). The researcher needs skill to ensure that the topic is generally adhered to and encourage all members to participate.

Focus groups may last any length of time, but $1 - 1^{1}/_{2}$ hours is usual (Robson 1989). Views on the size of the group vary. Robson (1989) suggests that five members mean more equal participation, a higher consensus of opinion and greater satisfaction for the

participants, though in market research eight people are considered the 'norm' for a group discussion. Hakim (1987) suggests any number between four and twelve, with six to eight being the most appropriate. Hedges (1985) considers that any more than ten in a group to be unfeasible, and suggests 'mini-groups' of two to four to be useful if

> 'working with shy or inarticulate people' (p. 75).

A further issue in organising focus groups arises around recruitment and group composition. A group consisting of people who know each other may be more relaxed about discussing opinions. However, if the subject is sensitive, they may be unwilling to disclose their true feelings, or may be more likely to agree with the group consensus. A heterogeneous group may have more diverse views, but still be subject to these drawbacks (Brown 1999). The venue may also make a difference to the willingness to respond, some being most comfortable in a professional setting, others in a more informal venue.

In the present study, focus groups were used as a method of triangulating the data analysis gathered in Phase One. Given that there were some dissimilarities between the couples in Phase One and Two, negative case analysis was used in Phase Three, wherein a different group of people are interviewed to examine any potential differences. The last phase provided the opportunity to explore in greater detail the categories identified earlier in the research.

All stages of the research study were expected to aspire to trustworthiness. The characteristics suggested by Lincoln and Guba (1985) were addressed. Interviews were held in the interviewees' own homes to ensure a natural location and the focus groups were held at the Family Centre, a setting which all the respondents were familiar with. The researcher had worked in the community for several years and therefore had tacit and holistic knowledge of the area within which the research took place.

Grounded theory, interpretivism and community development

Three areas of analysis and potential practice have been drawn on within this study, each of which has been useful in the understanding of both the approach and the research: grounded theory, interpretivism and community development. Each have their own offering in the understanding of any piece of qualitative research (Clarke and Pearson, undated).

As discussed earlier, the first paradigm which the researcher engaged with was the interpretivist perspective. This was because the mode of study identified appeared to be appropriate to this philosophical approach and that the research methods were coherent with the aim of the research. It was consistent with the qualitative nature of the research, which was concerned with understanding individual's and couple's own views of the world, accepting that these may change according to the setting and time of data collection.

The use of the principles of grounded theory were found to be useful in terms of understanding themes, which led to the identification of categories (Glaser and Straus 1967). Grounded theory was an invaluable tool in dealing with the masses of data which needed to be analysed. An interpretive approach to this perspective was adopted, wherein a single core category was identified initially, but a further category was found to be important in the analysis. Instead of Glaser and Strauss' (1967) insistence on finding a single core category, a more flexible approach allowed two main categories to be developed which could then be developed into a single model. (Charnaz 2000).

Finally, the principles of community development were employed throughout the research on a more practical level. This was because, at least in part, the researcher was a community development worker. It is an approach which again is interested in diversity and understanding respondents' different values and differing viewpoints. Although the researcher started the research from this perspective, interpretivism provided a wider philosophical basis for the research. Grounded theory principles fitted with both these

perspectives, particularly where analysis was concerned. Community development was then used as a basis for developing the potential applications of the final model.

The Role of the Pracitioner/Researcher

A further aspect of reflexivity includes an awareness of the researcher also being a practitioner. It has already been referred to that any researcher must be aware of any potential prejudices in order to put them aside for the fieldwork and analysis of the research, knowing that it is sometimes an impossibility. In such a case, prejudices need to be acknowledged with honesty and openness, in order for anyone reading a report of the findings can take account of this. This is similar to the problem of health promotion discussed in the previous chapter. We all have some agenda and this should be made explicit (Seedhouse 1997).

It is equally important that the researcher/practitioner is aware of the respondents themselves. Researchers can be in a situation which potentially exploits the respondents. For example, if the subject is aware of the researcher's professional status. This could lead to the former giving the responses he or she thinks is wanted, to ensure they continue to obtain health services. They may also consider the researcher/practitioner to be an 'expert', which may not fit in with our view of trying to redress inequalities (Atkinson and Shakespeare 1993). As a practitioner and researcher from an interpretivist perspective the aim is to reduce inequalities, in order to empower people to develop their own skills and confidence. This can be difficult if the respondent is expecting advice or counseling. Again, openness and honesty is important in identifying the interviewer's role.

A further aspect of the 'insider' role of practitioner/researcher is that he or she is likely to get more information as they may be known by local people. Alternatively, less information may be provided because respondents are conscious of giving too much information, which may then be passed on to other professionals to their own detriment. Assertions of confidentiality need to be followed as closely as possible, with full knowledge that there may be some responses that need acting on, such as child abuse.

However, the alternative is that the respondents know the practitioner and feel comfortable to talk about difficult subjects because of trust that has developed with the researcher as a practitioner.

The implications of being a practitioner/researcher need to be explored carefully before any research study is undertaken. Before the study began, the researcher discussed issues of confidentiality and possible exploitation with the supervisors. The key to this examination of the aims and objectives must be in presenting the study with honesty and openness, ensuring that the respondents are clear about the research and that an interview can be terminated at any point. Informed consent is an important tool to use to make this process explicit, as was done in the present study.

To ensure the appropriateness of reflexivity, interviews and topics arising from them were discussed in detail with the supervisors of the research study. A more experienced practitioner was appointed to support the researcher if any problems arose during the research. In the event, this was not needed as any practice problems that arose, the researcher was able to negotiate with the respondent as to what further services were appropriate and they were referred accordingly.

Method of Analysing Qualitative Data

Data was analysed in order to understand the multiple realities of the respondents. From the outset of the study, when an interpretivist perspective was deemed appropriate, it was accepted that any results would not be generalisable, but would be particular and would apply to the specific group under study. The use of focus groups as well as interviews with couples, plus interviews with women allowed for triangulation to increase trustworthiness, as did the research methods which allowed for rich data to be collected and for reflexivity on the behalf of the researcher (Brody 1992).

The data was analysed using both a manual index system and NUD.IST (Non-numerical Unstructured Data Indexing Searching and Theorising) computer package for qualitative

analysis. NUD.IST is a tool for organising data, so that as themes emerge, they can be categorised easily. Analysis was based on an approach based on the principles of grounded theory and was used to develop categories, which uses a systematic approach

> 'to develop an inductively derived grounded theory about a phenomenon'
> (Strauss and Corbin 1990, p. 24).

This is a particularly useful method for analysing data from an interpretivist perspective. The latter emphasises the importance of recognising that the social world is not static and fixed, but dynamic, with many different realities being expressed, according to the context of different individuals' lives. Any data collection and analysis will be subject to the researcher's own experiences and attitudes (Secker et al. 1995). It will also be based on knowledge of the subject gained from the literature. However, when the principles of grounded theory are used, it is not necessary to review all the literature before the study commences, as this should be an ongoing process guided by what themes emerge from the data (Strauss and Corbin 1990). Grounded theory is based on collecting data and developing theory initially through induction, so that the theory is grounded in the data.

The process of developing grounded theory is systematic and disciplined. This allows it to be open for scrutiny, and sometimes considered as more 'reliable' and 'valid' (Wainwright 1994). However, validity is not what qualitative research is concerned with, but trustworthiness and finding the best 'fit' of data with theory. Sanger (1994) gives an alternative perspective, suggesting that some researchers feel that if the analysis is too rigid, the spirit of the phenomenon under study is lost. From this standpoint, describing data in human terms, can absorb the reader into the world being researched:

> 'highly interpretative accounts may be seen to be closer to the spirit of the times....Here, the attempt is to maintain a holistic correlation between data and rendered account, either through phenomenological acts such as empathy or through the power of metaphor to portray more closely, likeness.' (Sanger 1994, p. 177).

Charmaz (2000) suggests that a grounded theory which has greater flexibility is more appropriate to new paradigm research, which does not seek a single, immutable truth, but to understand and address human realities. The decision as to which model to choose will depend on the researcher's philosophical perspective and the research question. The

present research drew on grounded theory principles, but allowed for a more humanistic and interpretivist approach. This included using the words of the respondents in quotes which would enable their voices to be heard. However, in accordance with grounded theory practice, further literature was reviewed as different themes and categories emerged and is found in subsequent chapters.

The process initially involves taking an overview of the transcript. This allows theoretical sensitivity to develop, which is about gaining a general picture of what the pertinent issues may be to develop theory and gain a broad insight into the interaction with the data obtained. Several sources help to develop such theoretical sensitivity. Examining the appropriate literature can improve awareness of the subject under analysis, as can professional and personal experience. The act of analysis itself entails the asking of questions, comparison of ideas and the development of potential theories, which increases understanding and insight into the phenomena under study. Once an overview has been gained, line-by-line analysis, known as open coding, is necessary. This involves

> 'breaking down, examining, comparing, conceptualising, and categorising data' (Strauss and Corbin 1990, p. 61).

The process then involves organising these concepts into groups, or categories. These contain concepts which seem to describe similar information. At the same time, the researcher makes theoretical notes, or memos, which contain thoughts about the process.

Axial coding is the next stage, and involves relating categories to the data contained within it. Strauss and Corbin (1990) suggest the use of a coding model, which ensures systematic analysis. It requires the researcher to search for the cause of the phenomenon under study, the context, the conditions under which action takes place, identifies the action and finally the consequences. The categories are given depth and richness through this procedure. This is a separate process to open coding, but will be taking place at the same time during the analysis. The process is not just inductive, but will also involve deductive thinking as theories emerge. Further data collection will be directed by the findings and continue until no new information is being obtained (theoretical saturation). The final stage is selective coding, which involves a similar process to axial coding, but

'done at a higher, more abstract level of analysis'

(Straus and Corbin 1990, p. 117).

It entails examining the categories and relating them to each other until a core category is identified, which is the central category of the analysis, in which the other subsidiary categories are connected. Strauss and Corbin (1990) are insistent that only one core category should be chosen. They describe one study where two significant phenomena emerged and one was subsumed, so that the focus was on one core category alone. As discussed above, this rigid approach has been criticised for providing a uni-dimensional and oversimplified account of complex phenomena. An interpretivist approach to grounded theory allows for less prescriptive procedures and suggests that more than one core category is acceptable because this allows for a greater understanding of the intricacies of human experience (Charmaz 2000). In consequence, grounded theory principles where used to analyse the data in the present study. Each phase developed from the previous phases in a logical progression. The limited success in obtaining couples to interview in Phase One led to trying to explore the issues in focus groups. Consequently, negative case analysis was used in Phase Three, which led to the use of a different way of engaging couples in Phase Four.

Trustworthiness of the analysis and theory development

The present study sought trustworthiness of analysis and theory development in a variety of ways. Triangulation by source was used, by interviewing many different couples, and comparing their responses. Negative cases were sought in Phase Three, wherein women were interviewed whose partners would not be interviewed, to ascertain whether there were differences when compared with the responses from the other phases. Triangulation by method was used, by using both interviews and focus groups. Also, epidemiological information was obtained in order to build up a picture of the community. This was aided by the researcher having worked in the area as a community development worker for several years.

Thick description was obtained by interviewing and transcribing the data verbatim. Notes were recorded about the time and place of the interview or discussion and additional information was recorded about other aspects of the encounter, such as were the respondents forthcoming, hesitant, who was present, interruptions etc.

Reflexivity was obtained by making notes, not just about the interviews, but also about the researcher's response to the encounter and how that may influence future research. At each phase, a summary of results with the emerging theory was written, and this was used in the next phase in order to ask respondents if this summary accorded with their own experiences. This provided a member check.

Summary

This chapter has sought to address methodological issues, both theoretical and practical. Interpretivism was identified as the most relevant perspective for the present research study. It is concerned with interpreting data from people's own standpoint and consequently detecting local truths. Some of the characteristics of an interpretivist approach to research were presented, and include using the appropriate setting, methods, sampling, analysis and presentation techniques.

The major criticism of interpretivist approaches to research was found to be that the findings would be subjective. This led to a discussion about the positivist's criteria for evaluating research which are validity and reliability. It was recognised that these standards would be inappropriate for qualitative research. Instead, 'trustworthiness' was identified as a basis for evaluation and the criteria to ensure this were credibility, transferability, consistency, dependability and neutrality.

The tools used to promote trustworthiness were described and included triangulation, thick description and reflexivity: triangulation would involve using several research methods to gain an all round picture; thick description would entail collecting rich data which will reveal close up detail; reflexivity would include all the ways a researcher

makes explicit any assumptions, perspectives, as well as responses to situations. The above can be enhanced by keeping a detailed field journal. It was identified that a further way of improving trustworthiness would be to use a team approach and to develop audit trails. Ethical issues were then discussed.

Suitable qualitative methods were identified, specifically semi-structured interviews and focus groups. These allow the researcher to explore the ways others see the world and gain an understanding of their lives from their own perspective. The importance of collecting rich data was reported and several skills were described which may improve such richness.

Finally, the methods of analysis were described, acknowledging that results would not be generalisable, but that would be in keeping with an interpretivist perspective. It was argued that an approach which draws on an interpretivist grounded theory was most appropriate to the present study. The method of ensuring trustworthiness of analysis and theory development was described and the response of the Local Ethics Research Committee was discussed.

The next chapter will present the findings from Phase One of the research. This will provide an analysis of the data collected from ten interviews with couples on low incomes who have at least one pre-school child.

Chapter Four

Phase One: Semi-structured interviews with ten couples

Introduction

This chapter describes the process of carrying out Phase One of the research, which consisted of semi-structured interviews with ten couples. It describes the sampling criteria used and the process by which the sample was obtained. Data collection and analysis are then presented and discussed. A potential core category is identified, the 'life course', and this was explored further in order to inform the next stage of the research.

The sample

The research was conducted in a small, deprived location in Gateshead (see Chapter One). The population from which the sample was drawn was families with pre-school children. This was because all families with pre-school children have a health visitor and a general practitioner with whom they are likely to have come into contact since their child or children were born. Nutrition was a topic which was regularly discussed with parents of pre-school children by health professionals at the time the research took place. Parents were therefore likely to be familiar with discussions about diet and eating behaviour.

The unit of analysis for the research was a 'household' which was identified as a family which contained both a male and female adult, who were married or lived as partners, and who claimed social security benefit (excluding universal child benefit). Benefit is provided for those who are economically inactive or on very low wages and receipt of it identifies those individuals as living on a low income (Dowler and Calvert 1995). One hundred and fifty eight households, with at least one pre-school child, were identified through child health records held at the local community NHS Trust's headquarters to make up a list for the sample frame. These records were not a complete representation of all potential households, due to families having moved house or non-registration with

community services, so the population was probably slightly larger. A random sample was not sought, as this would not have been in keeping with an interpretivist approach to research, which seeks to understand the respondents rather than to generalise results to a wider population. However, in order to obtain as wide a variety of families as possible, all the one hundred and fifty eight families identified were included.

Before any family was approached, the local health visitors and general practitioners were contacted by letter (see Appendix Five) to ascertain if they were aware of any reasons why the researcher should not contact the families, such as recent bereavement or serious illness. This was considered appropriate because these health professionals had knowledge of the families and it was considered inappropriate to pursue interviews with distressed families. None were excluded for these reasons. However, about half of the potential families were excluded because the health visitor knew the family was not claiming benefit. The remaining families were numbered and initially every eighth name was identified as a potential respondent couple to be interviewed to obtain first round interviews. Ten interviews, when transcribed and analysed, were found to be enough to allow for themes to emerge. Interviews were arranged in the couple's own home, as it was considered that asking couples to visit an outside venue would deter many from taking part. Also, it was felt that respondents would be more relaxed in their own home.

Prospective interviewees were initially contacted by a letter (see Appendix Six). This letter introduced the researcher and the nature of the research. A proposed time for the visit was given in the letter. The researcher's telephone number was included in the letter so that the potential subjects could cancel the appointment, refuse to participate or request further information. In the event, no-one did phone back. The researcher visited the home at the appointed time. If the respondents were not in, a card was left to say she had called and a new date was proposed. If the prospective respondents were not at home at the second visit and had not contacted the researcher, no further attempts were made to contact them, as it was considered inappropriate to pursue the matter further. It was assumed that they were not interested in participating in the research. When contact was made with respondents, a check was made to ensure that they did actually meet the

research criteria. If they did not, the interview was concluded. If a selected family refused to take part or could not be contacted, the following family on the child health record list was approached. It took eighty eight contacts (a successful or an unsuccessful home visit) to thirty nine households to obtain ten couples who were both prepared to be interviewed for the research. It is not known why the households declined to take participate. In some cases there seemed to be a reluctance to become involved in an 'official' interview. In others, they seemed to be busy to do so. As was found in later phases, there seemed to be an element of shyness or feeling uncomfortable talking to a professional worker.

In order to ensure that the couples understood what the research was about, an information sheet was provided for them to refer to, which the researcher read out first, in case of literacy difficulties (see Appendix Two). Local knowledge of the population from which the sample was drawn suggested that respondents may have had limited reading skills. Written consent for the interview from both partners was obtained, (see Appendix One), and again, this was carefully explained. This included a clause to ensure that the interviewees were aware that they could terminate the interaction whenever they wished, without concern that this would jeopardise any future treatment or encounter with health services. The use of the tape recorder was then introduced. Interviews and discussions were all audio-taped, and fully transcribed, with the consent of the couples. The data was analysed, drawing on the principles of a interpretivist grounded theory approach, as discussed in detail previously in Chapter Three.

The Interview Schedule

A schedule of questions to form the framework for the interview was initially developed for Phase One, based on information gaps identified in the literature review (see Appendix Three). This process led to the development of the interview schedule. The interviews were semi-structured: in Lincoln and Guba's words

> 'the interviewer *knows what he or she does not know'*,

unlike unstructured interviews, when

'the interviewer *does not know what he or she does not know'* (1985, p. 269).

In keeping with an interpretivist perspective, most questions were open-ended in order to obtain detailed and rich data. The schedule was divided into five sections: introduction, personal details, health, food and eating and health and diet.

Firstly, the introduction was aimed at introducing the researcher and verifying her identity by showing the identification card from the NHS Trust the researcher worked with. The research topic was explained, as well as the role of the researcher and the purpose to which the information obtained would be put. The respondents' personal details were ascertained in section two. Gender of the respondent was a significant aspect of the research and was asked about first, followed by who was in the family and what were the ages of the children. The couple were asked what benefits they were receiving and for how long. These basic demographic questions were to provide the basis of the couples' eligibility for the research.

The third section was a very general consideration of health. This was aimed at starting the interview with an open discussion, before focusing on food and eating. Lay people tend not to think about health, but when they do, tend to have very different attitudes when compared to those of professionals (Naidoo and Wills 1994).

Food and eating was the fourth section to be addressed. Families tend to eat what is familiar, particularly those on low incomes, who can not afford to try different foods (Dowler 1996). Furthermore, Warde and Hetherington (1994) found that eating was an unreflective activity most of the time, that people did not think about it in particular and it was just part of the daily routine. In consequence, it was expected that people would not necessarily think about what they ate and may have had difficulty answering open-ended questions. Probes were used when necessary to get round this problem.

The social role of eating within the family was explored. Several studies have identified the symbolism of sitting down at a table as a caring family unit (for example, Keane and

Willets 1984), and the opportunity it affords for teaching children manners and social formalities (Calnan 1990).

The antithesis of the family sitting down together with a home cooked meal is the scenario of everyone helping themselves to snacks and convenience foods and grazing through the day. Questions were asked about eating snacks. These were aimed at eliciting information about reasons for treats, such as the use of sweets to control children (Charles and Kerr 1988), which are usually extremely unhealthy, being high in fat and sugar content (Caraher 2000).

Questions followed which were aimed at investigating gender specific behaviour in cooking and shopping. The questions were designed to examine the gender divisions between the couple, identified as a significant issue concerning power relations within the family by most of the literature (Murcott 1983b, Charles and Kerr 1988). These studies have found that although the common view is that women choose what the family eat, it is, in fact, men who are the influential partner in food choice.

Respondents were asked if they would eat differently if they had more money. The aim here was to tease out issues arising from limited resources. Finally, to uncover whether couples ever had a change from cooking at home, they were asked about eating takeaways and eating out.

The fifth and final section on the schedule was about health and diet. The purpose of the section was to broaden out the interview slightly, to examine if couples thought there was room for change, without asking the question directly (Tones and Tilford 1994). The literature showed that the public as a whole is generally aware of what is considered to be a healthy diet (e.g. Anderson et al. 1995). Pill and Parry (1989) found that many people made an explicit link between food and health. Sources of information were asked about: whether it was obtained from the TV, magazines, health workers, leaflets, adverts, school, and whether or not they were good or useful sources.

The interview schedule was piloted with three women who were not eligible for inclusion in the research project: one was a lone parent, the other two had working partners. Minor amendments were subsequently made to the schedule.

Initially, the intention was to interview the partners separately, in order to determine if there were any gender differences between their responses. However, this proved impractical. The houses or flats where the couples lived invariably had only one living room, so the interviews proceeded with both partners present. The interviews lasted between one and one and a half hours. From the demographic information obtained at the interviews, it emerged that couples had been together for between three and twelve years and had between one and four children. Four of the men worked, but had low incomes and so claimed Family Credit.

Analysis of the data

The data was analysed using the principles of grounded theory. Initially, open coding was undertaken, with concepts organised in groups, for example 'times of meals' and 'eating at table or not'. Many such codes were identified, which were grouped together using NU.DIST computer software. This enabled a wide range of data to be analysed into gouprs, but it was not until axial coding ensued, which entailed relating the data, line by line, to the emerging groups or categories. This process involved identifying the phenomenon under study, the conditions, the context, the intervening conditions, the action and consequences. It provided the richness and thick description necessary to ensure trustworthiness. For example:

Phenomenon: family eat together at table
Conditions: children eat better, more likely to eat same food as each other and parents
Context: table in lounge, enough space
Intervening conditions: more comfortable, less messy, not distracted by TV
Action: parents insistence on eating at table
Consequences: eat better, have conversations at mealtime

Finally, selective coding took place, which is similar to axial coding but done at a more abstract level. This is described in the next section, wherein the emerging themes are discussed and, through selective coding, a potential core category is identified.

The Findings from Phase One

The findings from Phase One of the research study are presented below under six key categories which emerged during analysis of the data:

- Routines: eating meals and snacks
- Decisions: factors affecting food choice
- Sharing: cooking and shopping
- Food and Health: the links
- Sources of Information: about food and health
- Life course: influences affecting eating over the life course

Throughout this chapter, quotes are identified as male (M) or female (F) and the interviewer (I).

Category one. Routines: eating meals and snacks

This category was concerned with patterns of eating, both in terms of meal content and eating behaviour, such as the timing of meals, what was eaten by whom and the circumstances surrounding food intake. Most couples said that generally speaking all the family ate the same foods at mealtimes, though there were some occasions when they did not.

> 'I: Do you all eat the same things?
> M: Well, we try...but if we put S (child) something down that's different to us...he's not really very bothered about it you know...but if we all have the same, he is more liable to eat it'

> 'I: Does M (child) have the same as the rest of you?
> F: Yes... the whole family does...I keep telling him (partner) 'you can't be cooking three different meals...one meal for me...one meal for him and one or two for the kids...I just can't do it'

Thus, reasons given for families all eating the same foods was that the child was less likely to eat food that was different from the parents and the impossibility of cooking different meals for different family members. Most of the couples said that they did or would prefer to sit together around a table, but not all had the space to do so.

> 'I: Do you eat at the table or do you tend to eat sitting round the living room?
> F: I hated eating and having the TV on...that kitchen is so small
> but it's just big enough for us to squeeze a table in it...so we use
> the table'

Housing design does not always cater for the way people would ideally choose to live and consequently limits the way they live.

Several female respondents reported that they ate different food if their partners were working, saying they would grab a sandwich, not bother eating or would heat up a tin of food for the children.

> 'F: If he is on a day shift I would just have a sandwich for my dinner
> [i.e. midday meal]...or something like that...or a snack...I would just
> give the bairn a tin of meatballs...or beans and sausages...stuff like that'

> 'F: It's just when he's at work really that I don't eat much but when he's
> off I eat with the rest [of the family]'

Women in such situations would only cook a meal if their partner was around, and this depended on his working patterns. This practice was described by three other women, all of whom referred to 'not being bothered' to cook just for herself and the children, and reflects other studies (Murcott 1983 a, b, Charles and Kerr 1985). However, it was not clear whether they were pleased that they did not have to bother cooking or that they did not think it worth cooking just for themselves. Another reason for not cooking could be that it was an opportunity to save on the cost of a meal, given that other research has identified that when a family is short of money, the woman will go without food or eat less, so that the rest of the family can eat (Blackburn 1991). A further reason may be that this behaviour applies to all adults. It may be that generally people are less likely to cook for themselves, and men are just as likely not to bother cooking or preparing food for themselves if alone. The present research suggested that men were less likely to be left to

cook food for themselves, because the women were around to provide for him and the children.

Another reason for women not eating the same food as the rest of the family included being on a weight reduction diet. All but one of the women referred to being overweight and dieting. The woman who did not consider herself overweight had been anorexic as a teenager and seemed very conscious of the importance of healthy eating. Three men referred to dieting. One had started to eat salads instead of fatty meats because he had noticed his friend putting on weight and was concerned about his own size. One man referred to exercising more if he thought he was becoming overweight and one man was cutting down on junk food with his partner as they were going on holiday soon. In the two households where the man was changing his diet to lose weight, the women also changed her diet. However, the converse was not the case. Most women talked about the rest of the family eating the same food as always, and adapting the family diet or eating differently.

> 'F: I only have mashed tatie [potato] on my [Sunday] dinner. If it is through the week and they have some mashed tatie, I'll not have it. I'll have a jacket tatie...the only time I have chips is when my mam makes them on a Saturday'
> I: Do you cook chips for the rest of the family?
> F: Yeah'

> 'F: *I've* been eating baked potatoes, cut out all the junk food...I've had pasta... I've bought some Cupa Soups. I drink them and that's it. I've had some Slimfast as well'

Children who were described as 'fussy eaters' demanded certain meals or would refuse to eat. One strategy was to give the child what they wanted in order to ensure that he or she ate something.

> 'F: ... I've got to fight at times to get meals down him....if he won't eat a meal I'll say well he's had nothing, give him a bag of crisps.. at least he is getting something'

> 'F: He doesn't eat, the little boy...doesn't eat nothing...he just lives on cereal'

> 'M: He [child] won't eat the same, will he, because if you make a casserole he'll not eat it...you've got to make something else.
> F: He'll not eat chicken or anything like that...he'll eat sausages.

I: So he gets something different?
M: Yeah'

All couples reported having a Sunday dinner. This generally meant roast meat, potatoes, a variety of vegetables, Yorkshire pudding and gravy.

'I: What do you count as a Sunday dinner?
M: Chicken, tatie, like...Yorkshire puddings...anything like that
F: Broccoli, cabbage, turnips, peas, carrots...every time'

Sunday dinner seems to encapsulate the social role of food and eating.

'M: I suppose it's traditional...people all sit down for a Sunday dinner'

'M: Time when a family's supposed to get together'

The importance of the Sunday dinner and the way it is perceived as having a central role in giving the feeling, or at least the appearance of, a harmonious family unit has been identified in many research studies (Mucott 1983b, Charles and Kerr 1988, McKie and Wood 1990).

Several respondents commented on how much they enjoyed their Sunday dinner. Many families enjoyed a wide variety of vegetables at that meal, which appears to contrast with what some families eat during the week, but is presumably a cultural tradition.

'M: Carrots, peas, taties, turnips...everything...pork, ham...I enjoy my [Sunday] dinners'

Some of the families did not eat vegetables during the week, but ate lots on a Sunday. This finding is supported by the literature (Murcott 1983b, Charles and Kerr 1988). However, previous research has not offered any explanations as to why there was this difference between Sundays and weekdays.

All families reported eating snacks. The types of foods identified as snacks were generally those of high sugar and high fat content such as chocolate, crisps, sweets and biscuits. Very few alluded to healthy snacks, such as eating fruit. The term 'snack' was

used by the couples to refer to small amounts of unhealthy food which is eaten between meals or as a meal substitute.

> 'M: Oh, we're always in the kitchen getting biscuits and that'
>
> 'F: Oh, they're [children] terrible...they like having crisps, biscuits, ice cream...or a cornet or a lolly...something like that or some cake'

Most people said that they ate snacks between meals.

> 'I: What kind of snacks do you eat?
> M: Crisps...anything...hamburgers...
> I: But would you still eat your main meals?
> M: Oh yes
> I: Snacks as well?
> M: Oh yes'

Some people referred to eating snacks instead of meals because of a lack of time.

> 'F: It's when I've got time...if I have no breakfast, I go into the kitchen and if there's a bag of crisps there I'll get them, just to tide me over'

A few parents commented that they tried to cut down on their children's habit of eating snacks, because of harm to their teeth and one reported that she encouraged the children to eat fruit instead of sweets. However, most spoke about eating fruit only occasionally:

> 'F: Sometimes I buy fruit…I mean sometimes, like…I haven't any in the bowl just now'

Most people had a view that children will always want sweet things, since that is the way of the world:

> 'M: If a kid gets a preference it will be sweets, sweets, sweets'

One woman described giving her first child fruit in the first year and no sweet things, hoping this would train her child to like healthy foods. On her first birthday, she was given sweet food, but found her experiment had failed.

> 'F: She took one look at it [sweet food]...then looked at me and I knew what she was thinking...'You've been holding out on me"

Many couples referred to 'junk' food as a poor substitute for 'proper' food. Snacks were counted as 'junk' food. The term generally had negative overtones. Examples of 'junk' food included chips, fish fingers, pork pies, crisps, sweets, chocolate, hamburgers, sausages. 'Junk' food was considered by some to be fast food, pre-packed, convenience food, microwave food and fattening.

> 'F:I like to see the kids have proper meals...I hate to see them have rubbish meals...like a bag of crisps and a Kit Kat shoved in their hands'
> 'I: So what counts as junk?
> M: Just sweets or crisps...chips...burgers...sausage...
> I: Do you think it matters whether you eat junk food or proper dinners?
> M: It doesn't really bother me, some days I can gan [go] wanting slimming stuff and other days just gan [go] back to greasy stuff'

In contrast to 'junk' food, 'proper' food was generally taken to include cooked, non-processed combinations of meat, potatoes and vegetables. This food seemed imbued with some kind of moral superiority and was generally considered good for you.

> 'F: I like proper food, you know, I don't like cheap food.... We like home cooking'

Most families had reasons for their routines. They identified why and when they ate the same or different foods and offered reasons for making those choices, such as not wanting to cook different meals, giving the child what he or she wanted to ensure some nutrition, and weight reducing diets. There was a general consensus about the significance of the Sunday dinner, in terms of what it consisted of and that it was a time for the family to be together. There was also agreement about what constituted a 'snack', 'junk' food and 'proper' food.

Category two. Decisions: factors affecting food choice

Deciding to eat certain foods was influenced by a number of factors. As noted above (category one), concerns were expressed about the 'goodness' of the food. Another determinant of food choice was often seen to be dependent on who was cooking and eating. When asked who decides what to eat, most families agreed it was the woman.

> 'I: Who actually decides what you're going to eat?

M: She'll say 'What do you want?' and I'll say 'Whatever you're having'
F: Basically it's me'

However, further probing frequently revealed that what to eat was a much more negotiated decision. The woman often decided what she felt should be eaten and then checked out with her partner if that was acceptable. Occasionally the man might object or may request a particular favourite, but generally acquiesced.

'F: I know what he likes'

'F: We all like what each other likes'

'M: She does the shopping...but I just say what I fancy really... what I fancy eating'

This suggests compromises around family eating and is supported by earlier research which showed that men have an influence on family eating habits. This male influence was noted in the previous section, several women reporting being not bothered to cook if their partners were out and not eating with the family.

However, the couples interviewed did not appear to display such strong traditional attitudes that previous research had indicated would be prevalent in such lower socio-economic groups (Murcott1983b, McKie and Wood 1991, Charles and Kerr 1988). In these earlier studies, men's preferences were found to be a key influence on what the family ate. Men in the present study appeared to take a more active role, being more involved in making decisions with women about what food is consumed.

'I: Would you say K [partner] decides what to eat...or do you decide what you're going to eat?
M: Just what we bought between ourselves'

'I: Who decides what you eat?
M: Both of us...we have a discussion...I'll say 'I fancy something else' and she'll make it...we both discuss it'

It should be noted, however, that those couples who agreed to be interviewed may have been different from those couples who refused to be interviewed. It could be that their

sharing of decision making shows that the respondents interviewed were in more generally sharing relationships. Couples who refused to be interviewed may differ in some respect, for example, one partner being more dominant than the other.

Several participants, both male and female, but predominantly women, referred to weight and weight loss being an important factor in their choice of food, as noted in the discussion of category one. Six interviewees were actively trying to lose weight at the time. Strategies employed to lose weight included reducing fat intake, e.g. by grilling instead of frying and cutting out sweet things.

> 'F: Well, all the food I eat is grilled...just like I have...like the Country Vegetable Rice and that's done in water...I have...like eggs that's done in water, dried toast...mm...jacket potatoes, just to try and lose me weight, you know... I don't have anything with fat'

> 'M: Now and again I get to the stage when I'm too fat, aren't I?
> F: Yes and then he'll go on a diet'

Respondents did talk about 'eating what they wanted' and not being influenced by other considerations. However, some tensions remain for some households between eating what they want to eat, believing what they should eat, what the children should eat and/or losing weight. Again, a moral dilemma between 'should' and 'want'.

> 'F: It's one thing saying it and another thing doing it'

But there were several people had no intention of changing their diet from what they liked for any reason.

> 'M: This is life…you can stress the importance of eating proper, but you can lead a horse to water…you can't make it drink and that is the bottom line'

> 'F: ....if I want to eat it I'll eat it and if I don't, I won't. It's as simple as that ...as long as the kids are all right, that's all that bothers me'

Many couples felt that they ate what they chose to, but this has to be set within the context in which families live, where the influences of families, friends and the mass media are often of great importance (Borah-Giddens and Falciglia 1993, Anderson et al. 1995).

Category three. Sharing: cooking and shopping

Patterns of food consumption within the family are obviously governed by what food is purchased and cooked. In some households, shopping and cooking were shared between both partners but in others they were the responsibility of the women.

> 'M: Well...she does it most of the time...I do it once in a blue moon'

> 'M: I still cook now...now and again but she does the majority...
> but if she can't be bothered I do it'

Couples were more likely to identify the woman as the main cook, with the man helping if his partner was particularly tired, out of the house, or if he fancied cooking something special like a curry. One may conclude that if the woman cooks and shops, she would have more influence on what food is eaten within the household, but significantly, this does not seem to be the case.

Almost all the couples did a main weekly shop at a supermarket, buying things like milk and bread locally on a day to day basis. The literature showed that this was a typical pattern, with women primarily doing the shopping and some couples sharing this activity (Calnan 1990, Warde and Heatherington 1994). Only one woman went out shopping every day. She might not always buy something, but it was clearly a recreational activity for her, as well as a social event, as she often went with her mother. It seems that the couples deliberately limited their opportunity to go to a supermarket to once a week. This could be due to the difficulties they faced when offered access to a wide range of foods at such outlets. Shopping locally was less fraught with such difficulties because of the restricted range of foods available in shops nearby and could safely be visited for staples on a regular, often daily visit.

Respondents were asked if they would eat differently if they had more money. The response was varied. Some said they would eat the same.

> 'M: If I won 40 million quid I'd still go to Premier'

Others said they would buy better food, such as fresher, leaner food. In other parts of the interview lack of money had been given as a reason for not eating as they would wish. Thus, being on a low income had a significant effect on respondents' eating habits, a finding supported in the literature (Holland et al. 1996, Prout 1996), in which low income was often reported to be related to an inability to afford a healthy diet.

Category four. Food and health: the links

High fat and sugar foods were perceived as bad for health, yet were still eaten. Various reasons were given for eating an unhealthy diet. Tiredness and lack of time were an issue for some:

> 'M: Well normally...if I ...if I've had a hard day at work I can't be bothered to cook anything...and if she's had a nightmare day with these two...'

Healthy foods were considered expensive by several respondents:

> 'F: because we can't afford to have nutritious meals...so that's it really, but if I could do it I would, but I've never got the time, ...you know I've not got the money, it's as simple as that'

One woman described buying five pounds of potatoes and a big bag of sausages when money was particularly tight, which would last the family a couple of days and not cost too much.

Respondents showed a reasonable understanding of the basics of healthy eating. Several people said that a mixture was important, that you should not eat the same thing every day, but an occasional treat was all right.

> 'M: The occasional chip butty isn't going to kill you, but if you eat chips every day, then it's not good'

Reducing fat intake was perceived by most people as a healthy objective. The types of food considered healthy included fruit and vegetables, chicken and pasta. Several couples described trying to eat a healthier diet.

> 'F: I've tried to cut down [fats]...it's bad for your cholesterols and that...isn't it...like I don't drink tea or coffee either'

Several mentioned a healthy diet as being especially important for children. However, getting children to eat at all was a major consideration for some families.

'F: You've got to force them to have a nutritious meal'

Respondents did understand the basics of healthy living. Many couples remarked on the link between smoking and ill health.

'M: anybody that smokes will get every kind of disease under the sun'

However, some respondents minimised the impact on health:

'F: I smoke, like, but not many'

'M: You can walk across the road and get knocked down by a bus'

A few respondents remarked on drinking more than they considered to be healthy and these were all men.

Couples often talked about the lack of healthy eating habits being due to some other reason than their own choice. Those given included limited time, a lack of money or both. One way of coping with such difficulties seemed to be to deny them, in order to maintain their view of themselves as 'good' parents. This response has been described as 'cognitive dissonance', wherein a person holds conflicting beliefs simultaneously. This causes the individual discomfort, which he or she seeks to reduce by either changing one of the cognitions or changing behaviour (Festinger 1957). Thus couples recognised their unhealthy habits, such as eating a poor diet, smoking and drinking, but tried to reduce their perception of risk by denying the importance of healthy habits. This seemed regardless of previous expressions of recognising healthy eating as being important.

Category five. Sources of information: about food and health

Respondents obtained their information about healthy eating from a variety of sources. Mainly this was from advertising. Concern was expressed about the influence of advertising on children.

'M: Sometimes the kids will see an advert, some food stuff and "get that mam...get that dad, I like that"...it's because it's attractive...it's the way it's been put across'.

Some were cynical about the factual information offered on healthy eating:

'M: It's common sense, isn't it really...they're always on about it on the television about diets...I think that's a load of rubbish... like the diets they try to tell you about on the television...I think if you... if you just eat sensibly you shouldn't have a problem with your diet'

When asked about specific types of factual information, leaflets had been found useful by some respondents. The leaflets were mainly picked up at the doctor's surgery.

'F: We get leaflets and everything...all at the doctor's...and that you read them and they tell you'

Few read magazines, but labels on food packaging were a source of information for several.

'F: I always look at the ingredients...what's in them'

Unsurprisingly, a major source of information about food was family and friends.

'F: friends...when something new comes out they will say "have you tried this" and stuff like that'

'F: Since I started going down the Family Centre, there's more...I cook more'

There appeared to be considerable cynicism about the integrity of official information provided to the public on foods. A number of recent food scares had undermined the credibility of the information for respondents.

'M: Well...one minute they're saying the beef is safe and then you find out something that they've never had British beef in the House of Commons for the last ten years...so they must have known about it'

'M: They go on about the government and different laws and things on the telly ...it is a wonder the government or part of the government knows what the other part of the government...'

Men were more likely to object to the government's information or lack of it, some speaking quite vehemently about the subject.

Category six. Life course: influences on eating behaviour over time

As individuals grow up their eating patterns change. Some of these changes stem from obvious biological factors. For example babies are fed milk from birth, but as they develop they are gradually weaned onto family foods. However, most changes in eating behaviour are governed by social factors. There seem to be key points in an individual's life cycle that precipitated dietary changes.

The respondents were asked whether they ate in a similar way now as they had done when they were growing up.

> 'I: Do you eat similar to when you lived with your mam and dad?
> M: No...cause when I lived at home I was brought up on dinners ...dinners every night...now I just have dinners now and again... the wife was brought up on chips...I mean different families are different'

Some respondents felt they ate a healthier diet now than when they grew up because they had less fat in their diet. However, others now reported to eat a less healthy diet.

> 'F: I would say that the only difference to what I eat now to when I lived at home is that I eat a lot less fat...I don't eat fat at all now'

> 'F: But I have changed my diet because I eat rubbish because, like I say, I used to eat all the good stuff when I was younger'

> 'F: I don't want the bairn [child] growing up like me eating all the rubbish that I ate when I was little'

There were a few individuals who had specifically rebelled against the way they had been brought up.

> 'F: I mean, when I was a kid my mam always made me eat my greens and sprouts...and I used to say "I don't like them...don't like them" "They're good for you, you know...you will not grow up big and strong... not have curly hair" and all that'

This woman subsequently ate what she wanted to, with no concern for health. One respondent seemed to aspire to be like her mother and consequently cooked the same kind of meals she had eaten as she grew up.

> 'I: Do you eat similar things to what you did when you lived at home?
> F: Yes...my mother used to make mince and dumplings, spag bol
> so I do a lot'

Over and above the life transitions that all the couples had been through, there were other early influences of an individual's own experience. For example, one woman described a frightening upbringing, wherein she rarely got fed at home and had to rely on other sources of food.

> 'F: We didn't eat at home... we used to get fed at school'

She went on to describe the way she fed her family now, which was based on a pre-decided weekly menu with everything cooked from raw and no convenience foods.

Several interviewees described their diet changing considerably when they left home and had to fend for themselves. They ate cheap and easy to prepare food. For these individuals cost, lack of time and lack of motivation influenced their choice of food.

> 'F: When I first left home I used to live on baked beans
> because they were cheap...I just ate anything that was cheap
> because I couldn't afford anything else... so I used to live on
> tins of baked beans or spaghetti, eggs...'

> 'M: I ate a lot of fast food... didn't really cook nothing myself,
> like tins of stuff...Indians, Chinese, pizzas'

Some found they ate differently when they first got together as a couples.

> 'F: ..we were both working and we didn't have time....takeaways,
> that's what we mainly lived on...it's just since I've got a home
> and the kids'

Significantly, couples appeared to have different expectations when living together as a couple, compared to living alone or as a family with children.

In most couples, at least one partner reported that they had changed their diet since they had become part of a couple and this transition was even more marked once they became parents. Eight of the women and four of the men referred to such changes.

> 'M: It [a healthy diet] is more important for children than it is for us'

> 'M: We always used to have take-aways, Chinese...but now we're basically in the house now...we seemed to get more of a family when L [child] came... we seemed to have more responsibility when he came so we started acting a bit more sensibly'

> 'M: [eating has changed] Because we haven't the money I suppose'

They also talked of trying to encourage healthy eating habits in their children.

> 'F: I'm trying to get the bairn into like grills and…before he gets older and then he'll not go for… well… he'll grill the stuff as well which will be better for him'

Changes in eating habits may occur as a result of leaving home, becoming part of a couple, and having children. Often the interviewees reported eating differently now when compared to growing up, whether for better or worse. Some couples reported trying to provide healthy food for their children in the hope that this would encourage healthy eating patterns when the children grew up. This was despite their saying that they changed their own eating habits from those of their own childhood. They appeared to believe they had a greater influence on their own children than their parents had had on them. Women were twice as likely as men to change their diet on becoming a couple, which confirms the stronger influence of the male on eating patterns.

Life course as the potential core category

As the analysis continued, with memos and reports being compared and links being developed between the categories, the life cycle emerged as a potential core category. In order to assess the significance of the life cycle in the literature, a review was undertaken. Cohen (1987) suggests the term 'life course' should be employed rather than 'life-cycle' because the latter implies a stable social system, in which everyone lives through fixed stages in life. Society expects people to follow a similar pattern of childhood,

adolescence, marriage or partnership, parenthood, middle age and old age. Indeed, nine tenths of people marry or co-habit and of those who do, nine tenths will have children, so that at some stage in adulthood, most people will live in a nuclear family (Abbott and Wallace 1997). However, with high divorce rates and an increase in remarriage, life is not often a smooth cycle with the occasional hiatus. Families frequently have a constantly changing structure (Cronin 1995). The life course was identified as the potential core category, which could be used to detect the influences of such changes.

The life course can be described in different ways. Biologically there are defined stages: suckling, puberty, reproductively fertile adulthood, senescence. However, the social structures of society affect the way chronological or biological stage is experienced (Pickin and St Leger 1993). Socially constructed stages can be divided by ritual markers: private (first menstruation, first kiss); public (graduation, marriage); official (the right to vote, the right to learn to drive). Pickin and St Leger (1993) recognise the wider influences on health throughout the life course and identify four 'modifiers to health experience':

> 'socio-economic; environmental; ethnic (includes both racial effects and generalised cultural influences dependent on ethnic origin and background); cultural (includes potential local cultural influences)' (p. 56)

Of these cultural influences, gender is an important aspect, because men and women view the life course differently. Men tend to identify stages according to occupational changes, whereas women identify family events and personal relationships (Burgoyne 1987).There are also a number of other potentially influential points in the life course, when different approaches to health promotion are likely to be appropriate. For example, a couple who are both working and have a reasonable disposable income, will have a different approach to food and eating compared with a couple who have children and are on a low income.

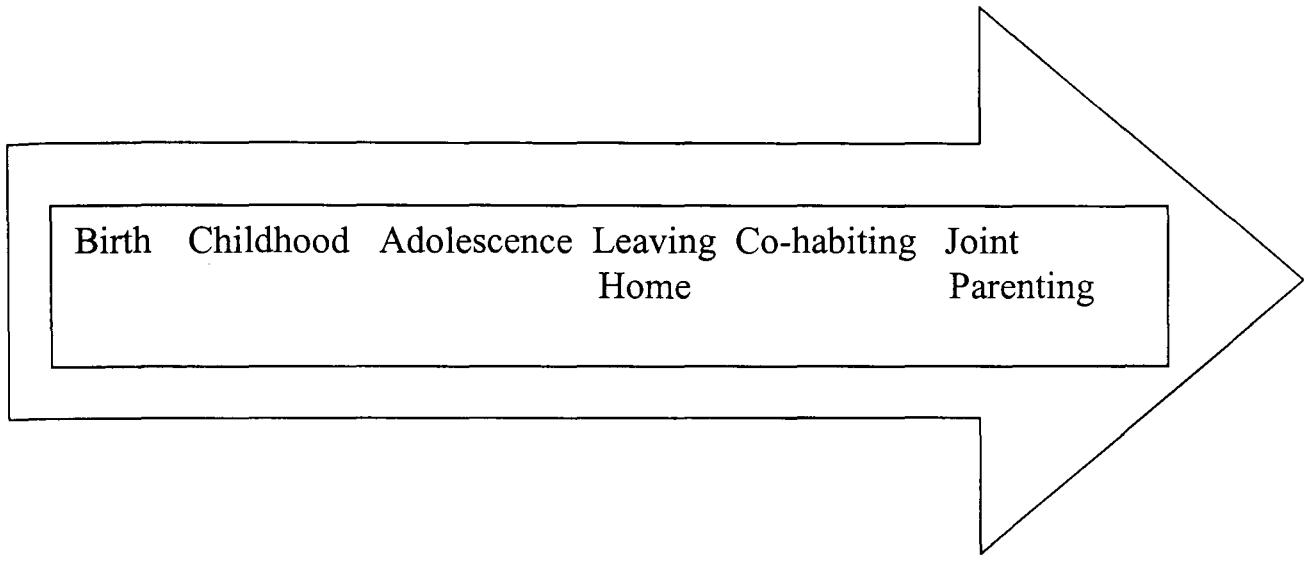
Further examination of the literature revealed the concept of the health career (Tones and Tilford 2001). It appeared to be a potentially useful framework further to explore the idea of the life course as a category. The concept of the health career evolved from the

sociological influences acting on people as they move through the life course. Socialisation is the process by which individuals acquire the society's culture within which they live. The family is the main socialising agency in early infancy. Close family members provide role models for children and reward or punish children for developing appropriate or inappropriate behaviour. Thus children internalise the rules, beliefs and values of the family and society. As children get older, other influences come into play, such as friends, the school and the media. These influences often have an impact on a person's health and can be described along a life course continuum, the health career (Baric 1978). The life course framework has been employed to plan health promotion programmes (Tones 1983, 2001) and needs assessment (Pickin and St Leger 1993), as it has in other areas of public health work, such as explaining inequalities in health (Shaw et al. 1999, Benzeval et al.2000).

Baric (1974) applied the health career to smoking and Tones (1983) suggested that the health career could be adapted to relate to other aspects of health promotion, such as nutrition, proposing a nutrition career which could be used to plan health promotion activities around food and eating which would be appropriate to the life-stage. However, analysis of Phase One of the present research findings suggested that the nutrition career could be used as a tool for research in the subsequent phases in order to explore the category of the life course. Phase One identified significant stages in the life course. These enabled the researcher to gain a greater understanding of the different influences at different points in the life course, particularly growing up, adolescence, leaving home, co-habiting and having children. Figure Two shows the basic framework.
In the next phase of the research, the focus groups were asked in much more detail about these stages and about changes in eating behaviour they could identify.

The decision was made to examine the life course as a possible core category in further detail through the use of two single sex focus groups, recruited from people attending the Family Centre where the researcher worked. This would be a method of showing trustworthiness of the analysis. The original couples were not approached again, because of the difficulties in recruiting them in the first place.

Figure Two. The nutrition career framework



Adapted from Tones and Tilford (2001)

Summary

This chapter has described Phase One of the research. This phase involved interviewing ten couples, who were on low incomes and had at least one pre-school child. All interviews were audio-taped and transcribed. Analysis was based on the principles of an interpretivist grounded theory approach.

Findings were described by the categories which emerged from analysis: routines, decisions, sharing, food and health, sources of information and the life cycle. On the whole, most couples said the family ate similar foods. They talked about enjoying the Sunday dinner, unhealthy snacks and 'junk' food, and about 'proper' food.

Although most couples agreed that it was the woman in the household who chose what to eat, closer examination suggested that there had been previous compromises and the woman had learned what her partner liked to eat. Despite this, the couples had less traditional attitudes to food and were more likely to share the shopping and cooking than previous research has suggested.

Most couples were aware that a high fat diet is unhealthy, but often referred to eating what they wanted, though there was a dichotomy between what they wanted to eat and what they thought they should eat. Finally, couples were asked about where they obtained information about healthy eating. A few read leaflets, magazines and labels, but the main source was television adverts. Families and friends were also strong influences.

A key theme to emerge was that people tend to change their eating habits at different times in their life. Significant times were adolescence, on leaving home, on co-habiting and on having children. This process of change was identified as the life course and was considered as a potential core category for the research. The literature was examined and the nutrition career emerged as a framework to explore the life course further.

Chapter Five uses the nutrition career to explore the life course as a core category in two focus groups. The interview structure was amended appropriately.

Chapter Five

Phase Two: Male and female focus groups

Introduction

This chapter describes Phase Two of the research, which involved conducting focus groups, one comprised of men only and one of women only. The purpose was in part to establish the trustworthiness of the analysis of the data in Phase One, by 'checking out' the findings with another group who were also parents on a low income. Phase Two also provided the opportunity to assess gender differences between the two groups. Finally, it helped to inform the process of recruiting couples for Phase Four of the research. The sample, from which the focus groups were drawn, was obtained by requesting involvement from people who attended the Family Centre.

The nutrition career was used as a framework for exploring the potential core category of the life course, identified in Phase One and was found to confirm the core category. There were found to be some similarities and differences between the genders in terms of eating behaviour.

Focus groups

The aim of Phase Two was further to investigate the findings of Phase One. In order to do this, three objectives were identified.

- To assess whether the analysis of the data accorded with other local people's views
- To substantiate the core category of the life course
- To explore gender differences with regards to eating behaviour

At this point in the research, there were a number of methods which could have been used. In Phase One, recruitment of couples was problematical. In particular, men were

difficult to engage. Several local people suggested speaking to men in alternative settings, such as the pub, club and unemployment benefit office. However, after considerable reflection, a female professional approaching unknown men on their own 'territory' was not deemed appropriate, and this suggestion was not followed up.

A decision was made to conduct two single sex focus groups, one made up of women only and the other of men only. This offered the opportunity of exploring any gender differences in responses, which may not have been elicited in Phase One, when couples were interviewed together. The use of a different methodology also provided scope for triangulation.

The sample

The sample was obtained from people who attended the Family Centre and who fitted the same criteria as used in Phase One. Although eight people were personally asked to each group, in both cases only four members attended. Both focus groups were of a single session only and conducted at the Family Centre. Respondents were all parents who attended parent and child groups there, had lived in the area for a number of years and were familiar with many other families who lived nearby. Informed consent was obtained as in the previous phase (see Appendix One). Both focus groups were audio-taped, with permission, and the tapes were subsequently fully transcribed. The male focus group lasted approximately one hour and the female focus group lasted one hour 15 minutes. The group members had all known each other prior to the group sessions.

The discussion schedule

The groups were given a synopsis of the interviewees comments and of the analysis of the findings from Phase One and were asked if they thought these would accord with the opinions of their own friends, families and acquaintances. The focus groups were also used to enquire what group members believed would be the most appropriate way of accessing additional local couples.

A brief discussion schedule (see Appendix Four) was then used to act as a stimulus to enable group members to expand on their own experiences and thoughts, rather than being directed by the researcher. The schedule included open-ended questions about themselves, their favourite foods and eating habits. Focus group members were asked whether they felt that their eating habits had varied over their life time, with different information being needed at different times. The nutrition career provided the framework within which to explore this proposition. They were further asked whether they thought that couples were aware of healthy eating messages and whether they acted upon them. In addition to the topics from Phase One, the groups were asked whether couples on the whole have retained the more traditional gender roles within Low Teams. The latter question was followed with a very general question about what it was like for themselves and others to live in Low Teams.

In the quotations in this chapter, the interviewer is identified (I), the four members of the women's focus group as J, M, A and G and the four members of the men's focus group as D, F, L and S. The findings are presented in the same six categories as Phase One, with the addition of a seventh category, 'Typical Teams'.

Findings from focus groups

On analysis, the findings were found to support the categories identified in Phase One. To some extent this was to be expected because the discussion schedule was based on the previous findings. However, care was taken to maintain sensitivity and reflexivity to remain open to other possible interpretations.

In both focus groups there was a great deal of consensus between group members in their responses to questions. On the occasions when there was dissent or disagreement, it was dealt with in a supportive way, with alternative suggestions being made about how to deal with a particular problem. Another aspect of the supportive atmosphere of the two groups was a willingness to offer solutions to problems raised by one of the members.

'A: … it's taken me a while to get me mam to say that, though… at one time they could play me off against me mam… cause they knew for a fact they would get it off me mam
D: How did you manage that?
A: I just blew my top one day… because I had said 'no' and me dad went straight into the kitchen and gave them whatever it was… and I just blew me stack… literally… and from then on they have always sort of, you know, took my side
D: Do you want to try that with my mam?' (women's focus group)

The members had all been attending the Family Centre for at least several months and some for a year or more. They had all been involved in group work and had experience of the ethos of valuing other's experience and this could have had a positive effect on how they functioned as a group.

When provided with the synopsis in verbal form from the researcher, there was general agreement with the findings from Phase One, though more so with the men's group than with the women's.

Category one. Life course: Influences affecting eating over the life course

The potential core category of the life course emerged from the data in Phase One and questions were asked based on the nutrition career, which was used as a framework which could reflect the category. For this reason it became 'category one', that is, the potential core category.

The focus group members described their changing eating habits as they grew up. They all talked about eating 'junk' when they were growing up. The women in particular all had horror stories about their unhealthy eating habits as children and adolescents.

'A: Jam sandwiches… that's what I lived on … jam and bread
M: Chips
J: Sugar on bread
A: Aye… I used to live on jam and bread…
M: I lived on egg and chips'

However, their diet was not due to lack of alternatives. The women all talked about their own mothers always cooking dinners. They did not like them, however, so ate junk food.

The women's focus group described their partners' eating habits when they met. One would only eat fish portions and chips, another only baked beans and another would not eat meat. The men also talked about changes in their eating patterns from childhood and adolescence to adulthood and becoming a couple. They talked about their mothers' cooking, one saying how he lost weight when he moved in with his partner and how he still goes to his mother's to eat her food.

> 'L: Nowt to beat your mother's cooking'

One man reported that he started to eat in a more adventurous way after moving in with his partner. Two of the men identified that when they were younger and working, but still living with their parents, they would expect their tea to be ready, which they recognised as behaviour copied from their fathers.

> 'S: See when I was grafting and my tea wasn't ready ... I'd go off it... cause I used to see him [father] at it'

They also believed that as people get older they get 'wiser'.

These findings reinforce those found in Phase One of the study, that people's eating habits often change over time. This appears to happen at the time of particular life changes and so endorsed the life course as an appropriate core category, reflecting the social concept of rites of passage through life.

Category two. Routines: eating meals and snacks

In contrast to the findings in Phase One, the women talked about family members eating different foods. In particular, the women asked the children what they wanted to eat and cooked accordingly. Although the children may all eat something different, it appeared to be a 'mix and match' meal, so the mother would provide a meal, in the knowledge of what the children wanted, and they would eat what they chose:

> 'G: For example... last night for tea... one had pizza and chips... another had corn on the cob... and chips... and one had pizza and corn on the cob and chips'

The women described often eating after the children had gone to bed, so as to avoid the children interrupting their meals. Otherwise, they talked of standing up snacking whilst the children ate. This enabled the mothers to watch the children and ensure that they were eating their meal. None of the women described eating together as a family in general, though they did talk about eating Sunday dinner together.

Interestingly, the men described a different approach to mealtimes. They reported eating together as a family and all eating the same food. One of the reasons for this was that the children would pester the men if they ate separately. Another reason given for eating the same food was cost. It was perceived to be more expensive for family members to eat different foods. Most of the men had Sunday dinner together as a family.

When asked about snacks, the women talked about foods with high sugar and high fat content, particularly crisps, biscuits and sweets. They had a similar view to the Phase One interviewees, that children always want snacks and that management of their intake was required. They described situations in which the children would eat all the biscuits bought that day as soon as they came home and episodes of crying when they were refused sweets. One mother kept snacks for after tea, another only let the children have sweets as a treat given by her own mother. They described the difficulties of managing the intake of snacks and how often their attempts to do so were thwarted by other family members, for example, the father and the grandparents. Two of the women had decided to take this in hand and had told the offending person to refer to her before offering sweets or biscuits.

The men were more explicit than the women about what they considered was healthy food and what was not. They criticised their partners for pandering to their children's demands for sweets and 'rubbish' and thought that a balanced diet was important for children:

> 'S: It's more important [a good diet] for kids than it is for us... cause they're growing... it's important for them they have a balanced diet... check their growth...but as long as the bairn's eating properly
> L: Too many sweets I think'

The men in the focus group appeared to be more aware of the importance of avoiding unhealthy food. This could be due to the men being participants in the activities of the Family Centre, which fostered an awareness of health issues.

All participants recognised the poor nutritional status of snack foods, as being high in fat and sugar. However, responses to this differed, with the couples in Phase One and the men in their focus group being more critical of the practice of giving children snacks. The women, on the other hand, described the consequent problems of denying children sweets and the like. These women had more responsibility for their children, with partners who were less involved in childcare than the other groups covered by this research. This could mean that these mothers had little or no support in caring for the children and therefore fewer resources to combat less reasonable demands from the children.

Category three. Decisions: factors affecting food choice

In contrast to the literature which identified men as the decision makers concerning food choice (Murcott 1983, Charles and Kerr 1988), the women agreed that it was they who generally decided on what to eat. However, this was revealed as a more negotiated decision with the children. As described earlier, all the women in the focus group referred to the important influence of children's choices on diet.

The cost of food affected choice.

> 'I: [to women's focus group] What things do you think people would buy if they had more money?
> M: Well it wouldn't be chips every day
> J: Na
> G: Dinners
> A: It would probably be proper meals
> J: Fruit…'

Lack of money was emphasised by the women when shopping was discussed, particularly with reference to men and their lack of understanding of the cost of food. Ease and speed of food preparation was an influencing factor. Some women described having 'carpet picnics', comprising sandwiches and crisps eaten on the floor, which were

quick and easy to prepare and eaten in front of the television. For the men in the focus group, cost was also a consideration, notwithstanding the women's view that they did not understand about the cost of food. They talked about spending money on alcohol, meat and exercising if they had more resources.

Category four. Sharing: cooking and shopping

Once patterns of cooking and shopping had been established by respondents, they rarely changed their roles. The women in the focus group did the shopping because their partners had no idea of the cost of living and commented that if men went shopping, they would spend far too much money. The women cooked for the children and themselves. Only one of them cooked for her partner, and the others expected their partners to fend for themselves.

> 'A: Oh I'll do the kids... I'll not cook for him... don't see why I should... I don't cook for him
> M: For the past 12 years he's cooked his own'

This was a surprising result when put in the context of the other phases of the research, wherein women largely cooked for their partners as well as the children. It suggests some different family dynamics which were not uncovered during the research.

In contrast, the men in the focus group referred to cooking occasionally, but generally it was their partner who did it. However, if they left their female partner to choose what to eat, they would refuse to eat it if they did not fancy the chosen meal, implying that they had the ultimate veto on diet. They did describe one way that women had of getting their own back, which was to burn their meal. This was a bone of contention and caused many derisory comments about their partners.

> 'S:...they've burnt it...just on purpose ...they moan if you ask them [about tea]...and moan it you don't
> L:...she sits and yaps
> S: That's it...every woman's like that
> L: Aye...they're all like that'

The men only went shopping occasionally. They complained that their partners took too long and that the children tended to misbehave, so they gave either all or part of their Social Security Benefit to the women and left them to get on with the shopping.

Category five. Food and health: the links

Both the men and the women identified high fat foods as being unhealthy. The men particularly commented on grilling rather than frying, whereas the women focused on eating proper meals and dinners. This was seen as especially important for children

> 'A: I try and give mine more...kind of...proper meals...with me not liking fruit, veg or meat...I make sure the kids eat it'

Most of the time, however, the women said they did not have time to consider health and diet and if they did, it was generally related to weight loss.

> 'G: You sit and you think 'I shouldn't be eating this, I should lose a bit of weight'...but that's all you do...think...you don't do nowt about it...you haven't got time'

The men seemed to have a better knowledge of the relationship between health and diet than the women and were more firm about the importance of a good diet for children.

> 'F: It's more important for kids than it is for us...cause they're growing ...it's important for them they have a balanced diet...check their growth'

The men talked about eating grilled rather than fried food because of fat levels and recognised the relationship between fat and heart disease. This contrasts with the literature, in which women were identified as being more aware of healthy food than men (Pill and Parry 1989, McKie and Wood 1990).

Category six. Sources of information: about food and health

Several potential sources of information were discussed. The women gained information about food and suggestions for meals from each other. The extended family was also identified as being a relevant source of information on food.

As noted above, the men seemed to have a better knowledge of nutrition, but it was not clear where they had gained this. They referred to 'the beef scare'. The threat of BSE did

not deter the men from consuming beef; rather, it was relished as an opportunity to eat more, due to it's being cheaper than hitherto.

> 'D: When the beef crisis was on we was getting cheap beef
> S: Aye...when we was getting cheap beef...having beef all days of the week'

The media, both television and newspapers, has covered the issue of BSE at regular intervals over the last few years, so it could be assumed that their knowledge was gained from these sources. Other sources, such as leaflets were not mentioned. Unlike the women, the men emphatically did not gain information from each other.

> 'L: Well, we don't talk about food...you wouldn't say 'Oh, what did you have for your tea?"

However, one man commented that they had in fact been talking about food on and off for the last few days. It transpired that one member of the group had argued with his partner, who had subsequently refused to cook for him for the last three days. This was a subject raised regularly, if only to tease the man.

Category seven. 'Typical' Teams

As a result of the Phase One of interviews, when it proved to be difficult to recruit couples, the focus groups were asked if they could suggest about why it was so difficult to recruit men and what was it like living in Teams. The responses led to the development of a seventh category: 'Typical' Teams. One respondent suggested that the men who refused to be interviewed, and the women who refused to let their partners be interviewed, were more likely to be traditional households with more stereotypical lifestyles with the women caring for the household and performing domestic chores (Finch and Morgan 1991).

Within the focus groups, questions were raised with group members about what a typical family in Teams was like and what roles did partners tend to take on within a couple. The women described the typical family in Teams in traditional terms. They talked about men being interested in drinking alcohol and that they would spend their money on this

activity, ending up having to borrow money from friends and family when they had spent it all. They went on to describe men in a typical Teams household as being'the boss'.

> 'A: Well, it's like 'yee do this' and they [women] do it... it's like the men say 'do it' and they do it... 'I want this' and they get it... the men'll say 'I want this for me tea, yee go and make it"

The women thought that some women in Teams were quite happy with this state of affairs, because they did not have to think for themselves. Interestingly, none of the women in the group felt that they fitted into this stereotype.

> 'G: He wanted something through the night... and he says 'will you make... something to eat...' he wanted me to make something to eat... and I says... 'You can... you can go and... jump''

In contrast to the women, the men thought that despite the differences, women today had a more equal status than their mothers had. They described how it used to be: men out working, with women at home, making sure the tea was on the table when their husbands got back from work. There was some ambivalence to these changes: on the one hand they thought it was better, but on the other, things were in danger of going too far in women's favour.

> 'D: Na, I don't agree with some of the things... I think it's all for women now... They get all the jobs... there's more groups out there...
> L: It used to be the blokes in the jobs, going down the bar, getting your tea made
> S: Aye... them were the good old days...I think men are softer now... I don't think women accept like anymore...which is a bit of a knocker like ... na, na, I don't agree with half what me father used to ... used to make ... if me mother hadn't got his tea on the table he used to go off it'

There were complaints from the men that women sit around talking all the time, discussing other people, how the children are dressed and what is for tea. In contrast, men's conversation was less personal. The men identified that men and women have little in common.

> 'S: I just think women like women's company... and men prefer men's ... I think they just tolerate each other most of the time
> D: Just cause trouble when they're around'
>
> 'S: Well, we don't talk about food.... it's all about football...
> L: Football... racing... beer... that's what we talk about'

They expressed a deeply gendered world, despite having at least some involvement in family life.

Discussion of findings

Before comparing the results from Phase Two with those from Phase One, the male and female focus groups will be compared in order to assess any gender differences. Both groups identified that their eating behaviour had changed over the life course, but the men were more aware of it. Although both groups agreed that the woman in the relationship had primary responsibility for the shopping and cooking, differences between the two groups were apparent. The women described themselves as relatively independent of their partners. Their role was to care for the house and the children and most of them would not cook for their partners. Their male partners participated little in family life. This description is like the picture painted by Young and Wilmott (1975) of working class family life, with the different genders living virtually separate lives.

Data collected from the men's focus group suggested that their partners cooked and shopped, as did the women in their focus group, but mealtimes were more shared occasions, as in the Phase One interviews. The men had an influence on what was eaten and seemed better informed about health and food than the women, in contrast to the literature (McKie and Wood 1991). However, these men attended the Family Centre, which suggests that they may have different characteristics from the partners of the women only focus group. Few men attend the Centre and it seems likely that those who do so are more likely to be involved in the caring of their children and therefore more involved in family life as a whole (Ghate et al. 2000).

Both focus groups were asked about the 'typical' family in Teams. This arose out of the difficulties of interviewing men in couples and was an attempt to uncover why some men would be interviewed and others would not. Both male and female focus groups agreed and stated unequivocally that women and men do not mix well and have little in

common. This reflects the literature, which identified that although there is a perception within British culture of men and women sharing housework and childcare, this is rarely the case.

The men in the focus group seemed to have two perspectives, one of their own sharing relationships and one of the culture in which they live, wherein gender divisions are deep. It could be that they considered themselves as different from the cultural 'norm', or that there is a difference between how they perceive gender relations and how they live them. However, from an interpretivist perspective, these conflicts in personal viewpoints and experiences of reality are likely to occur according to context and time (Reinharz 1981, Secker et al. 1995). Perhaps when they are with their gender equivalents, people are more likely to identify with their peer group, whereas when they talk with their partners they are more likely to identify themselves as a couple. This was confirmed in later findings.

There was a gender difference between the two focus groups in members' views of power and control within families. The women considered themselves to be different from other, 'typical' families in Teams, in that they had more power within the family than other women in the area and did not automatically acquiesce with their partner's demands. They considered that most women in Teams did as their partners wished, with the men being in the traditional male role of decision maker, as other researchers have found (Charles and Kerr 1988, Finch and Summerfield 1991). In contrast, the men's focus group thought that, in general, women had a more equal partnership within marriage.

The findings from the male focus group accorded with those from Phase One much more than did the findings from the female focus group. Although the men in the focus group were less likely to share shopping and cooking than the men in Phase One, they reported to have more sharing relationships than the women's focus group. They functioned as a couple, at least some of the time, unlike the women in the focus group who lived almost separate lives from their partners. As discussed earlier, the men in the focus group were more involved in childcare, which included attending the Family Centre, and were

therefore likely to have a relationship which was to some extent more sharing than the women's focus group, in that they had some involvement in childcare.

Both focus groups were finally asked if they would be prepared to be interviewed with their partners in their own home. The members of the male focus group all agreed to be interviewed and they were included in the final phase of the research. Only one member of the female focus group agreed to this, the others saying they would not. This again raised the question about what, if any, are the differences in relationships, especially around sharing of activities around eating, between those couples who would be interviewed and those who would not.

Summary

This chapter has discussed the findings from Phase Two of the research. Focus groups were used as a method of obtaining feedback on the findings from Phase One results to establish increased trustworthiness through triangulation as well as identifying some of the gender issues which were not addressed in Phase One.

In both focus groups in Phase Two there was a consensus about members' experiences of food and eating, as well as of bringing up children. Both groups agreed that their eating habits had changed over their life course, tending to add to its status as a core category. When asked about mealtimes, the women described a situation in which the children chose what they wanted to eat and all ate different meals. In contrast, the men ate together as a family. Cost was a significant factor for both the men and women. Both groups agreed that it was women who did the shopping and cooking in their respective families, though some of the women let their partners fend for themselves.

When asked about living in Teams, the women described families in which gender roles were traditionally defined, with women caring for children and the household and subordinate to men, who were often out drinking and/or spending time with other men. The men, however, thought that men and women had more equal status compared to their

own parents. Both groups were clear that men and women have little in common and so tend to prefer their own gender's company.

Chapter Six addresses couples whose partner could or would not be interviewed to discover if they could be different in important ways from those who would be interviewed. Therefore, a decision was made to seek out women who would be interviewed themselves, but would not allow their partners to be interviewed. They were in a similar position to most of the women in the focus group. This would offer a negative case analysis, wherein if further differences were found, it would inform the study that families on low incomes in Low Teams are not a homogenous group.

Chapter Six

Phase Three: Women only interviews

Introduction

This chapter describes Phase Three of the research, which involved interviewing six women who were interested in the research, but were not prepared to permit their partners to be interviewed. The purpose of Phase Three was to provide negative case analysis in order to increase the trustworthiness of the overall analysis of the research findings this far. The non-participation of male partners is examined. A stereotype of these women's family lives is described, which is then placed on a continuum of the traditional through to sharing relationships identified in the previous phases of the research.

Phase Three: Women only interviews

In Phase Two, it was recognised that although there were similarities between the responses from the men's and women's focus group, there were important differences. In particular, there was a contrast between the patterns of family life, with the men living shared lives with their partners, whereas the women lived almost separate lives from their partners. To explore this contrast further, it was decided to interview additional women whose partners could not be interviewed.

Several women who had been approached by the researcher in selecting the sample for Phase One, were willing to be interviewed but said that their partners would not be prepared to do likewise. The reason most frequently given was that he simply would not speak to an interviewer. It was difficult to assess whether it was the men who refused or the women who surmised they would not cooperate, or, again, that the women themselves did not want their partners to be interviewed for whatever reason. Thus, these women acted as gatekeepers to accessing their partners. However, it was felt that these very

women would be able to shed some interesting light on potential differences between themselves and those women who agreed to be interviewed with their partners. It may be that power relationships between these couples was different, which may affect influences on eating behaviour. Obtaining data from cases which appear to negate the emerging theory is known as negative case analysis, as discussed in Chapter Three. As one woman in an interviewed couple said

> 'F: The ones who won't speak to you [men]... they'll be the ones who make them [women] do all the cooking and that'

The decision was therefore made to interview some of the women with non-participating partners on their own, given that they may be in a different kind of relationship and therefore reflect different experiences of family life and influences on food choices. Informed consent was obtained in the same way as in Phases One and Two. Six women were invited to become part of the research at the Family Centre who fitted the criteria. Each was interviewed separately at the Family Centre for between 20 and 30 minutes. Each interview was audio-taped and transcribed, with permission.

An adapted form of the interview schedule used in Phase One (see Appendix Seven) was used in Phase Three. Minor changes to the order of questions, such as asking about shopping before cooking, were made, which seemed more logical, but some specific areas were expanded based on the framework of the nutrition career, and different points in the life course were identified. In consequence, the question from Phase One, 'Have you ever changed your eating habits?' was expanded: 'What did you eat when you were growing up?', 'What about when you were a teenager?'. The probes went on to inquire about leaving home, meeting their partner, moving in together, having children and having children old enough to decide what they will eat. After each answer, respondents were encouraged to answer 'How?' and 'Why?'. As in the focus groups, the women were asked what it was like living in Teams. A brief synopsis was provided by the researcher about the results of the research so far. This technique was drawing on projective methods described by Walker (1985), in which the question is not directly aimed at the respondents, so that it is less threatening.

The sample

All six subjects were in long term relationships ($5^1/_2$ – 15 years) and the children were all products of that relationship, except for an older child in one family. Some of the women had worked in local industry briefly, before pregnancy, but none were working at the time of interview. All their partners were unemployed, except for one, who worked as a labourer and claimed Family Credit due to low wages. Any work that the men had done previously was of an unskilled manual nature. When asked about family health, most felt they and their partners were unhealthy, mainly due to being overweight and eating the wrong food. Smoking was mentioned twice, as was lack of exercise, and drinking alcohol was a troublesome issue in half the households. The children, however, were all considered to be fit and healthy by the parents.

Findings from Phase Three

Analysis of the data from this phase of the research revealed common features in the data collected from the six women. There were also some considerable differences between their responses and those of the couples interviewed in Phase One.

In this chapter the interviewer is again identified (I) in quotations and the six respondents as B, E, Y, N, P, and C.

Core category. Life course: influences affecting eating over the life course

When asked about changes in eating habits throughout their own and their partner's life course, there was generally a negative response. They felt they ate the same as they had done as children. One respondent commented that she had had to learn to cook for herself when she left home, but thereafter cooked in a similar way to her mother. This is in contrast to the information obtained by both the interviews of couples in Phase One and the focus groups in Phase Two. It could be that these women have very traditional relationships, as was suggested by the data, and they followed in the footsteps of their own mothers. Just as their parents had gender divided roles, and so do they, and so do not

challenge their parents' way of life. In consequence, they look after their children and the house as their mothers did and cook in a similar way. The life course did not seem to have much relevance to these women.

Category two. Routines: eating meals and snacks

All the women reported similar eating routines. The children were generally fed after school, with women eating off the children's plates, or left-overs.

'E: Me? Scraps off the kids…that's all I eat…scraps off the kids'

Women and children generally ate similar foods, with the man eating his own meal separately. This was similar to the women's focus group and in contrast to the men's. However, most of the women in this phase of the research cooked for their partner, unlike the women in the focus group, of whom only one did so.

Most women mentioned Sunday lunch, but not in quite the same way as the couples interviewed. Only in one family did they eat Sunday lunch together as a family, and the man cooked it. Several women went with their children to her mother's, with their partners going to his own mother's. In one case, the man stayed at home and his partner brought a plate of food from her mother's home for him to eat. There appeared to be little contact between the men and their partners' families.

As in Phases One and Two, snacks were recognised as being unhealthy. Several tried to reduce sweets and crisps and to encourage children to eat fruit, though cost implications were recognised as a deterrent. Unlike the women's focus group, none of them referred to being reduced to giving sweets because of children's demands for them.

Category three. Decisions: factors affecting food choice

As in the previous phases, women perceived themselves as the one to decide on the family diet. Again, on analysis, partners and children had a considerable influence:

'N:…the kids say what they want'

'I: Who decides what to eat?
P: Me…I'll ask him…I'll say 'do you want this or do you want that?''

Other influences included cost and time. The expense of healthy food, particularly fruit, was recognised as a major deterrent to purchasing them. Convenience food, especially frozen food, was considered the quickest way to produce meals:

'N: Just anything quick…so when the kids want fed, they get fed'

Category four. Sharing: cooking and shopping

When the women were asked about household tasks, a predominantly traditional, stereotyped picture emerged of the women doing the childcare, cooking, shopping and other domestic activities as previous studies have found (Morris 1990, Finch and Morgan 1991). Unlike the focus groups, in some households the man was described as being helpless in the kitchen.

'I: Does he ever cook?
P: No
I: Never?
P: Doesn't know how to use the cooker, I don't think… Never cooked'

'Y: He wouldn't know what a frying pan was'

'I: Does he ever do any cooking?
N: No… he might hurt hisself… it takes him all his time to put the kettle on to make hisself a cup of tea'

The only reason a man might get something to eat for himself was if his partner wasn't around, and then it would be something like a sandwich. Only one man was ever reported to cook and that tended to be the Sunday lunch. As far as decisions about the content of meals went, the women tended to say they decided, because they did all the shopping. Several talked about trying out new dishes and waiting for a response from their partners. They would or would not repeat the dish according to the man's response, so, in a sense, were cooking very much according to male preferences.

Category five. Food and health: the link

As in previous phases, most women recognised fat as being unhealthy and identified foods such as chips, kebabs and crisps as being unhealthy. Fruit was particularly considered healthy by the women, as were salads. There was some understanding that carbohydrates, such as jacket potatoes and pasta were also healthy.

Category six. Sources of information: about food and health

Most of the women referred to local doctors, health visitors and the Family Centre as possible sources of information, which is not surprising, since the women all attended the Family Centre. It was difficult to assess the effectiveness of information obtained from these sources and to what extent dietary changes were consequently made. Most of the women also referred to the television and magazines as potential sources of information. When asked if they thought there were better ways of distributing information, few had any suggestions. One woman did propose putting leaflets through doors. However, when asked whether she thought people would read them, she was unsure.

> 'C: Some might...just like...like curiosity...they might 'Ah, what's this then?'...then see what it's about and bin it... 'I cannot afford that... bin it''

Category seven. 'Typical' Teams

When asked about Teams, several women were well aware of the problems of poverty and unemployment that many families experienced. Families were considered

> 'C: Hard up...poverty stricken...I mean there is some families like...you know what I mean...like go to Netto shopping and... dead excited they spent £20 and they've got two weeks shopping'

> 'Y: Well there's no money is there? There's too many unemployed...hardly anyone working round here'

Some women considered that in a 'typical' family in Teams, the men were in charge and there was little sharing of chores between the couple. As identified in Phase Two, men spent time with their mates, sometimes out and about, sometimes in one particular man's home. When asked what her partner did when with his mates, one woman replied

> 'N: Drinks...goes down the bookies as well...bet on the horses'

Any winnings would be kept to himself. Even on coming into some money, there was virtually no sharing.

> 'P: He won a sick appeal in March...he...£1600 back off his appeal...I did not see a penny of it...spent £45 on the kids between them...he has never given me any'

Although Teams is a small geographical area, another woman identified different characteristics of the place at one end compared with the other.

> 'Y: I only come down this part to the local shops and to come here [Family Centre]...but I am mostly just up there [own home]...it is very quiet up there...there...across the road it is like the Bronx'

Male partner's refusal to be interviewed about eating behaviour

All the women were asked why their partners would not speak to the researcher. Several women described their partners as 'shy', that the men would not speak to health professionals, such as doctors or health visitors. When asked why partners would not speak to me the replies were all similar.

> 'N: Because he is shy... he doesn't like talking to people... you know when the health visitor comes... he goes into the other room'

> 'I: Do you think it would be different if it was another bloke?
> P: I don't know... D [partner] would still be too shy to do it... even when the doctor comes for the bairns [children], if I'm in the sitting room, he'll go into the bedroom... he's terrible'

> 'B: He will not talk to anybody he does not know so I do all the talking'

> 'C: When I first met him and I took him to my Mam's ... he wouldn't have anything to eat at my Mam's for months... I had to force him to have a sandwich... but he's dead shy in front of you, like people he doesn't know... even my Dad... I've been with him 11 year... when my Dad comes he hardly says anything... he's just that sort of person'

These comments emphasise the difficulties in talking to this hard to reach group of men. If these men will not speak to their extended family, after many years, it is hardly surprising that they will not speak to a researcher, whom they do not know. Several women suggested that alcohol would loosen men's tongues.

> 'Y:... if the men were drunk...put a drink down their neck...A [partner] would if he had a drink down his neck he would'

The resignation of several of the women at times became more like resentment towards the lack of male involvement in family life.

> 'C: ...a man would say like 'I'm going out' and he could be away hours...

but if you're away more that ten minutes…it's 'where've you been?'…
even though they are his kids as much as they are yours'

'N: Yes, when I came out of hospital with R [new baby]…I had…
had an emergency caesarian and I was not supposed to do anything
…for…six weeks….no housework or anything…I was up cleaning
the bathroom after two weeks because he had not cleaned it…it was
filthy…not his job'

'E: ...he's a pain the arse…he doesn't speak to me…he likes to be by hisself,
him and the dogs…and his flippin' cockerels'

These couples appeared to be living 'traditional' family lives, with women caring for the children and household in the privacy of the home, and men living in the public sphere, notwithstanding their being unemployed. But there are obvious tensions around these gender specific roles in several families. This was made explicit in one interview.

'I: He sounds very traditional
E: Yes… 'A woman's place is in the home'
I: How does that make you feel?
E: Mad…because he's got me where he wants me…stuck at home
with the kids'

A picture or stereotype of family life as described by these women could be drawn. The 'typical' family described by these women involves a couple in a long-term relationship, with two or three children. Both had worked before the first pregnancy in unskilled manual occupations. The women primarily care for the children and the house. The men have little involvement with the household, despite being unemployed. She does the shopping and the cooking for the family, though he will get himself a sandwich occasionally. She asks the children what they want to eat and she often eats what is left over on their plates. She decides what to cook for him, and may try new food types, bought ready made or frozen, which he will eat, but will let her know his views of the food. If he does not like it, she will not get it again. The woman takes the children up to her mother's, who lives nearby, for Sunday lunch, whereas he may go to his own mother's. He only looks after the children when necessary, if she has to go out for some reason and he spends much of his time out of the house, either on his own or with 'the lads'. Although he goes out drinking fairly regularly, they virtually never go out as a couple and rarely as a family. He will tidy round the house sometimes, but that is as far as

any involvement in household chores goes. Leisure time was also gender divided, with the men spending time with their friends, in public places like the pub and women staying at home or with their own extended family of female relatives.

Discussion of findings from Phase Three

Phase Three of the research involved women-only interviews. Strauss and Corbin (1990) suggest negative case analysis as a further method of ensuring trustworthiness of analysis. This entails seeking out cases which do not 'fit' with the analysis to date (Lincoln and Guba 1985). If analysis of these negative cases differ from the positive case analysis, it suggests that the differences between the two groups are more likely and therefore more trustworthy. On analysis, the findings were similar to the women's focus group. This is not surprising, since three of the four women in the focus group did not allow an interview with their partner, but they differed notably from Phase One and the male focus group.

The description of family life given by the women shows that, although the men do not work, they maintain traditional gender roles. Indeed, much research has shown that despite unemployment, men are unlikely to take on household responsibilities (Morris 1990, Dignan 1999). This appears to be due to the importance of maintaining gender identity and roles. From this perspective, work is considered the mainstay of masculinity (Morgan 1992), so when men are deprived of it they are more likely to adhere to a male gender divided role (Morris 1990). Perhaps this makes the men in Phase One and the male focus group more remarkable, because, even if they do not share tasks equally, they are prepared at least to take on some domestic tasks.

The only major difference identified between the female focus group and the Phase Three interviews was in terms of life course changes. The women's focus group recognised that their eating habits had changed over their life course, whereas the Phase Three women did not consider there to have been any change. These women seemed to have been in still more traditional relationships than the focus group women were. It seems likely that

the women in these very traditional relationships had never questioned their roles, or had been unable to challenge them, and so have continued to provide in the way they were brought up themselves. In consequence, they did not experience the life course changes and so the framework of the nutrition career was not relevant. In contrast, all other phases of the research identified through the nutrition career that life course changes were significant in their changing eating habits.

A continuum can be identified (see Figure Three) which ranges from traditional relationships, wherein the man is dominant and does not participate in household work or childcare, to sharing relationships, in which couples divide these activities between themselves. Phase Three women and members of the women's focus group, who had the least companionable partnerships would be at one end. Male focus group members referred to a more sharing relationship, but Phase One couples described having the most sharing and companionable partnerships and would be at the other end of the continuum.

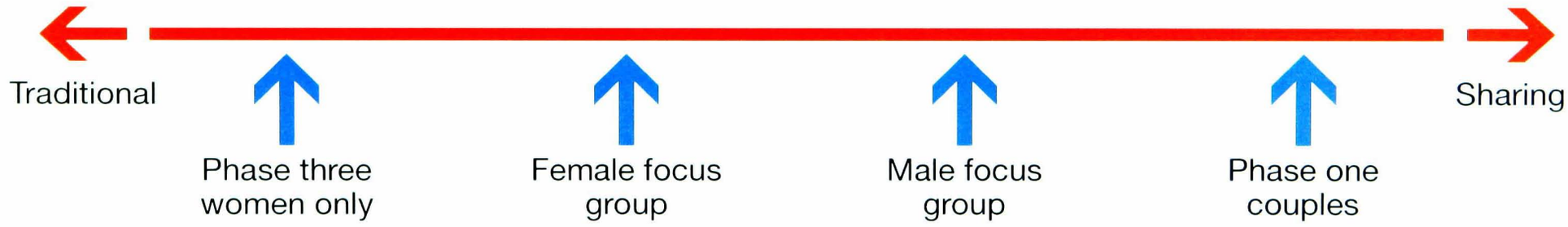
Such differences could be due to the couples 'constructing' their domestic roles for the researcher. This problem has been recognised in the previous researcher. It is a problem of all research, whether quantitative or qualitative, because the research is based on presuppositions of the researcher, who always start the process with some preconceived ideas. The way to ensure this affects the research is to use the three corners of trustworthiness: triangulation, thick description and reflexivity.

The differences identified in the relationships could relate to the different experiences of the couples, which need to be set in the context of the social and geographical area within which they live. Local residents have described Low Teams as a close-knit community, where extended families still live in close proximity to each other. The relationships of these couples are affected by the wider set of relationships within which they are involved. The more closely-knit the network of relationships outside the marriage is, the less the couple need to rely on one another for support. They are therefore more likely to develop their own, separate sphere of life outside the marriage (Clark, 1991). This is in contrast to couples who do not have such networks, who depend exclusively on each

other. Although this may not lead to partners sharing roles, it may lead to the expectation of closer companionship, understanding and communication, often associated with middle class marriage (Finch and Summerfield, 1991). It may well be that, although not middle class, Phase One and male focus group couples were not part of social networks within the area, whereas the female focus group and Phase Three couples were. Perhaps the latter were likely to have been born and bred in the area and consequently had a wide group of family and friends to rely on and socialise with and therefore were less reliant on the companionship of a partner.

Having obtained information from the focus groups and the women only interviews, it was considered that an appropriate strategy would be to interview a greater number of couples in their home. These interviews form Phase Four of the research. It was recognised that the core category of the life course had relevance for the focus groups and that more detailed exploration was required. For the women only interviews the life course had limited relevance but this was not deemed to reduce trustworthiness of the initial results, in that these women lived very different lives from those in the other phases and so the data provided through negative case analysis helped establish a greater trustworthiness.

Figure Three: Relation to different phases to traditional/sharing continuum of relationships



Summary

In Phase Three, six women were approached whose partners could not be interviewed. These women presented a very similar picture of family life to each other which was in contrast to Phase One. They reported that they lived very separate lives from their partners. Their role was to look after the children and home, with the men having little involvement in the family. The men and children had considerable influence on the family's eating habits. Unlike the previous phases of research, these women did not think their eating habits had changed through their lives. When asked why their partners would not become involve in the research, they described them as shy.

The family types identified in the research could be described on a continuum, with very traditional families at one end, where the Phase Three women would be situated, with Phase One couples at the other end with more sharing relationships. The focus groups were situated in between. Reasons for these differences were speculated upon in terms of the geographical and social context of the relationships.

The next chapter describes Phase Four of the research, which involved interviewing 22 couples in their home, using the nutrition career as a tool to explore the life course in further detail.

Chapter Seven

Phase Four: Interviews with couples

Introduction

This chapter describes the fourth, and final, phase of the research, which continued the exploration of the categories which had emerged in the course of the previous phases of research in order to confirm or otherwise the life course as the core category. This final phase of the research involved interviews with 22 couples. These interviews used the framework of the nutrition career to explore significant stages which were influential in making changes in the eating habits in the life course of the couples, both as individuals growing up and leaving home and as couples getting together and having a family. Routines, decisions, sharing, food and health, sources of information and developing an understanding about the community in which they lived were further explored. A second core category, family culture was identified. Finally, variations in findings across the four stages are examined.

The sample

As the initial strategy for enrolling couples (list sampling) had been extremely time consuming and had a high non-response rate, a different method of sampling was used. Lee (1993) suggests several strategies for sampling hard to reach populations, which were examined to assess their relevance for the research study. One suggested technique is known as snowballing, or networking, and it was decided that this would be an appropriate method to obtain an improved response rate. Couples who were known to the researcher, who were willing to be interviewed themselves, were asked if they knew of any other similar couples who would be prepared to contribute to the study (O'Connell Davidson and Layder, 1994). The major advantage of this method is that people feel less vulnerable.

> '[The intermediaries] are known to potential respondents and trusted by

them. They are thus able to vouch for the researcher's bona fides'
(Lee 1993, p. 65).

This is a very different situation from that of an unknown researcher knocking on people's doors in the hope that they will be willing to participate.

The use of the snowball sampling technique led to a much better response rate, because most of the couples contacted knew about the research and were prepared to be involved. This success appeared to be partly due to the researcher being already known to the local community as a community development worker from the Family Centre. Working within a local community can provide access to respondents who may otherwise be hard to reach. However, it does have disadvantages in terms of couples feeling obliged to answer in a way they think the researcher would like them to, thereby introducing bias (Jones 1985). It was important in all phases to ensure couples did not feel coerced into participation because of knowing the researcher. In some ways, it was of greater importance in Phase Four, concerned as it was with couples who did not know the researcher themselves but whose names had been supplied by friends who were people known to the researcher. There was the potential for these couples to feel they should honour their friend's commitment, but to be wary of what was entailed. Provision of precise explanations of what the research entailed, both vocally and on paper and obtaining informed consent was of particular importance. Reflexivity and sensitivity was also required, as in any research, in order to ensure that the findings are as close to an appropriately analysed result which reflects the respondents' view at the time of interview.

The respondents had been together an average of 6.7 years, though this ranged from five months to 19 years. Most families had two children, though three had only a single child, three had three children and the largest family had four. In all, the couples had 48 children between them, of which 30 were under five years old. None of the women worked, though some had worked previously, mainly as cleaners and shop assistants. Nine men worked, but claimed Family Credit, one each as a window cleaner, a mechanic and a van driver, with the rest working as labourers.

The couples were asked about their health in general, as an introduction to the interview. The women perceived any poor health as predominantly due to poor diet. Sixteen of the men referred to some aspect of health being poor: seven had knee or back problems, three had chest problems or asthma, and six considered that they had a poor diet, leaving them either under- or over-weight. Some of the men blamed their unemployment as being due to poor health. Fifteen couples specifically referred to smoking affecting health and four noted the negative effect of drinking too much alcohol.

Findings from Phase Four

The interviews were conducted in the couple's homes using the interview schedule developed within the framework of the nutrition career for Phase Three (see Appendix Seven). The interviews lasted for between one hour and one hour and three quarters, with both the male and female partners being present for all or most of the interview.

As in previous phases, in quotation the interviewer is identified (I) and respondents (M: male, F: female) by initials.

Core category. Life course: Influences affecting eating behaviour over the life course

During analysis of the data from the couples in Phase One, it became apparent that the life course was a possible core category. It became clear that the stages of the life course were of great importance in the way people's eating behaviour was mediated. Respondents recognised how this had changed since they were growing up and going through adolescence and leaving home. Co-habitation seemed to be a particularly significant event in terms of eating behaviour, as did having children, once they were old enough to express opinions and accept or refuse food. The focus groups had confirmed that the life course was a suitable concept to explore as a potential core category, but the women only interviews appeared to deny the life course as an appropriate category. As discussed earlier, such mismatch of findings is acceptable from an interpretivist perspective.

Growing up

In Phase Four of the research, the concept of the life course was found to be more pronounced than in other phases. It may have been due to the more focused questions asked using the nutrition career as a framework. However, the same schedule was used in Phase Three and the responses did not confirm the core category of the life course. It can be assumed that if the life course was not relevant to couples in Phase Four, it would have become apparent, and would be rejected as a core category. Likewise, there is no reason to assume the couples in this last phase of the research were not expressing their own awareness of their experiences, which confirmed the importance of the life course.

Couples were asked what kind of things they ate when they were growing up. The predominant response was 'dinners', that is, meat and two vegetables, or 'cooked food', which seemed to mean that it was not ready cooked food from the freezer or bakery.

> 'F: Seven days a week we used to have a dinner'

> 'M: She [mother] used to make all her own soups, pies, everything… she still does'

> 'M: Loads and loads of dinners when I was at my mother's…dinners…salads'

> 'F: Never chips or anything like that…it was always vegetables and meat'

Several individuals seemed quite nostalgic about their mother's (predominantly) home cooked meals, with the implication that such food was superior to what they presently ate or to quickly cooked, convenience food. Many respondents reported to eating other foods, but gave these other foods less importance to 'dinners'.

> 'F: Well, we had occasions when it was quickly prepared…if it was something like fish fingers…but normally it was all cooked'

Most people thought such food was healthier.

> 'F: Make a pan of soup…that would be good for you…good for the bairn [child]'

Only a few considered the food they had eaten when growing up was unhealthy.

> 'M: When I was growing up…all the wrong things…it's all the things that …that to me…I find that most people that were born in the fifties… late fifties…were brought on the same thing… mince…mince and

dumplings and things like that…all the fatty stuff'

This was someone who had considered himself overweight and had subsequently started watching his diet and weight training and so was very knowledgeable about food.

Several individuals talked about meal routines.

> 'F: I can tell you what I used to have… I remember on a Monday we used to have, egg, chips and beans… on a Tuesday we used to have shepherd's pie…on a Wednesday we used to have mince and dumplings….on a Thursday we used to have pies and peas, because my Grandad used to come and that's what he used to have and everybody ate the same meals sort of thing …we always had a pudding as well'

> 'M: Set days for set stuff…Monday you have a dinner…on a Tuesday you have chips...on a Wednesday you have a dinner…on a Thursday you have a dinner…on a Friday you have a fry up…on a Saturday you have chips and on a Sunday you have a dinner'

Some couples talked about eating 'junk' food as they grew up, but most referred to eating home cooked dinners. Thoughts about the relative healthiness of the food they ate now when compared to food as they were growing up were mixed. Some couples thought they ate more adventurously, whereas others felt they ate more convenience foods now. Most couples recognised that once the children were old enough to make choices about eating, changes to the adults' diet occurred. Many of the respondents who now allowed their children to make their own choices with regard to eating commented that this was not the way they had been brought up. They had no choice when they were children. Food was provided and they were expected to eat it. So some not only described different foods they ate as they were growing up, but also commented on the different parenting styles.

> 'M: Oh yes... like I was brought up not to back answer, be cheeky... lippy or anything like that...I used to get wrong and my mother used to say 'right, well you're staying in'...she knew that's all... cause I hated staying in...I used to say 'Ah, let me out mam'... but she wouldn't'

A minority of respondents described their bizarre childhood eating habits.

> 'F: Mashed tattie with smarties in it…mashed peas, marmalade and egg sandwiches'

Another woman gave an account of her 'funny' eating as a child.

> 'F: Jam and bread…I lived on jam and bread
> I: That was because that's what you chose to eat?
> F: Yes
> I: But your mam was actually cooking…did the rest of the family eat?
> F: Oh yes…they love all their food…my two brothers can't get enough of their food'

These respondents seemed to have had the opportunity of eating a 'proper' meal, but were allowed to eat what they chose in a similar way to the focus group women. In most households, however, meals were cooked from basic ingredients. This may be due to fast, convenience foods being unavailable at that time.

Adolescence

Many respondents described changing their eating habits when they became teenagers. Predominantly they talked about eating chips, particularly from the fish and chip shop.

> 'F: I used to be out most of the time…you know what I mean…
> I used to eat food from outside…chips from the chip shop'
>
> 'F: We never went into sandwich shops…just go to the chippy every day'

This confirms previous research (Lupton 1996, Caplan et al. 1998) which suggests that adolescence is a time of rebellion. Teenagers are generally aware that fatty foods are unhealthy and seem to choose such foods as a way of asserting their own individuality. There is also teenage culture, which tends to involve 'hanging around' with their friends, away from home and school, which are perceived as institutes of authority (Seymour and Dean 1997). However, this is also a time of self-consciousness, particularly for young women. Concern for body size is common and can lead to eating disorders. Two women described being hospitalised for anorexia when they were teenagers.

> 'F: …I was quite big and I didn't eat for about a year…I ended up in hospital …I ate like…I would eat fruit but that's all I dared eat…fruit and drink water'

Leaving home/living alone

Many couples moved straight from the parental home into a co-habiting relationship and had no experience of living alone. Those who had lived alone principally talked about 'not being bothered' or eating 'rubbish'.

> 'F: I hardly ate on my own…I don't know…I just couldn't eat by myself…I just wasn't bothered about anything'

> 'F: …when I was on my own I didn't eat…very very rare I'd have something to eat'

Take-away meals and pub snacks were mentioned by a few men.

> 'M: …I used to have a pub meal, you know…or have a Chinese…a Chinese or fish and chips or something like that…it was pointless going in the house and, say, doing a couple of tatties, making just enough Yorkshire pudding and, like, a small piece of meat'

> 'M: …a pub lunch of pizza, chips and a pint of beer'

Getting together as a couple

Most couples described a change in eating habits when they began to co-habit, though several could not remember whether or not there had been a change. Some thought their diet was more healthy in consequence.

> 'M: It's really since I met L [partner] and her family…'cause her family's really health conscious and things…and her brother-in-law…he's told me what to eat…the good things to eat and things'

> 'M: A big difference I did find moving in with you [partner]…I found that my parents…especially my mam overcooked all her vegetables considerably…totally overcooked…too much salt…I stopped using salt'

These couples were more likely to talk about eating new foods when they got together. For example, they talked about eating pasta and rice dishes, which they had not eaten when growing up.

> 'F: when I met G [partner] and I changed my attitude to food and I wouldn't dream of eating chilli con carne…I wouldn't dream of eating tuna… and G said try this and try that'

Others talked of not bothering to cook until they co-habited.

> 'F: Well...he moved [in with] me and that's when I started cooking

...cause...like for him and me...but I wouldn't cook just for me'

One woman described how when her partner moved in, he would have fads about certain foods. She would buy and cook whatever his latest craving was until he became fed up with it, and this process repeated itself.

The man or woman in the couple were both likely to introduce changes into the diet. However, it appeared that changes suggested by the woman would only be acted upon if the man approved. The woman was most likely to accept any changes her partner suggested, regardless of her own needs. One startling example of the power differentials in one relationship are evident in the following quote.

> 'F: G [partner] sent me a lovely letter and he said 'I will go out with you as long as you lose weight'...and I have still got the letter today...I will never forget it...I sewed my mouth up and stopped eating'

Many couples said their diet was now less healthy than when they were growing up. This seemed to be related to eating 'proper' food previously and eating convenience food now, such as frozen pizzas, fish fingers, and sausages. Some couples reported eating the same food as they ate when they were growing up. However, on closer examination, several of these couples having started talking about no change in diet, went on to describe differences.

> 'M: I was married when I was 17.
> I: And did what you ate change then?
> M: No...didn't change much...just the same...potatoes, chips, sausages... much the same...
> I: What about when you two [present partner] got together?
> M: Just about the same...it has always been the same
> I: How do you think it compares ...what you eat now to what you ate when you were growing up?
> M: It is probably pretty bad what I eat now...yes...it seemed healthier with all the potatoes and that'

It seemed that it was not something they had considered before. With further probing from the interviewer, they reflected on their eating habits and realised they had changed their diet.

Having children

When a woman gets pregnant, she is in contact with many health professionals: the general practitioner, midwives, health visitors. All pregnant women should receive nutritional advice, which is based on Ministry of Agricultural, Food and Fishing (now called the Department of Environment, Farming and Rural Affairs) guidelines (Health Education Authority 1997), along with more specialist advice about eating during pregnancy. During the present research, no-one mentioned obtaining information during pregnancy nor did they report having changed their diet.

Many couples talked about their eating habits changing when they had children, in that they went out less and had fewer takeaways, which echoed responses from earlier phases of the research.

> 'M: Definitely [changed diet]...especially before we had the kids because we used to go out drinking and it was, like, pizzas for our supper and things like that...whereas now we do not do that...we have a Chinese meal about every three months'

The change in diet was not particularly noticed until the children became old enough to make demands. Once this was the case, most parents allowed children to make their own choices. As discussed earlier, this situation was often in contrast to how they were brought up themselves. The main reason given was that food would otherwise be wasted. Families on low incomes could not afford such waste and most, though not all, found it to be more cost-effective to provide different meals to meet individual demands. Often, however, mothers (predominantly) found ways of making the preparation of different meals easier by producing 'mix and match' meals, for example three or four food types would be prepared and the children would pick the bits that they wanted.

> 'M: Yes [we eat]...at the same time...but just different meals'
>
> 'F: Someone might have some fish fingers... and chips and somebody might have salad sandwiches and chips and ...things like that'

Not only were children given choices, they also had a strong and direct influence on what was eaten, by refusing to eat certain things. Again, giving choices was related to the waste involved in children refusing to eat food.

> 'M: We've made all sorts

F: Everything like that and put it down and they just won't eat it
M: It just gets thrown away'

A few respondents were less accommodating.

'I: With the kids…do you let them choose what they want to eat?
M: Most of the time…but then a lot of the time it is 'you're getting what I'm making and you will eat it"

That children have an increasing influence on food choice is unsurprising, given the changing role of children within society. The change of perspective on how children are perceived has led to children's voices being heard in a way that was inconceivable fifty years ago. Consequently, a culture that is more accepting of children's views will produce children who are more vocal and influential. It is therefore not surprising that within many families, children are given more autonomy and opportunity to influence what they eat. However, the picture of children autonomously participating in decision-making within the family seems somewhat idealised. A reason given by many parents in the present study for cooking what children requested was because there was no point giving them what they did not want, as they would not eat it. This seemed more to do with the fear of waste, than a concern for autonomy, but could be a mixture of the two.

Category two. Routines: eating meals and snacks

Most of the couples interviewed in Phase Four did not eat with their children. This reflected the women in the focus group and in Phase Three, but contrasted with Phase One and the men's focus group. Only approximately a quarter of the families sat down together at the table and ate the same food. There were varying reasons given for this. For several families, house size was an issue. The kitchen was considered too small for a table which would accommodate the whole family, so only the children would eat in there. There was a common response when respondents were asked about where the family ate.

'F: We have to eat in front of the telly because we haven't a table'

'F: We've got to eat in here [living room] at the minute because we haven't got the kitchen done…we're waiting …we've got the table, but we want chairs now'

The most frequent approach to mealtimes, particularly the evening meal, was to feed the children first. The couple would eat together later, when the children were asleep. This would allow them to eat in peace without interruptions from the children.

The following extract from one interview expresses several of the above points.

> 'I: And do you all eat together?
> M: We try
> F: Most of the time, we try to
> M: It's me mainly that's not… I'm the one that normally doesn't eat with you's
> F: Yes…if he's like out…we try to wait but if not I like make the bairns… the bairn doesn't eat with us… most of the time…she does but I try to give her her's before we have ours so, so she's not…
> M: So she's not greeding off us [child eating from parents' plate]
> F: Greeding off us… or if like…I've got to sit and try and eat mine and feed her at the same time… I give her's beforehand…..
> I: But the older one, you eat together?
> F: But she eats in the kitchen and we eat in here
> M: So will K [younger child] when she gets older
> F: Oh yes…K will as well…We'd all eat in the kitchen if we had a table…but that kitchen's tiny and we haven't got a table
> M: Definitely, definitely
> F: We'd all eat together if we had a table
> I: So do you all eat the same sort of things?
> F: No
> M: No
> F: I have to make different meals…most meals I have to make different…'

Within this interview, the couple start by saying that they try to eat together, but quickly go on to give several reasons why, in reality, the child eats separately. Such reasons were because she eats off the adults' plates, the kitchen is too small and there is no table. They then say they would eat together if they could. The couple appear to contradict themselves, but it may well be more complicated. The couple seem to think they *should* eat together at a table, which is why they initially say they do. As they come to reflect on the reality of mealtimes, they recognise that this is not the case, even if they would like it to be. This view seems to express a dichotomy between the ideal and the practice.

The results from Phase Four of the research, which concerned changes in routine at weekends, closely mirrored those from Phase One of the study, as well as numerous other

studies (Murcott 1983b, Charles and Kerr 1988). Many couples did speak of eating less formally on Saturdays, such as going for a take-away or to McDonald's. Sunday dinner, however, was mentioned as a highlight in the week for most families. As in all phases of the research, it was overwhelmingly the most popular meal. It comprised meat, potatoes, a wide variety of vegetables, Yorkshire pudding and gravy. Most respondents referred not only to eating a variety of vegetables, but to eating large portions of vegetables. This appears to contrast with what families ate during the week, as many families reported they did not eat vegetables during the week, as identified in Chapter Four.

Only three couples did not have Sunday dinner, two of them because they could not get round to it.

> 'M: Sunday dinners are like a thing of the past'

Just one couple spoke negatively about it.

> 'M: I think most of the traditional foods is just awful…I cannot stand Sunday lunches. Everyone eats and feels sick immediately afterwards and spends the afternoon sleeping it off'

A few couples responded that they were more likely to go up to his or her 'mam and dad's' house for Sunday dinner, than cook at their own home. This was less common in this phase of the research than for the women in the focus group and in Phase Three. One reason given for visiting their parents was because the Sunday dinner was perceived as a family occasion, which indicates the strong social significance of this meal. It may be valued as the only time that the wider family to get together.

However in a few families, the male partner opted out of sharing the Sunday dinner with the rest of the family. Two women carried a plate of dinner home to him, from her mother's house

> 'M: She goes up for her dinner and she fetches mine down'

Whether this was to do with poor relationships between him and her family or that the man wanted time to himself was not clear. In a few households, men took time out on a Sunday to pursue their own leisure activities: fishing, football, going drinking.

Noticeably, none of the women talked of taking time out for their own leisure activities, apart from seeing the family on a Sunday.

When couples were asked about breakfast, there was a mixed response, with approximately half saying they always ate breakfast and a quarter saying they never ate breakfast. Most referred to eating cereal and/or toast and a few reported eating a cooked breakfast. It seemed that once the children were old enough, everyone was left to get their own breakfast, as has been reported in other studies (e.g. Moore 2000). Lunch, that is the meal eaten in the middle of the day, was quite a moveable feast. Several families talked about getting something like a pie or pasty from the bakery, picking up chips from the fish and chip shop or putting a sandwich together. Several women mentioned not eating anything. Dinner, or the evening meal, was the main meal of the day for most families, and could comprise a wide range of foods.

'F: We eat dinners all the time now, though, don't we…like for the tea'

'M: chips one night and dinner the next'

'F: bit of pizza, yes… chicken burger… something like that'

Most people referred to eating snacks, as in other phases of the research. The kind of foods considered to be within this category included crisps and nuts, pies and pasties, cake and biscuits, sweets and chocolate and pop. One man said he would have an apple as a snack and one woman said she may have a slice of melon. Four couples referred to giving their children fruit, but several were inhibited by the price. In general, snacks were high in carbohydrate and/or sugar. Several people were aware that snacks were unhealthy.

'F: We have it in our heads that it is not good to snack'

Couples were asked about both going out to eat and getting takeaways. McDonald's and other similar fast food outlets were mentioned by several couples, who would go there as a family outing. Only one couple talked of going out to a restaurant together, and this was only occasionally now they had children. However, it was a very different story with regards to takeaways, with all couples reporting buying takeaways. This could be fish and chips (though some clearly did not count getting chips from the fish and chip shop as 'a

takeaway'), Chinese, kebabs, pizzas, Indian, Mexican. Most couples only had a takeaway occasionally, when they had enough money. A few had a takeaway once or more per week, with two couples reporting that they ate them nearly every day. It seems unlikely that they could afford this considering that all couples were claiming benefit. However, perhaps these families had an additional form of income.

A very different form of eating out is school meals for children. There were mixed responses to this provision. Of those who mentioned school meals, some children had their lunch provided at school, whereas others took packed lunches. In some ways, this is surprising, because all the families were claiming benefit and were therefore entitled to free school meals. However, some stigma may be attached to this, so packed lunches are preferred. There were a few positive responses.

> 'M: Them always get a good dinner at school, though…you know what I mean'
>
> 'F: Yes she always has a cooked dinner at school so when she comes in she sometimes doesn't want a cooked dinner'

Another was more guarded.

> 'F: He gets his meals in school…so I don't actually know what he's eating'

The social aspect of lunchtime was mentioned by two parents, whose children complained that they were given little opportunity to eat their packed lunch. Presumably this is to fit in with school timetables.

> 'F: [they] only get 10 minutes to eat their packed lunch'

<u>Category three. Decisions: factors affecting food choice</u>

As in the previous phases, many couples identified the woman as the one to decide what the family would eat. This view often seemed to be based on the fact that the women did the shopping.

> 'I: So, who would you say decides what you eat?
> M: Well, she does the shopping'

However, as identified in the discussion of category two, few of the families in Phase Four ate together or ate the same meals. This suggests that family members were

consulted separately as to their food choices and this was confirmed in the interviews.

The influence of the man was evident

> 'I: What will you cook for tea tonight?
> F: I don't know
> M: Mince and dumplings
> F: Yes
> M: Yes...because I fancy some tonight'

> 'F: I wouldn't just put a meal down in front of him...I couldn't do that... he wouldn't eat it'

The woman may make a suggestion, which may or may not be rejected.

> 'F: I tend to say to D [partner] 'I was going to do this...do you want the same as what I'm having?' and if he says 'no'...I will say 'well what do you want?' and do whatever he's having...and 9 times out of 10 times, I end up having what he wants'

In some couples, if the man wants a particular dish, the woman may make it, even though it is not to her own taste.

> 'I: Who decides what you eat?
> M: Me
> I: So do you tell her what to eat?
> M: No
> F: He eats garlic and I don't like nothing like that'

The woman in this couple cooked separate dishes for her and her partner. This couple had been unable to negotiate shared meals because of such differing palates. However, in other couples, negotiation had taken place at an early stage of their relationship, as found in the previous phases.

> 'F: Now, when we first met I think it was like I didn't know what he liked or, I think I was more frightened than anything else... frightened to experiment on making things...a lot of the time [now] I make it and it's put down...cause now I know what he likes and what he doesn't like'

Not only was the man found to have a strong influence on the diet, but also the children. As noted earlier, in most families, children were asked what they wanted to eat, and often all children in a household would want something different.

In Phase One, several couples referred to 'fussy' children. In contrast, this was a term rarely used in Phase Four, which seemed to be made up of couples who did not expect the family to eat together. If children are allowed to eat as they choose, problems about enticing them to eat food they are less keen on are less likely to arise. Just one woman referred to having particular problems with her son.

> 'I: Would you ask him [4year old son] what he wants to eat?
> F: Yes, but we were told that was wrong when we were seeing a dietician...we were told we shouldn't ask him...we've just got to give him it but it didn't work...I was...just scared he was starving ... so he chooses his own food'

This woman had identified a problem, but the health professional's advice was considered unacceptable. The mother returned to her original practice, with which she felt more comfortable.

Taste was given as a major influence on eating behaviour. Couples were asked what their favourite foods were. As in Phase One, by far the most popular meal was 'a dinner'. It was particularly enjoyed by men and children. That women were not as keen, may reflect that it was usually they who made it.

A dinner was considered 'proper' food and was often associated with home cooking and healthy eating, though some recognised that there were other foods which could be classed as 'healthy'. Cost was prohibitive for many, who felt they would eat more healthy, 'proper' food had they more resources.

The next most popular food was 'junk' food, particularly with children. Most couples did refer to 'junk' food at some point during the interview, usually recognising it as unhealthy. Chips, 'fatty stuff', lard, dripping, margarine, butter, burgers, sausage, pizza were categorised under this heading. Usually it is high fat content, processed, convenience food. Other foods identified as favourites included salad, surprisingly, by men, although women talked more about salads, and pasta and rice were particularly popular with women.

Category four. Sharing: shopping and cooking

In Phase Four of the interviews, there was less sharing in shopping habits than in Phase One, which was reflected in cooking habits. In Phase One, it was a mixture of the woman shopping with her partner, alone or with a female friend or family member. In Phase Four, if the men did go shopping, they were more likely to go to 'push the trolley'. However, most said that they would pick something off the shelf if they fancied it.

> 'I: And if you saw something that you like… or just fancied…
> would you put that in the trolley?
> M: Oh yeah… probably yeah'

In this sense, the men clearly had some direct impact on what was going to be cooked.

In a more indirect way, the women know what the men like, and shop and cook accordingly.

> 'M: I wouldn't eat it [something cooked he did not like]… but like
> she's… she gets stuff in … she tends to get stuff in that I like'

As noted previously, it seems that earlier in the relationship, food decisions were negotiated. Once they had been together for a while, the woman had found out what the man liked.

As in Phase One, the pattern of shopping was of a major weekly activity at a supermarket in the centre of town – usually Kwiksave, Tesco's and Iceland. Virtually all couples talked of shopping locally in between the weekly main shop. This would be to buy perishable items such as bread and milk, or items the family has run out of. Very often couples talked about a regular shopping process with many of the same foods being bought each week by the woman.

> 'F: No… it's the same really… it's not very often any different'
>
> 'F: It's just routine I think… it is you go and get the same things'

Cost was a significant issue for most families.

> 'F: No, no… cannot afford Tesco's … I go to Kwiksave'
>
> 'F: You have money for $2^1/_2$ days every two weeks… it's not much…
> I go straight to Tesco's and get some essentials'

Cost not only affected certain families in terms of where they shopped but also what they bought, unless the male partner was present.

> 'F: The dole money only goes so far, so… that's why I have to do other things to try and tide us over'

> 'F: He doesn't read the prices of the things… just puts them in the trolley
> M: If I fancy it, I just throw it in the trolley'

Only one couple, however, referred to using a cheaper option, such as the market.

> 'F: Newcastle for my veg… I'll buy in bulk'

Newcastle could be too far away for most couples. Gateshead market is situated close to the supermarkets used by most couples, but no-one referred to using this market. This may be because Gateshead market is an unpleasant place in which to spend time, and has a reputation for poor quality, as well as carrying a residual social stigma.

To avoid the temptation of buying a variety of foods, shopping is limited to certain supermarkets.

> 'F: I used to go to Morrison's and Asda and that...but I over spend, so I just go to Kwiksave ...cause they sell like...like top brand names but they haven't got loads and loads of stuff...so I can't go wild...we're limited to what we can buy basically'

Couples were asked whether they would change their diet if they had more money. Unsurprisingly, the overwhelming majority said they would. Two couples specifically said they would eat out or have takeaways much more often. Others said they would shop at different places.

> 'M: …shop at Marks and Spencers instead of Tesco'

> 'F: Maybe more at Tesco'

The supermarkets perceived as more up-market were seen to provide more choice and better quality. Many couples also associated more expensive food as being healthier.

> 'M: … if I had the money I would buy all the good gear… if had… had the money to afford, like fruit, fish… you know…things like these meals that you can make with fish that are good for you…all these fancy meals and I'd do it…But, like… it's like I think the healthy foods are definitely more

dearer…it's as simple as that'

'F: Yes… because it costs too much [healthy eating]...too expensive'

The amount of money couples spent on food varied from £30 to £60 per week, with extra money spent on 'bits' during the week, such as milk and bread. The amount of money spent did not depend on the number of children or whether they were claiming income support or family credit. It is difficult to make any claims about this information without more detailed data. It was clear that people's circumstances differed. In some families, the man worked and claimed family credit, and were presumably better off than those on purely income support, but in some cases, extra income must have been received from elsewhere, maybe from other family members or on the black market.

In confirmation of other studies (Murcott 1983, Charles and Kerr 1988), it was found that generally the woman did the cooking. With two couples, this was a shared activity. In many couples, the man would cook occasionally, mainly if he chose to. In such cases the woman did the 'everyday' cooking and the man did it when he felt like it.

'I: You don't cook very often?
M: Not very often… when I feel like doing it I do it … but otherwise she does it'

'F: He cooks mostly on a weekend… or suppertime'

'F: Yes… he does Sunday dinner most of the time'

In several couples, the man was identified as 'good' at cooking; indeed, two had previously worked as chefs. This made no difference and their partners cooked most of the time. In this last phase of the research, women saw cooking as their responsibility, an attitude supported by the men. The former seemed to see any help from their male partners in cooking as a bonus: men cooked what and when they chose to and that in these circumstances it was accepted that he would cook according to his own liking.

'F: He likes experimenting'

In comparison, women did the cooking most of the time and this was generally about providing fuel for the family to get by with on a day to day basis. Women not experimenting was, again, closely linked with families not wanting wide choices at the supermarket, because it encourages spending. Equally, trying different meals is fraught with the possibility of the family rejecting it the food going to waste.

Couples were asked how they learned to cook. Many learned cooking skills from their parents, or from necessity.

> 'M: Just from watching my mother and father... or helping myself... like making myself some supper'

Several talked about doing cookery lessons in school, particularly the men.

> 'M: Yes... I've got GCSE in cookery'

> 'M: I used to like cooking actually ... I used to be in the cookery class 'cause I couldn't read an write right'

In terms of developing cooking skills, it appears that, from this research, cookery classes were useful. They may be enjoyable, especially for boys, but this does not mean that they will then use their skills in cooking for the family. However, the loss of cooking from the school curriculum can only be seen as yet another opportunity lost for developing skills in cooking and healthy eating. This was expressed by one woman.

> 'F: I can't do nothing...when I got to the older school... I took typing and shorthand... and I didn't have the option for cookery... I think all kids should know how to cook... because I can't cook or bake or nothing'

Category five. Food and health : the links

Couples were asked about what they considered constituted a healthy diet. Most had some ideas, as in previous phases, but they tended to be mixed in their attitudes and emotions towards a healthy diet. Virtually all respondents referred to a reduction in fat to be important for health.

> 'F: If you eat fatty things you will put on loads of weight'

> 'M: Watch for fatty foods and food that are high in carbohydrates and things like that... and if you're active, high energy foods... I mean sugary foods and that... try and cut them down or cut them out completely if you can'

This last interview extract shows understanding of the importance of reducing fat and sugar, but not of the relevance of eating unprocessed carbohydrates. This was common to virtually all the interviewees – fat was considered bad for health and most couples referred to grilling food rather than frying, a few mentioned sugar being unhealthy, but only one referred to increasing fibre and decreasing salt as important aspects of healthy eating. Indeed, one person talked of a low fibre diet as being healthy. Clearly some healthy eating issues are being absorbed by this group of people, whereas other issues are not being accepted yet.

Although virtually no-one mentioned fibre, many couples talked about a healthy diet including fruit and vegetables.

> 'I: What do you count as a healthy meal?
> M: loads of veg and stuff like that'
>
> 'F: Well, pasta and that... plenty rice and potatoes if you don't fry them ... fruit'

It has already been shown how couples considered that healthy foods are too expensive. If they equate eating fruit with eating a healthy diet, then it is understandable that it seems beyond their means, as fruit is a comparatively expensive way of obtaining calories (National Food Alliance 1994).

Other people talked about a 'balanced' diet. These people tended to concern themselves with having a variety of foods, that eating too much of one item was unhealthy.

> 'I: What do you mean by balanced?
> M: Well...
> F: Not pigging out you know...just...
> M: Something that's going to fill you ... but isn't too fatty... that's a balanced diet in my opinion'
> 'M: ...eat too much of anything, it can kill you..'

Another aspect of a 'balanced' diet for some, included eating regularly.

> 'I: What would you count as a healthy eating?
> M: Potatoes, fish, pasta
> F: Eating at regular intervals, having three proper meals a day...most important meal ... your breakfast... knowing what proportions to eat and not to fill yourself up...drink plenty of water and things like that'

This view of a healthy diet is promoted by the Health Education Authority, who produce a guide called 'The Balance of Good Health' (1997), which shows the proportions and types of food needed for a diet which is well-balanced and healthy.

Many couples were equivocal about the importance of a healthy diet. Some said in one part of the interview that it was important, particularly for children, and in a different part of the interview that it was unimportant. It seems that in principle, people think eating healthily is a good idea, but when it comes to practice, it is less easy. Certainly one aspect of healthy eating is the cost, and many couples referred to this as a reason for not eating well. Several couples talked about the importance of a healthy diet for children, but not for themselves.

> 'I: Do you think it is important for the kids to have healthy foods?
> F: Yes... them but not me...I'm not really bothered what I eat as long as the kids...'

> 'F: Oh, yes, I tell her to give him [child] load of stuff that's good for him'

Several people talked about being on weight reduction diets, as in Phase One. This was predominantly women, with just one man discussing weight. The latter was related to weight training. Three women described drastic weight loss as teenagers, to the extent that they were admitted into hospital for anorexia. Childbirth was a reason for weight increase for some women. They talked of particular diets which were reputed to work, but of weight increase when they went off the diet. Self image seemed to be the main reason for trying to lose weight.

> 'F: I got a lovely compliment off him... he said I looked lovely... but I know I'm not happy [about weight]'

<u>Category six. Sources of information: about food and health</u>

As in Phase One, many respondents reported gaining information on eating from the television, especially adverts. Products advertised on television were referred to, in terms of the product itself, but also occasionally on the advert content.

> 'M: ...that Flora advert with...what do you call him...that miserable one in `One Foot in the Grave``

Several people found food programmes unhelpful. Few said they tried any recipes and they were not perceived as meals appropriate for themselves.

'F: ...most of it's for the 'in' crowd...very posh, you know'

Labels on packets were considered important by just a few.

'F: I always look on the back of packets before I cook anything'

'F: I do now [read labels], yes...there's 23 grams of fat in a bag of crisps... custards only 1.5 grams, so I'm going to have that'

Couples were asked about leaflets, where they had come across them and did they find them useful, but responses were mixed.

'F: You can...get leaflets from the doctor's and things like that...
healthy eating
I: Do you read those?
F: Oh yes...but...like it's for them to say that's exactly what you should be eating...how do they know? You know what I mean'
'I: What about things like leaflets at the doctor's?
F: Oh...I look at them if I'm bored...but I don't pick them up thinking 'Oh, there's a leaflet on healthy eating...I'll have a read of that''

In Phase One, friends and families were identified as important sources of information on healthy eating. In Phase Four, they appeared to be relevant, but of less importance to couples. Generally, in this phase, it was unclear where people got information about food from, apart from adverts. They possibly gained it from looking round the supermarkets, in which case advertising, whether on the television or in the shops, is by far the most important source of information on food.

Category seven. 'Typical' Teams

Couples were asked what it was like living in Teams. Responses were quite markedly different. Individuals had strong views. Some loved living in the area, thought there were lots of amenities and, most importantly, that people were friendly. The alternative view was that families were desperate to get out of an area which they considered to be deteriorating at a great pace, and did not want their own children growing up in such an

environment. When asked what a typical family in the Teams was like, again, responses were either very positive or the opposite.

> 'F: It's alright once you get to know people'
>
> 'F: Right gossips…they all are…they want to know everybody's business …that's why I don't like it'

Family ties were of particular concern to families - both positive and negative.

> 'F: I wouldn't … move away with nothing…I mean my father lives across the road and L's mother just over there…so…like we're both near each side of the family…but it's horrible when you're living near your family because you've got another side interfering…you can not do anything about it…everyone knows your business'

Some respondents remarked on the positive aspect of having family close to hand, and obviously relied heavily on the social support that this provided. Those new to the area found this close knit community oppressive and felt that they were under surveillance by neighbours and subsequently felt threatened at times.

Of those people who had moved into Teams, several described a significant change in eating habits which had occurred as a result of moving. Two respondents described moving from the country into this inner city area and how they had changed from eating what they described as 'fresh and healthy' food to eating much more convenience food. This is an example of another influence on the life course, wherein geographical changes affect eating habits. Such influence may have a major impact, but they only affect a minority of households, unlike universal life course events.

Couples were asked about the differences between men and women who live in Low Teams. When asked about what men talk to each other about, they said

> 'M: Just about what happens…stupid things on the telly…we play on the computer and then we shout at each other for cheating…or getting beat at a game of cards…what happened in the cards… I don't know…just talk about nothing'
>
> 'M: We don't talk about problems'
>
> 'M: Football…when the football season's in'

Women recognised the same issue.

> 'F: Men don't seem to talk about day to day...you know...like women... men don't seem to sit and chat like that'
>
> 'F: It's just women are different in everything'

These attitudes reflect the findings from the literature review, which identified the difference between men's and women's attitudes to life, with women being involved in household activities and discussing their experiences, unlike men (Skelton 1988, Brandthe and Kvande 1998). Some people described men they knew who went to the pub in the afternoon, went home for their tea which had been prepared by their female partners and then returned to the pub. These men spent their money and ended up borrowing off whoever they could until they could collect their benefit. Drugs were perceived to be a problem, though less so than alcohol. However, a few respondents linked drugs with crime in the area.

The researcher asked couples about why men were reluctant to speak in an interview.

> 'F: Cause men want to think they're in control'
>
> 'F: I think the men are too embarrassed ...they say 'I'm not doing that ...sitting talking''
>
> 'M: Women like talking...men just like...I don't know...just getting on with life...you know...women just like gassing....'
>
> 'F: Women just like talking ...men ...just quiet and shy'

These extracts from interviews reinforce the traditional stereotypes of men and women in Teams, as perceived by couples, though they did not perceive their own relationships in such a way. This is not surprising, given that these were the very couples who were prepared to be interviewed.

Common themes were drawn from the first phase of the research, and subsequently explored in the further phases. Both similarities and dissimilarities were found across interviews and focus groups. An interpretivist perspective anticipates such affirmations

and contradictions. This paradigm suggests that humans interpret all their experiences, according to their own subjectivity. There are no absolutes or objective truths. In consequence, people will respond differently in different circumstances and with different people. In a similar way, the researcher will interpret the data from his or her own perspective, as discussed in the chapter on methods. However, if themes emerge that have coherence, then these should be explored further. The aim of the researcher is then to represent these findings in the most trustworthy manner.

Summary

This chapter has reported on the Phase Four of the research, which involved interviewing 22 couples. Life course was the core category based on influences on eating habits over the respondents' life time and was explored using the nutrition career as a framework for research. Life course is examined in detail in the following chapter. As they were growing up, most couples talked of eating 'dinners'. As they moved into adolescence, the majority of respondents described a change, wherein they would eat chips from the chip shop, away from home, which seemed to be a partly rebellious act. On leaving home, several people talked about not bothering much with food. When first co-habiting, there was a mixed reaction, with some considering they ate a much more varied diet, whereas others referred to eating mainly convenience food.

Further analysis of the key findings

The subsequent sections in this chapter include the relationship between development of a second core category, family culture. The next section explores and draws together aspects of the influences on eating in low income families that were found in most responses within the research. The scope of the research study did not allow for all the influences, both external and internal, as identified by Tones and Tilford (2001). Consequently, areas that were particularly emphasised by the respondents are examined

more closely. Finally, variations between the Phase Four findings and the previous findings are identified.

Second core category. Family culture and eating patterns

Families were found to engage in different family cultures, which had a bias to a particular pattern of eating, and families could consequently be categorised into groups. Approximately half reported allowing each family member to choose what he or she wanted to eat, within defined and accepted parameters. Preference was often for convenience or frozen food and was often eaten at different times, with the children eating when they came in from school and the adults eating when the children had gone to bed. These families could be described as 'quick and easy'. As well as frozen and convenience food, they tended to eat bacon, sausage, egg and, of course, chips, either from the fish and chip shop, home-made or oven cooked.

Another family culture, accounting for approximately a quarter of families, was identified and could be described as 'organised'. These families tended to home cook from unprepared ingredients and were much more likely to eat together as a family at a table. They ate little convenience food and were more likely to eat vegetables.

> 'F: This is what you would call an old fashioned kitchen...when it's... everything cooked'

A further culture, accounting for the final quarter of families, were those who did not have a routine and put together meals as and when it became a necessity. They would cook whatever was to hand or go to the local shop to get food for immediate use. If at all possible, they would offer the children choices, but sometimes the need to eat what was available prevented this. These families could be described as 'rushed'. Several women in this group stated that they often snatched a bite of a sandwich when she got chance, or did not bother eating.

> 'F: He's [child] not a very good eater...and the stuff he leaves...I'd probably pick at'

Some life course changes were common to all three family cultures. For example, men are influential at most times over the life course, but have a particularly strong influence when a couple start to co-habit.

The male influence on eating behaviour

The present research found that men had a major influence on food choice in most families. At one level, it is not surprising that the man's tastes are taken account of, in the sense that people generally want to eat what they enjoy and the woman will provide accordingly. However, the power differences between men and women are demonstrated by women's tastes generally being subordinated to their partner's. Thus, at all levels of negotiation, the man within the relationship had a profound influence on the couple's diet, if not the children's. Women seemed conscious of their partners' choices from early in the relationship and were prepared to accept providing these choices, regardless of her own preferences.

The significant level of negotiation in the early stages of the relationship as to what food was acceptable raises issues about the level of communication that takes place between partners in establishing a relationship, which will be different for all couples. Negotiation within a relationship can reveal communication problems, as identified in the literature review, and may involve vagueness, early anticipation of what the other will say, tactics to avoid conflict, such as refusing to discuss issues or becoming competitive (Sharpe et al. 1996). These differing approaches were identified in different phases of the research. When couples were interviewed in Phase One and Phase Four, anticipation of the other partner's response was common, one often answering for the other and interrupting. The other, less common style involved couples referring to each other and one speaking on behalf of the two. This appeared to relate to the family culture.

It was common for men to be oblivious to the cost of food, much to the annoyance of their partners. If a man did go shopping, he would spend far more money, because he was not aware of the cost of food or would not think of choosing the cheapest product.

Cost: eating on a low income

All families in the study were on a low income and cost was a major influence on food choice, as would be expected. The literature review identified how poor health was linked to poor diet and how this was associated with poverty. The families interviewed in the research were all on a low income and, although the majority of respondents talked about eating what they wanted to, the cost of food was found to have a strong influence on the food people chose to buy. This was given by many as a reason for not eating more healthy foods. Such food, which was identified as including fruit and vegetables and lean meat, were considered expensive and beyond the means of these families on benefit. Lobstein (1995) calculated that families on benefit had only eight pence to spend per day for every hundred calories for a child. At the time, to obtain one hundred calories from fruit or vegetables would have cost at the least twenty five pence and from lean beef or pork it would have cost forty pence. In the poor financial circumstances in which they found themselves, it is unsurprising that these families on low income rely on white bread, pies and pasties, which are considerably cheaper in terms of cost per calorie, for example, the cost of 100 calories derived from white bread would be three pence (National Food Alliance 1994).

Not all people said they would change their eating habits if they had more money. This seemed to be related to the social and moral ramifications of eating identified earlier. The impression they gave was that they were reluctant to admit to eating a poor diet, as this somehow reflected badly on themselves. However, given the influence of cost, it seems likely that if families did have more money, they would be more likely to eat more healthy foods, which many families conceded to be the case.

Several respondents said that if they had more money, they would shop in more upmarket supermarkets, such as Tesco, Asda or Marks and Spencer. These were recognised as offering a much wider variety of foods, unlike Kwiksave and Iceland, which provide basic foods. The importance of eating a variety of foods has been well documented (Department of Health 1994, Dowler and Calvert 1995). However, most of the couples in the present research did not buy a wide variety of food. They bought similar foods each

time they shopped, knowing what they and their children would eat, so as to avoid waste. It has often been reported that families on low incomes can not buy a variety of foods, since they are unavailable to them because of cost and this is seen as another example of inequality (Low Income Project Team for the Nutrition Task Force 1996, Lang and Caraher 1998). In the present study, however, some couples did not want more variety because they would not then be tempted to over-spend.

The literature review identified that many inner city areas have become food deserts in which low income families have reduced access to food. However, in the present research, all respondents referred to doing a main shop, either weekly or fortnightly. Virtually all respondents used supermarkets in the centre of Gateshead. Although only a few of the couples had a car, there were no complaints about the distance of supermarkets, which are about two miles from Low Teams, with a good bus service. As such, it could not be argued that the couples were living in a food desert. However, all respondents talked about getting 'bits' from the local shop, such as milk and bread. The local shop does not sell fresh fruit or vegetables and the food it does sell is mainly expensive, processed food. Unless fruit and vegetables are easily and locally available, it will always be difficult for low income parents to provide healthy food for their families on a regular basis.

As discussed above, cost had a major impact on diet. Often lack of time was linked to this. Respondents stated that food had to be cheap and quick to prepare.

Time - eating within the constraints of time

Many respondents referred to time restraints which prevented them cooking as they wished. On analysis of the interviews, it was not clear why convenience and speed is of such importance. On the surface, one may imagine that these couples had plenty of time, given that all the women and most of the men were not in employment. It may be because taking the children to school, looking after children at home, shopping and housework are very time consuming activities, especially without a car.

Time was particularly an issue for the 'quick and easy' families and the 'rushed' families. It was especially an issue for the latter, who seemed to dash from one task to another and had little time to spare to prepare food. In consequence, food was chosen because it was the quickest to prepare and often was a snack. The 'quick and easy' families, although more prepared for mealtimes, also reported that lack of time was an important element in their choice of food. In most of these families, different members ate different meals, which obviously had time implications. If several meals are being provided at each mealtime to cater for each family members' tastes, it may be impossible to do so without using convenience foods which will reduce the time spent on preparing each one.

In contrast, although the 'organised' families prepared food from raw ingredients, lack of time was not considered a problem. This could be because they placed more value on food and it's preparation and therefore set aside time specifically in order to cook. In these families it seemed that the importance they placed on food meant that they prioritised time to prepare the family meal. All members of these families were more likely to eat the same meal as each other, which may reduce the time to prepare food for the family by eliminating duplicate or parallel preparation.

The influences of the male, cost and time also relate to the social aspects of eating, such as how the family behaves, the roles adopted within the home and the subsequent family culture that predominates within that family.

Social aspects of eating

The literature review identified the important social role of food and eating and the findings of the study confirmed this. Many of these aspects have already been referred to, but will be drawn together under the present heading. The social meaning of food was found to be linked to respondents views of 'good' and 'bad'. The findings show how often respondents made judgements about what was good or bad. A dichotomy was often identified between the ideal, that is, what was perceived as good, and the reality, which was how the family actually behaved. This often created difficulties around how they perceived their behaviour, because they may aspire to their ideal but be unable to achieve

it. This resulted in cognitive dissonance for many respondents, as identified in Phase One. On finding themselves in this uncomfortable position, couples gave explanations about why they could not achieve their ideal. Examples of this included explanations about why they did not share chores, about why family members did not eat the same food as each other, about why families did not eat together at a table and about why they did not eat healthy food or 'proper' food.

Sharing chores was an area where this dissonance occurred for several couples, which the other examples given above can be related to. The Concise Oxford Dictionary (Thompson, 1995) gives six definitions of the word 'share'. The relevant definition in this context refers to

> 'a part contributed by an individual to an enterprise or commitment' (p. 1273).

It does not refer to the size of the part contributed, yet there seems to be some expectation of equality. When talking about sharing tasks in the household, some couples did express such an expectation, in the belief that there was supposed to be more gender equality these days, even though they recognised that this was not necessarily so in their own relationship. There appears to be some kind of moral imperative these couples felt, in that they thought they *ought* to share equally, thus expressing another aspect of the dichotomy identified between the ideal and the practice. However, there may well be families who have no interest in an egalitarian relationship. Indeed, any attempt to increase equality may have the reverse effect. For example, in an attempt to encourage men to share with the shopping, supermarkets might be encouraged to be more appealing to men. However, as happened in some families, the man might pick more items of food that he fancied off the shelf, without concern for the cost. This could place an added burden on the woman, who is finding it hard to keep within her budget. A further consequence could be that, given that men have a strong influence on the family diet as it is, if they were to share more in the shopping, they would have an even greater influence.

The findings demonstrate that women do the majority of cooking and shopping. They have been perceived by health professionals as the 'gatekeepers' to the family diet and, in consequence, have been the focus of health education.

> 'Women, especially mothers, are subjected to particular attention by health educators because of their pivotal role in family health care and health maintenance' (Pill and Parry 1989, p. 51).

It seems that women are put in an unenviable situation. They may well know what is healthy for the family, but be unable to provide such food because of the man's preferences. They then get bombarded with health promotion messages about the importance of a healthy diet. To start targeting men on nutritional issues, rather than women, would be a possibility. Keane (1997) found that men, aged 40 -60 years, were more likely to seek information about health if they perceived themselves at risk of a heart attack. These men were more likely to be white and middle class. Young men, particularly those in their early twenties, had a blasé attitude to potential health problems. The men in the present research were predominantly under 40 years old, and likely to be resistant to traditional health promotion strategies, such as one-to-one counselling or the provision of leaflets and so different approaches would be needed to effect changes in behaviour.

Food was described by some respondents as a means of controlling children's behaviour in order to conform to socially acceptable norms. The possibility of using snacks and sweets as a bribe to control children's behaviour thwarted some women's attempts to curb their intake. The cynical display of sweets at the supermarket cash point exploits this problem, by tempting children waiting in the queue. Buying some may be the only way parents feel they can control a potential tantrum. The need to use snacks and sweets as bribes suggests that perhaps some families would benefit from support to help find different ways of rewarding children. Most health professionals advise the use of basic behavioural techniques, which involve rewarding good behaviour and ignoring bad behaviour. The men's focus group responses did not recognise this aspect of the use of snacks, and berated their partners for 'giving in' to children's requests for such unhealthy food. This could well be that they were with the children less, particularly in potentially difficult situations like shopping. Indeed, these men identified one reason for not shopping was children misbehaving.

A further aspect of control included reducing intake of food. A number of women referred to losing weight by reducing calorie intake to be a significant influence on what they ate. There are conflicting views about how women themselves perceive dieting. McKie et al. (1993) found that women were resentful of the expectation of maintaining an ideal body image, whereas Lupton (1996) stresses that women who diet should not be seen as victims, but as people who are taking control of their lives. The present research found that women dieting seemed to be resigned to consistently being on a calorie controlled eating programme, even though it required constant effort. Tackling the potential problems associated with dieting is a difficult topic, given the enormous media pressures placed on women. Robinson (1996) suggest that a holistic approach may be the most appropriate, wherein women are encouraged to address not just the issue of weight, but also the mental, emotional and social aspects of their health. A further potential problem of weight control is the predicament of developing eating disorders as a response to maintaining a specific body image for some young women. Indeed three of the women interviewed described themselves as having suffered from anorexia as teenagers. This emphasises the importance of understanding the relationship between food and health.

Food and health: understanding the relationship

When asked about the relevance of diet to health, several couples minimised the impact of personal behaviour on health. They had a fatalistic outlook, wherein they considered that they had no control over their health. This was expressed in the idea that they could get run over by a bus any time. Such an attitude to health has been shown to be more common in social classes IV and V (Naidoo and Wills 1994). It seems to reflect a rational response to a situation when there is a lack of choices available. Many couples talked about the absence of healthy eating habits as being due to some reason other than their own choice, such as lack of time or money, or both. A way of coping with such difficulties seemed to be to deny them, in order to maintain their view of themselves as 'good' parents. This finding reflects the literature, which identifies that people on low incomes have standards below which they strive not to fall, such as having a roast joint of meat on Sundays and using butter rather than margarine (Wilson 1989). It also affects

where people choose to shop. In addition, it reflects the findings discussed earlier concerning the perceived dichotomy between the ideal and the reality.

One aspect of understanding the relationship between health and food is having the knowledge. This is not the only what is needed, but is an essential part of healthy eating.

Sources of information on food and health

Sources of information about food identified by respondents included television, magazines, leaflets, health professionals and family and friends, as well as labels on tins. Different sources were recognised as being more or less influential than others.

Television provides a range of information, from cookery programmes to documentaries to adverts. The plethora of cookery programmes on television at present would suggest a greater interest in cooking from raw ingredients and developing new cooking skills. However, families on low incomes are excluded from benefiting from such interest because of the cost. A few respondents referred to watching and enjoying celebrity cookery programmes, but less said they ever tried to cook the meals shown. The need for a host of different ingredients was doubtless a difficulty. Although people on low incomes may wish to try more unusual dishes, they can not afford either the range of raw foods or the variety of spices or herbs required. They may leave ingredients out, but the dish then hardly resembles the original recipe.

Documentaries and news items on the television, the radio and in newspapers were a source of information for some respondents. Although these respondents did not specifically identify the television, radio or newspapers as places where they obtained facts when asked, the knowledge gained from the media was implicitly revealed when they talked about food scares. Several men in particular were bothered by BSE, listeria and salmonella. A few reported to have stopped eating beef as a consequence. The general feeling about these scares was a cynical view of the government, that these health problems had been known for some time, but the government had decided not to let the general public know. Reilly and Miller (1997) identify instances in which the government

has reported food to be safe. When later information surfaces to show that this was not the case, it appears that the government had known this for some considerable time. This confirms that lay people are correct in being sceptical about what information is provided via the media.

Health promotion has generally sought to effect change in eating habits by giving information and advice about food via health professionals, leaflets and national campaigns. This has focused on improving the individual's or the family's diet. Some respondents referred to obtaining information from health professionals such as general practitioners and health visitors and those who attended the Family Centre said they had gained information about food there. Given that all families had at least one pre-school child, it is perhaps surprising that health professionals were not mentioned more often, as most families would be in regular contact with the primary health care team. It was not clear whether they had not absorbed any information offered through these sources, had rejected it, had forgotten it or did not have enough for it to make an impact.

Information is just one aspect influencing eating behaviour, but social exclusion was another factor that respondents referred to.

Social exclusion - the experience of living in Low Teams

There was a clear view amongst most respondents that people who live in Low Teams generally live in a traditional, gender divided society. This view was held regardless of how they perceived their own relationship, which most considered generally to be more sharing and equal than was usual in the area. This perception could reflect the likelihood that the respondents recruited for the study were in more companionable relationships than others in the area.

The couples and the focus groups generally described the 'typical' relationship in Teams as one in which men are 'in charge' and expect women to do all the house-keeping and childcare. There was a general view that family relationships are changing, with couples becoming more sharing. However, on the whole, although women are working more,

there is little evidence of a major shift to shared responsibility within the home. This is reflected in the literature: young men leaving school today maintain a conservative view of domestic life.

> 'Young men's views of masculinity in some ways conformed to the notion of a 'lad' but also emphasised domestic conformity... The main impression, however, was of the continued dominance of a 'traditional' masculinity rather than of a new version of masculinity which might be more in tune with the requirements of a service-based economy' (Henwood et al. 1987, p. 1).

Part of this 'laddish' culture (Henwood et al. 1987) was described by several respondents in terms of the prevalence of alcohol drinking and drug taking in the area. In terms of anti-social activity, there was a perceived split in the area of Low Teams with one end considered much more prone to crime than the other. Terms used to describe the West end of the area where there was particularly poor housing included 'the Bronx' and 'Beirut'. Those who lived at the 'better' end tended to disassociate themselves as much as possible from the other end. In a small area, such splits have the potential for great social division, with those in the more deprived areas feeling even more excluded within an already marginalised geographical area (Botes and van Rensburg 2000).

Variations in findings between Phase Four and other Phases

All men in the focus group agreed to being interviewed with their partners in their home. Subsequently, differences were noted between men interviewed together with their partners as a couple, compared to when they were in a single sex group. One man acknowledged this.

> 'M (alone): Some of my mates would say I don't get on with her...but I know for a fact they're different in the house...you know...when you go down their house...it's totally different'

Interviewing the men from the focus group showed that their responses were different when with their partner compared to when they were with the men in the focus group. These couples came across as much more sharing in their attitudes when together, when compared to the men's responses in the focus group, with much less emphasis placed on

gender divisions. When the couples were interviewed together, given the present dominant ideology of marriage as companionable (Finch and Morgan 1991), it may be that most couples felt impelled to present a picture of an equal, sharing relationship. The focus groups were single sex and members could potentially be more open, as their partners were not present. They expressed solidarity with their group members, so that the men referred to 'men sticking to men and women sticking to women'. Both couples and group members could have encouraged each other to present a picture of reality which reflects their experience at the time of interview. It also could reflect a dichotomy between the experience of being in a couple and being in a single sex group.

Unfortunately, most of the women in the focus group were not prepared to allow home visits to interview their partners so no comparison can be made. However, the one woman who agreed to be interviewed with her partner did support the difference found with the men. She talked about them always eating together and was one of the only couples to talk about going out together, even though in the focus group, she agreed with the other women, that men and women have little in common. Again, she provided a different perspective when in a gender specific group compared to when with her partner.

From a positivist perspective, such differences may be interpreted as disproving the validity of the data collection and analysis. One of the disadvantages of focus groups is that they involve group dynamics, which may lead to the group censoring any deviation from group norms (Kitzinger 1994). Equally, it could be argued that the female partner could be censoring the man's response when being interviewed as a couple. However, these differences are not surprising from an interpretivist perspective. Individuals do not live in a static world, but in an ever changing environment, which they interpret in different ways at different times. Thus when the men were together, they perceived themselves as a homogenous group, whereas when they were with their partners, the similarities between the two as a couple were reinforced and acknowledged. The tools of 'triangulation, thick description and reflexivity' (Brody 1992, p. 177) need to be applied to ensure trustworthiness of data collection and analysis in these changing contexts.

A major difference between these Phase One and Phase Four was that women in the latter group were more likely to cook and shop. These families were less likely to eat all together or to eat the same foods, many preferring a 'quick and easy' approach to eating.

Within the continuum described in Chapter Six (see Figure Two), Phase Four couples could fit in alongside the male focus group members, as having companionable relationships, though less so than Phase One couples. However, ideas about the importance of companionable partnerships needs to be explored more closely in the context of domestic life. It already has been identified that over the last 50 years there has been an increasing idea of relationships being more sharing and couples focusing on their partnership rather than on the wider family. However, evidence has shown that women still have the major responsibilities within the home (Oakley 1974, Graham 1984, Blackburn 1991, Brandthe and Kvande 1998). The present study found that the majority of couples did consider themselves to be in sharing relationships, at least to some extent. However, it is questionable to call a couple's relationship more companionable just because the man sometimes shares the shopping and cooking with the woman. Many of the couples referred to the man cooking occasionally, but generally this was when and what he wanted. However, perhaps it is not the actual behaviour of individuals within a family, but the perceptions that make relationships more personally supportive and rewarding. Phase Three women and the women's focus group members appeared to have no expectation of such a relationship, and seemed to accept the situation they were in.

Some of the differences between the Phase One and Four couples could be due to the recruitment methods used. The former were contacted directly by the researcher. Most couples who eventually agreed to be interviewed at this stage were unknown to the researcher. Given the number of contacts needed to engage ten couples, those who were willing to be interviewed were more likely to be interested in food and eating. In contrast, Phase Four couples were recruited by the researcher, in the context of working as a community development worker, knowing them personally or via a person the researcher knew. In consequence, these couples were more likely to be 'doing a favour' for the researcher or their friend. They may, therefore, be less interested in food. This seems to

be reflected in the differences in responses in that Phase Four interviewees considered the provision of food to be a necessary requirement of the daily routine - 'food as fodder'.

The research showed that this cohort of low income families had varying attitudes to eating behaviour, as would be expected from an interpretivist perspective. The attitude of many of the couples was predominated by keeping the family 'filled up' i.e. food that is cheap and palatable, regardless of the nutritional input. But if food is considered simply as food, then it could be imagined that it would not matter what the food is, as long as it filled the individual up. To some extent this was the case the case,

Summary

This chapter has reported on the Phase Four of the research, which involved interviewing 22 couples. Life course was the core category based on influences on eating habits over the respondents' life time and was explored using the nutrition career as a framework for research. Life course is examined in detail in the following chapter. As they were growing up, most couples talked of eating 'dinners'. As they moved into adolescence, the majority of respondents described a change, wherein they would eat chips from the chip shop, away from home, which seemed to be a partly rebellious act. On leaving home, several people talked about not bothering much with food. When first co-habiting, there was a mixed reaction, with some considering they ate a much more varied diet, whereas others referred to eating mainly convenience food.

The majority of couples used convenience food routinely, for speed and ease. Families could be classified according to their cultural bias. Most could be described as 'quick and easy', because they were quite content using convenience food most of the time, to provide the variety of foods the family wanted, and had regular mealtimes. A smaller group could be described as 'rushed', with snacks often replacing meals. Another, small group were 'organised' and cooked from raw ingredients. Family cultural bias was identified and is explored in greater depth in Chapter Eight.

The couples did not describe changes in diet when they first had children, but did when the children were old enough to make their own choices. Most said they provided children with what they wanted, which may entail different dishes for each family member and adults eating separately from children. Despite this, dinners were identified as a favourite family meal, which they may well have during the week, as well as on Sunday.

The couples in Phase Four of the research shared the task of shopping less than those in Phase One. If the man went, it was to push the trolley, though they were likely to pick things from the shop shelves if they saw something they fancied eating. Cost was a prohibitive factor for most. Again, the women mainly did the cooking, with men cooking occasionally and when they themselves chose to.

When asked about health and diet, most referred to fat being unhealthy and fruit and vegetables being healthy, as in the earlier phases. Many couples were equivocal about the importance of a healthy diet and often a compromise was made between eating what was considered healthy and unhealthy. As was found in earlier phases, weight reducing diets were mentioned by several people. Couples referred to obtaining information from television adverts and friends and family. Many were equivocal about the usefulness of leaflets. When asked about living in Teams there were polarised attitudes, with some reporting very positive feelings and others very negative ones. Many felt that general attitudes in the area were gender stereotyped.

Common themes were explored, which included the male influence on eating, the effects of living on a low income, time implications for cooking, understanding the relationship between food and health, sources of information about food and social exclusion. Variations between the findings in Phase Four and the previous phases were discussed.

The next chapter will discuss the two core categories of the 'life course' and 'family culture' and identify a model which could be used for assessing, planning and evaluating health promotion activities.

Chapter Eight

Discussion

Introduction

This chapter presents a discussion of the first core category which was the Life Course. The Life Course emerged as a potential core category at an early stage and was confirmed as such as the research progressed. In order to explore this category in greater detail the nutrition career was developed as a framework for research. The Family Culture then emerged as a second core category. Further analysis of families' responses who had previously been identified as 'quick and easy', 'rushed' or 'organised'. Grid-group analysis identified these groups as potentially being within a culture of 'individualism', 'control', 'subordination' or 'co-operative'.

Family Culture was recognised as changing over the life course and the 'Life Course and Family Culture' model was discussed, and it's unique contribution to the knowledge based is expressed. This model was developed in the form of a questionnaire for assessment, which is offered as a potential practical tool for assessing family eating behaviour and planning health promotion activities. It is proposed that the questionnaire could be used as an evaluation tool. Finally, the application of the questionnaire to other areas of health promotion is considered.

The life course as a core category

Following the analysis of results in Phase One, the life course emerged as a potential core category. The literature was reviewed and the nutrition career was found to be a useful framework for exploring the concept of the life course further (Tones 1983). It proved to be a helpful device for examining each stage of the life course in greater detail.

On final analysis of the Phase Four results, the life course was clearly recognised as a core category.

Many of the couples interviewed in Phase Four initially found it difficult to talk about food, particularly the male partners, because it was not something they necessarily thought about. They knew what they liked to eat, but had not considered if or whether it had changed over their life course. An interview schedule based on the nutrition career provided an opportunity for them to identify times in their life when changes to their eating behaviour may have occurred. It provided a framework which guided the researcher through a chronological and systematic path of questioning in those situations where respondents had difficulty in articulating their thoughts.

Most individual's lives do not run in a smooth line as the nutrition career may suggest. For example, family break-up may lead families into very different lifestyles, with one parent living alone and the other caring for the children, with each eating in very different ways. However, there are still discrete phases that are usually described in the literature as stages of relevance when change might take place (e.g. Pickin and St Ledger 1993; Tones 1983; Tones and Tilford 2001). For example, childhood is a specific phase which most people recognise in their lives as being different from adulthood, in that they are growing up, going to school and have adults to care for them. The time that childhood lasts for will differ from person to person, from culture to culture and from one historical time period to the next. In a similar way, most people in the UK identify adolescence as a time in their lives when they were gaining independence from the family, although this also varies according to the individual, the family and the culture.

Leaving home and living either alone, or with others can be an important change of circumstances, although most respondents in this study reported moving directly from their parents' home to a shared home with a partner, when they would immediately be negotiating with each other about eating behaviour. Co-habiting is usually an important change in an individual's life, wherein a man and woman start living together as a couple (the research did not approach same sex couples). Some people do change relationships

regularly, and so this may be a less momentous event for them. However, the data showed that the couples in the study were in stable relationships, which had lasted for an average of 6.7 years. It may be that some of the couples who refused to be interviewed were not in stable relationships. For example, the women in Phase Three who would not be interviewed with their partner did appear to have less sharing relationships than those who were prepared to be interviewed as a couple. A reason for refusal could be that having an outsider coming into the home questioning their habits was considered too threatening to an already unstable situation. The couples may have felt vulnerable to exposing existing rifts within the family to an outside researcher.

Given that many of the couples had been in paid work when they got together, it is perhaps surprising that the loss of employment was not identified as a time of important changes in eating behaviour. The accompanying loss of finances would suggest that couples would need to reduce household costs, of which food is an important element, but there was no evidence of this in the data. Cost was identified as a significant feature affecting food choice, even if it was not related to being out of full time employment. People talked about eating out and eating takeaways prior to loss of paid employment, but did not explicitly recognise a specific change in habits. Perhaps this was because such changes took place slowly, with a gradual reduction in finances. It could be, for example, that one partner became unemployed first, so the couple adjusted by eating out less and when the other partner stopped working, they had already become more accustomed to having less money. Many identified having children as making a significant difference to finances.

The stages in the life course described above were identified on analysis of the findings. It could be that different groups of people may recognise different stages in their lives which would be of relevance. For example, one woman described particular changes during her childhood which affected her eating behaviour. She reported that she had been poorly cared for by her parents in the first ten years of her life and was only fed erratically. She was then placed with a foster family who were vegetarian. She was subsequently placed with another family, who gave her the food she wanted. The changes

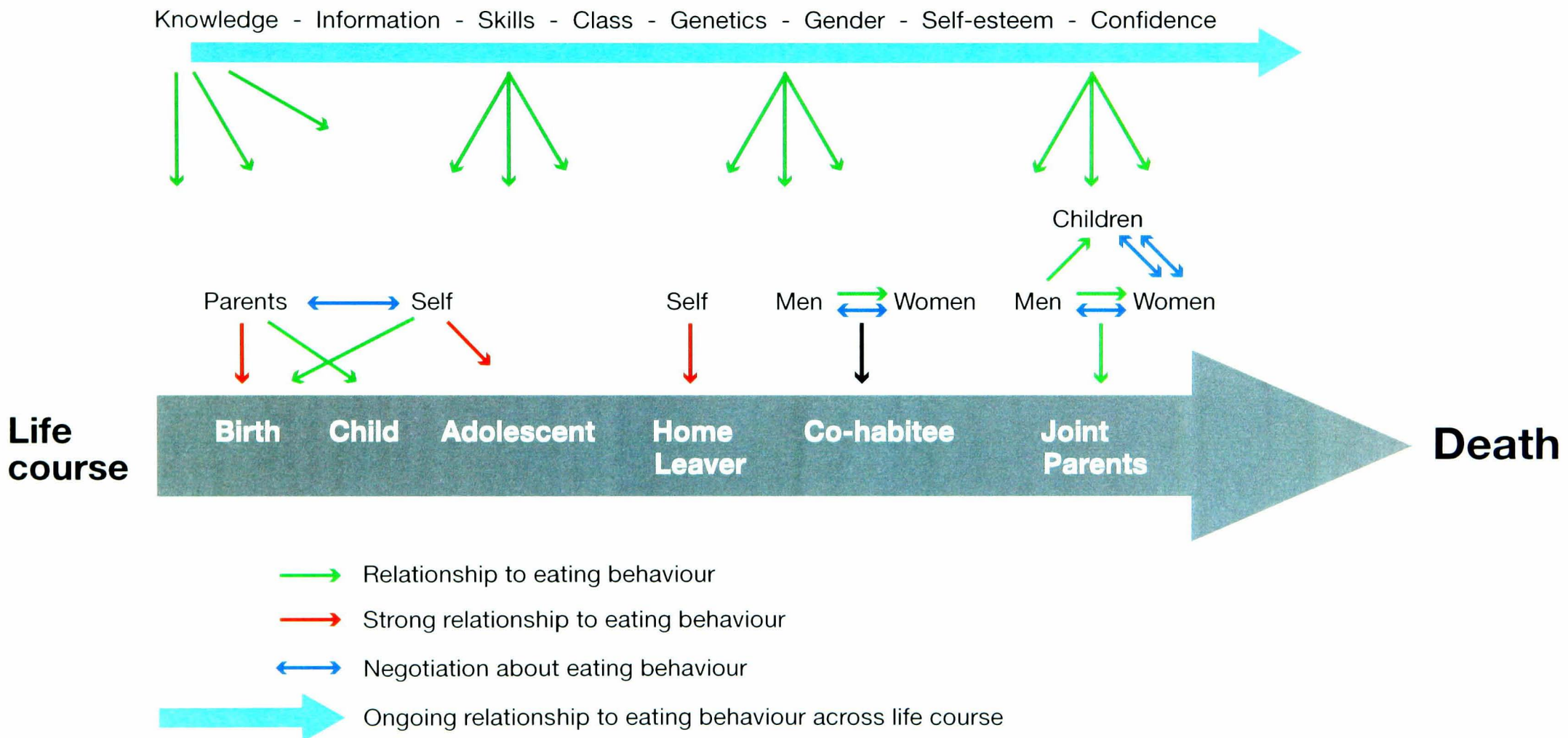
in this woman's eating across her life course could be clearly marked using the nutrition career, but using different stages.

Influences on eating behaviour from within the family

From the findings of the study, the original basic framework of the nutrition career, described in Chapter Four (see Figure Two), can be augmented with details of the influences on eating behaviour within the family. Relationships between family members and eating behaviour are presented diagrammatically in Figure Four. They are depicted in the upper section of the original framework for the nutrition career showing different strengths of relationships between the individual identified and eating behaviour, as identified from analysis of the data. For example, at birth and during infancy, parents have a major influence on the individual's eating behaviour, whereas once a child is old enough to make choices, or at least to refuse food, the influence of parents is often reduced. Usually there is some negotiation, which is represented in the model by a two way arrow. Thus, during childhood both the child and the parents influence eating behaviour.

As children become adolescents, the findings showed that they become more independent and so have much more control over their own eating behaviour. However, once they co-habit, negotiation takes place between the couple. Although changes in eating behaviour are likely to take place, whether instigated by the male or the female, these changes will only be accepted if the man accepts them. The negotiation tends to be dominated by the man and he therefore has a much stronger influence on the couples eating behaviour than the woman within the couple. In Figure Four, this is expressed by a two way arrow between the couple and a further one way arrow from the man to the women, expressing the unequal influence on eating behaviour. Once they have children who are old enough to make choices, further negotiation takes place between the parents and the children, though this is much more likely to be with the mother. At each stage other family members may be influential, for example couples' own parents. Similarly friends may affect eating behaviour, through discussing past or future meals or meals they particularly enjoyed.

Figure Four: Influences from within the family on life course using the nutrition career



Other influences were located within the family, which will modify food choices across the life course. Socio-economic status is influential in eating behaviour, but may change across the life course. For example, a couple who initially were social class IV may move into social class II through their work, moving house and bringing their children up in a different way than they themselves were brought up. In consequence, their eating behaviour could be very different, with a greater emphasis on wholemeal foods and fruit and vegetables (Wadsworth 1997).

Hereditary influences will not change, but the affects of genetics will be manifest over the life course, if only through the process of ageing. Coronary heart disease, stroke and cancers all have an element of hereditary input, so an individual with a family history of, for example, heart disease is at higher risk of suffering from the same conditions themselves (Department of Health 1998c). Knowledge of this risk may lead an individual to modify his or her eating behaviour, for example, after a close relative suffers a heart attack. An example was of a man, on marrying, was influenced by his new brother-in-law and became much more careful that he only ate 'healthy' food.

A further influence on eating behaviour is the knowledge, skills and information available to individuals about food. Knowing what food is healthy and how to prepare it appropriately is an essential aspect of eating healthily. This will be relevant at different times, as will self-esteem, confidence and individual empowerment. If people do not have the confidence to shop and cook healthily, then they are disadvantaged in gaining the benefits of a healthy diet.

Influences on eating behaviour from outside the family

Influences outside the family are presented in the lower section of the nutrition career (see Figure Five). They are depicted on a separate diagram overleaf for clarity. Financial resources are influential throughout the life course and are likely to change according to circumstance. At times there will be specific sources of influence, such as:

- midwives after birth
- health visitors

- parent and toddler groups, playgroups and other pre-school provision for under five year olds
- school, teachers and school nurses for school age children
- further education and youth workers for adolescents
- work, employers, colleagues and occupational health services for employees.

Other influences may also be relevant at different times or have relevance throughout the life course. These include people such as:

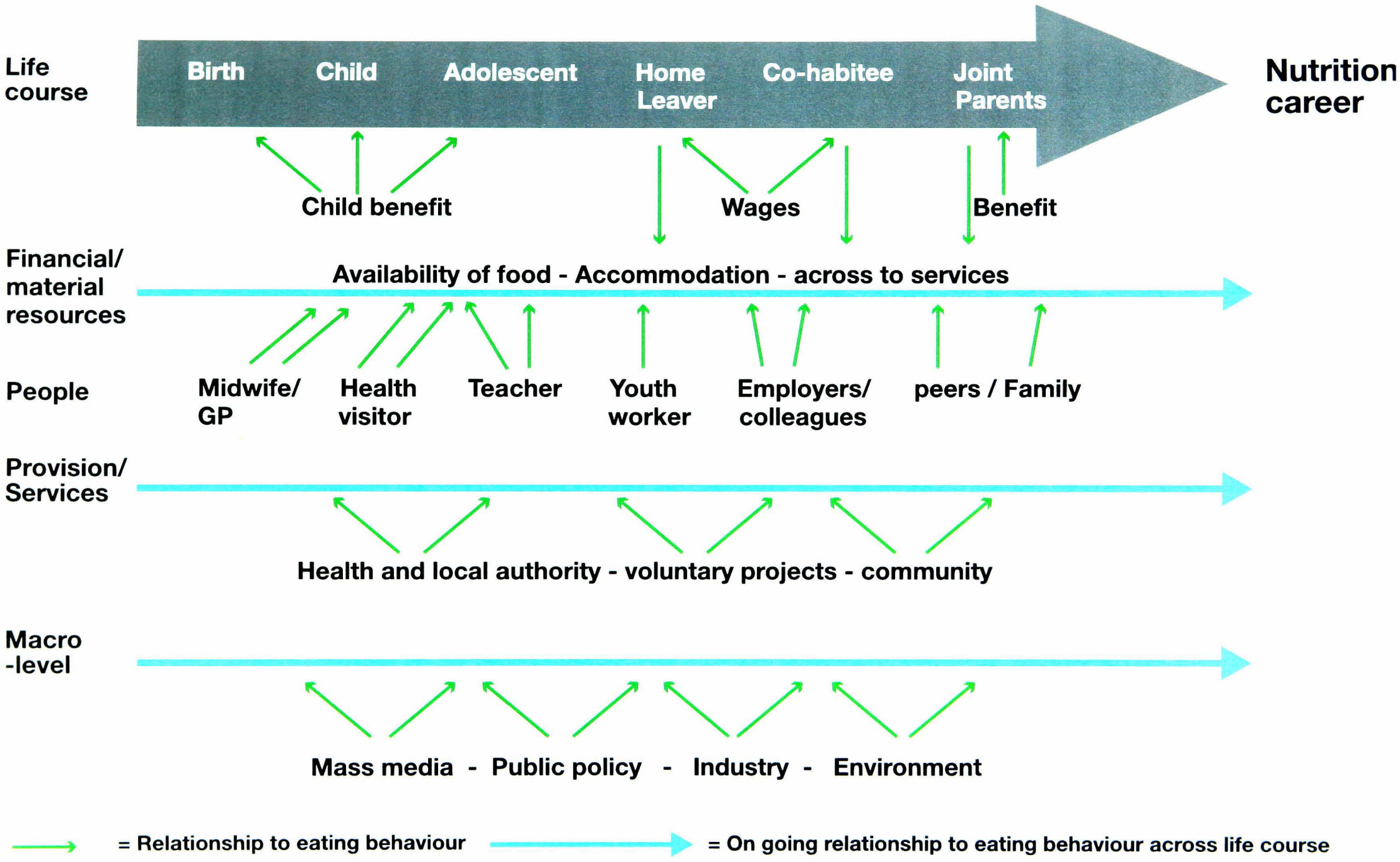
- members of the primary health care team
- local community and voluntary/community workers.

There are services which can be influential, such as:

- health services including hospitals and clinics
- local authority services including housing, education, social services and environmental health.
- the mass media
- public policy, which is concerned with governmental departments such as the Department of Health, Department of Social Security, Department of the Environment, Food and Rural Affairs and the Department for Education and Employment
- commercial industry
- the wider environment

There are a multitude of other influences, some of the most relevant of which are included in Figure Three. Some respondents identified many of these external influences, particularly those described as 'organised', whereas others did not report any such outside influences, which were particularly the 'rushed' families.

Figure Five: Influences from outside the family on life course using the nutrition career



A potential drawback of using the nutrition career as a tool to map significant changes across the life course is the way it could be perceived as concentrating on lifestyle issues. It provides the framework for examining what individual people or families actually eat at different stages of their lives. This has the potential for victim blaming, wherein individuals are seen as being responsible for their own health. If they choose not to eat well or live a healthy lifestyle, then, it is argued, they have only themselves to blame for ill health. However, in this study, the nutrition career was used to explore respondents attitudes to eating behaviour, and to set these in a context within which appropriate health promotion strategies could be identified, so as to take account of the many structural barriers and social factors faced by people living on low incomes.

The family culture as a core category

In the initial analysis of the findings, the life course was identified as a potential core category and the nutrition career provided a framework to explore this concept. Further analysis of the data revealed another potentially important category, which was labelled 'family culture'. The life course and family culture were found to be intimately linked. Many proponents of grounded theory are insistent that the focus of any study should be on only one core category (Glaser and Strauss 1967, Strauss and Corbin 1990). This study drew on the principles of grounded theory using an interpretivist approach. From this perspective, a less rigid approach to data analysis is recommended, wherein identifying one process alone may not reflect the multiple realities of people's lives, which may be affected by more than one core category (Charmaz 2000). Consequently, the concept of family culture is explored as a second core category. In this study different family cultures have been identified and described as 'quick and easy', 'rushed' and, on further analysis, 'organised'.

This classification of the 'quick and easy', the 'rushed' and the 'organised' families led to a review of the literature around culture and other studies which were found which reflected these differences (Prout 1996, Holland et al. 1996). A family's culture will mean

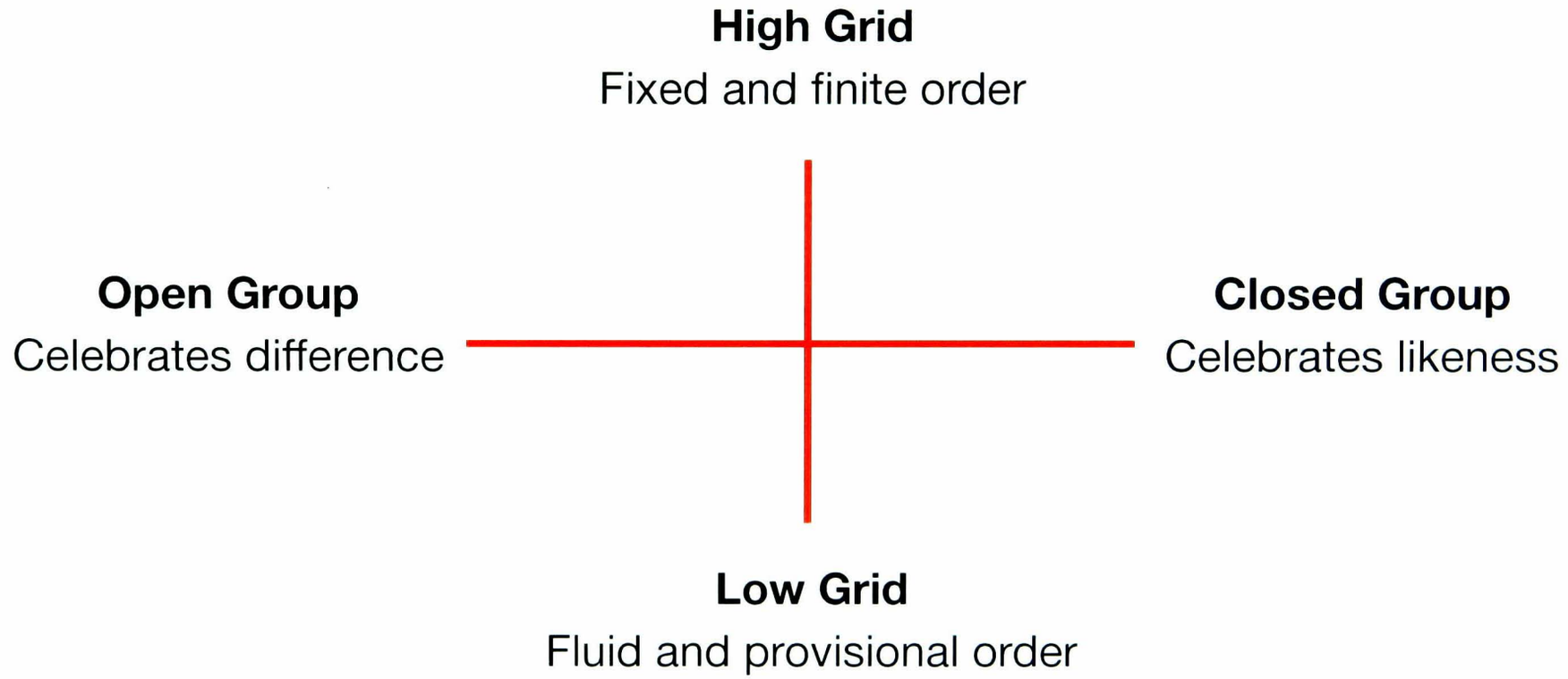
that families have a tendency to respond to events in a certain way and have particular views about eating behaviour, but that these are not rigid. Life changes can occur which may challenge a family's or individual's culture and bring about change.

Group-grid analysis of family culture

Understanding the particular culture a family may have can be aided by grid-group analysis, in particular by the two-by-two matrix (see Figure Six), of which one axis is 'grid' and the other is 'group' (Douglas 1992). 'Grid' refers to the extent to which that individual, or family, is constrained by the rules and restrictions imposed by the social environment in which the individual or family is situated. 'High grid' relates to a situation in which culture has a strong influence and where roles are fixed and rigid. 'Low grid' refers to a situation where order is provisional and fluid, where hierarchies are not defined and roles are negotiable and open to change. 'Group' refers to the extent to which people are connected to other people. 'Closed group' means that people are strongly bonded to their social group, which is well-defined and has many similarities. 'Open group' applies to those who are only loosely attached to the social group, with boundaries which are weaker, and individualism is commended.

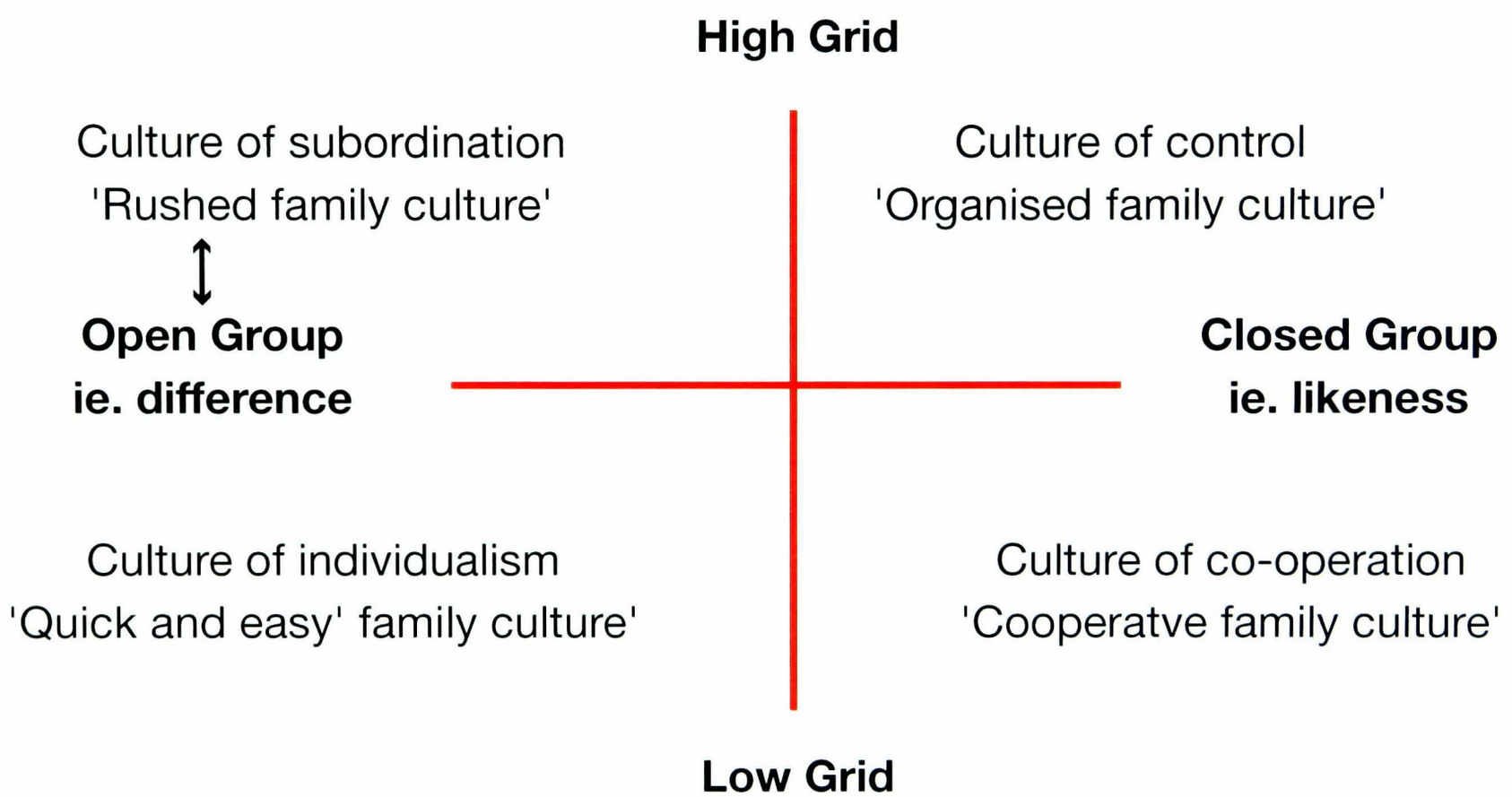
It is claimed that all social contexts and environments can be identified within this matrix (Douglas 1992). The position of a family within this framework will reflect and shape attitudes, behaviour, beliefs, tastes, desires and motives, though families may change their position according to changing circumstance. Beattie (1993) identifies the situation of high grid and group, as a 'culture of subordination' (see Figure Seven). Within this culture certain family members will consider themselves superior to others and have authority over them, will have rigid views, and members are expected to conform to the rules laid down within the family. Consultation and negotiation in this setting is limited and decisions are made unilaterally, usually by a parent, based on his or her own views.

Figure Six: Two-by-two matrix of cultural analysis



Adapted from Black (1992)

Figure Seven: Four main types of cultural bias



↕ Key: 'Rushed family culture' veers between culture of subordination and individualism

Adapted from Prout (1996)

A family with an open group and low grid culture will have little structure and little control. This is described as a 'culture of individualism'. All family members will be encouraged to make their own choices, and be responsible for them. There will be open negotiation, though self-interest and personal autonomy is promoted. These families will be open to all kinds of influence on their behaviour, and will be likely to try many different things. Personal preference will be the major reason for eating certain types of food, which will have little reference to health.

A 'culture of control' exists when there is a culture of high grid, closed group. Such families will be structured and behaviour will be determined by the adults, leaving limited opportunity for children to negotiate. Choices will be made by the parent or parents and children are expected to be loyal to their parents' views, which are likely to be based on authoritative sources. Consequently, parents will value health information coming from a source they consider appropriate, such as health workers, leaflets and the media.

The fourth quadrant of the matrix represents the culture of 'co-operation'. These families recognise that situations are ever-changing and that they need to be open to other ideas. These families may be interested in alternative views of health and may explore complementary and alternative therapies. Parents are interested in helping children come to their own conclusion, in a spirit of co-operation. Honesty and truth are valued, as well as empathy. The families identify themselves as part of a community and so are likely to be involved in community groups and in looking at solving problems from a community perspective. There is likely to be an interest in environmental issues. Such families may well be vegetarian and use organic foods when possible.

Prout (1996) used Beattie's (1993) framework described above as the theoretical basis of his study of the culture of 12 families. He identified two patterns of culture, that of 'individualism' and that of 'control', though he noted that a larger study may uncover other patterns. In families with a control culture, the 'closed group' aspect was expressed in the

lack of contact with other families. Their social networks were limited, and those friends and family to whom they were close shared a similar outlook to themselves, as the result of positive selection. They were concerned about preventing outside, 'undesirable' influences affecting the children. Children were expected to conform to the parents' views and guidance. The 'high grid' element was manifest in the way they accepted health messages and strove to abide by them. There was an emphasis on self-control.

The culture of 'quick and easy' families

In the 'quick and easy' group, families appeared to be quite happy with their eating behaviour, and ate accordingly because convenience food was perceived as quick and easy to prepare, particularly if different members of the family ate different foods. This state of affairs can often be different from the way people were brought up, and may change over time.

Half of the families were classified as 'quick and easy' and equated with Beatties's culture of individualism (1993). Children chose what they wanted to eat and often family members ate different meals. They were concerned with enjoyment and had a somewhat fatalistic attitude to health, wherein food and health bore little relation to each other. Furthermore there was the view that if food was not specifically requested, it might not be eaten, and this was considered a waste of money. They may all eat at different times, but the commonest pattern was for the children to eat on return from school, and the parents to eat later. Convenience food was predominantly used, particularly frozen foods.

The culture of 'rushed' families

The families described as 'rushed' used convenience foods, but were less systematic about mealtimes. Snacks, such as crisps and chocolate biscuits might be substituted for a meal. These families were more likely to describe their children as fussy eaters. Food refusal is often seen as a way gaining attention (Parry and Jowett 2001), which could be used if the parents were constantly busy and trying to catch up with chores.

The 'rushed' families did not fit into the grid-group classification quite so easily. Their culture seemed to veer between subordination and individualism. Because these families felt they were always short of time and money, family members were fed whatever was to hand. Children often had little control over what they ate, so in this sense the parent was in charge and dictated what would be eaten. This equates to a culture of subordination. The choice of food for the children was rigid and about filling people up, using food as fodder, rather than being concerned with what was healthy. Although the parents did not necessarily consider themselves as being superior, there was no room for negotiation. However, there were aspects of the culture of individualism, in that when food was purchased, it was in the knowledge that the family would eat it. Choice was not always ruled out at the time of purchase and, when possible, family members were given choices as to what they ate.

The culture of 'organised' families

The third group was labelled 'organised'. These families tended to cook meals from raw ingredients, using little convenience food. They were the most likely to sit around a table and eat the same food together. They tended to be more interested in food and were more aware of the benefits of a good diet on health.

The 'organised' families most closely fit into the control group as discussed by Beattie (1993). Decisions were made according to what was considered healthy, although this was not always rigidly adhered to. Couples tended to discuss between themselves what to eat and expected the children to accept this. One family wrote a weekly menu, so every one knew what their meals would be and the father would shop around for the cheapest ingredients. This was linked to providing nutritious meals on a budget and was in contrast to the 'quick and easy' and 'rushed' families. These two groups gave lack of financial resources as a major reason for not eating 'proper' food, as they perceived it to be cheaper to provide meals of convenience foods. In contrast the 'organised' families considered it cheaper to cook from raw ingredients and all eat the same meal, so emphasising the importance of conformity.

The culture of 'co-operative' families

On further analysis, using the cultural matrix, it emerged that two of the families initially categorised as organised, could be classified as 'co-operative' rather than 'controlled'. One couple was vegetarian. They had stopped eating meat for predominantly ideological reasons, although health had been a concern, due to such issues as BSE and animals being fed antibiotics. They ate no processed food, with everything being cooked from raw ingredients. They had an allotment and were expecting to harvest their own grown organic vegetables shortly. The children were happy to eat the same diet, and they sat down as a family together to eat. They could be described as 'co-operative' because negotiation was always considered appropriate about eating behaviour. They were concerned with the wider environment and the effects it had on food. The other family which had a co-operative approach focused on their wide network of friends and families. Their emphasis was on the importance of eating what they enjoyed together and welcomed people to share food with them at all times. They were very much a part of the community in which they lived.

Changing family culture across the life course

Analysis of the life course and the concept of the family culture showed that many couples reported having been brought up on a different regime to the one they now maintained. In some cases, they had grown up in a family that could be described as 'quick and easy', that is a culture of individualism, but were bringing their own children up as an 'organised' family, with a culture of control. More frequently, however, the change had been in the other direction. Many respondents grew up in a family with a control or subordination culture, but now feed their children on the food the children themselves want. These changes need to be set in the context of societal change, wherein convenience food is now more widely available. However, on re-examination of the data, it was clear that some individuals grew up in a family where an adult, usually the man, was in charge of the household. These men dictated to their partners what was to be eaten.

Often a weekly menu was adhered to, with certain foods eaten on certain days. It is not possible from the data to obtain any information about the reasons for this set menu, but it did seem to relate to the community culture in the sense that it was a generally accepted way of eating. It could be an echo of older traditions such as Monday meals being a stew made of the remains of Sunday's joint or eating fish on a Friday for religious reasons. Health was not mentioned, but 'proper dinners' were expected to be provided and there was a further expectation that 'proper' food was 'good' for one. Several respondents referred to the male head of household expecting his dinner to be on the table when he came in from work and there would be 'trouble' if it was not. This reflects historical working class culture and the view of the man as breadwinner and head of the household (Skelton 1988, Dignan 1999). It reflects a culture of domestic subordination, as identified by Prout (1996).

The grid-group classification is not a rigid framework for exploring culture, and families and individuals may fall into different categories at different times, according to circumstance, as would be expected from the analysis of the life course. The different cultures described are not fixed and people or groups may be more or less typical of each situation described. For example, a family may fit the label of 'individualist', allowing everyone to choose whatever they want to eat and when they eat, being quite happy with that arrangement. Another family may have a similar outlook, but have to compromise, because of cost or time, ending up in the 'rushed' category, when they would prefer to offer choices all the time. This could happen in a number of ways, as described below.

In some families, for example, couples reported a wish to eat together and eat the same food, but were prevented from doing so, because they could not afford to waste any food which was not eaten. They consequently provided food they knew that each family member would eat, and so, although ideologically were more biased toward a culture of control, financial constraints meant they behaved in an individualistic manner. The opposite was the case in other families. They reported that they would like to be able to allow all family members to eat as they wished, but found they could not afford to do so, so they all ate the same: an individualist ideology but a control culture behaviour. This

reflects the dichotomy between the ideal and the practice identified earlier. In one family, the parents each had a different culture. The father usually cooked for the family, and the culture of control predominated, whereas if he was out, the mother would prepare food the children wanted, which the father called 'rubbish'.

Changes in the life course often substantially affect the family culture. For example, a person may grow up in a family culture of subordination, wherein the father is the head of the household and makes all decisions. When that individual moves into adolescence and then away from the family, a culture of individualism prevails, and he or she eats as and when choice dictates. As the person cohabits and has a family, he or she feels it to be important that the family eats together and attempts to provide healthy foods. The family culture becomes one of control. This could well change, as the life course develops, for example, as the children leave home, the culture may revert to individualism, because there is no longer the perceived need for the same structure around eating.

Different families had different outlooks on life, had different moral and political positions, and often were quite fluid in their movements from one viewpoint to another, according to circumstance. The aim of interpretivist research is to try to understand a person's experience from his or her own perspective. In the following section the interplay between the concepts of the life course and the family culture will be explored.

The Life Course and Family Culture model (LCFC model)

It has been shown how the family culture changes over the life course, according to the stage an individual or family is at and the circumstances in which they find themselves. It is an interactive process which is negotiated between family members, even if women do a disproportionate amount of work around food and eating and men have the greater influence.

Using the nutrition career framework, the influences internal and external to the family across the life course were explored and are represented in Figures Four and Five. A

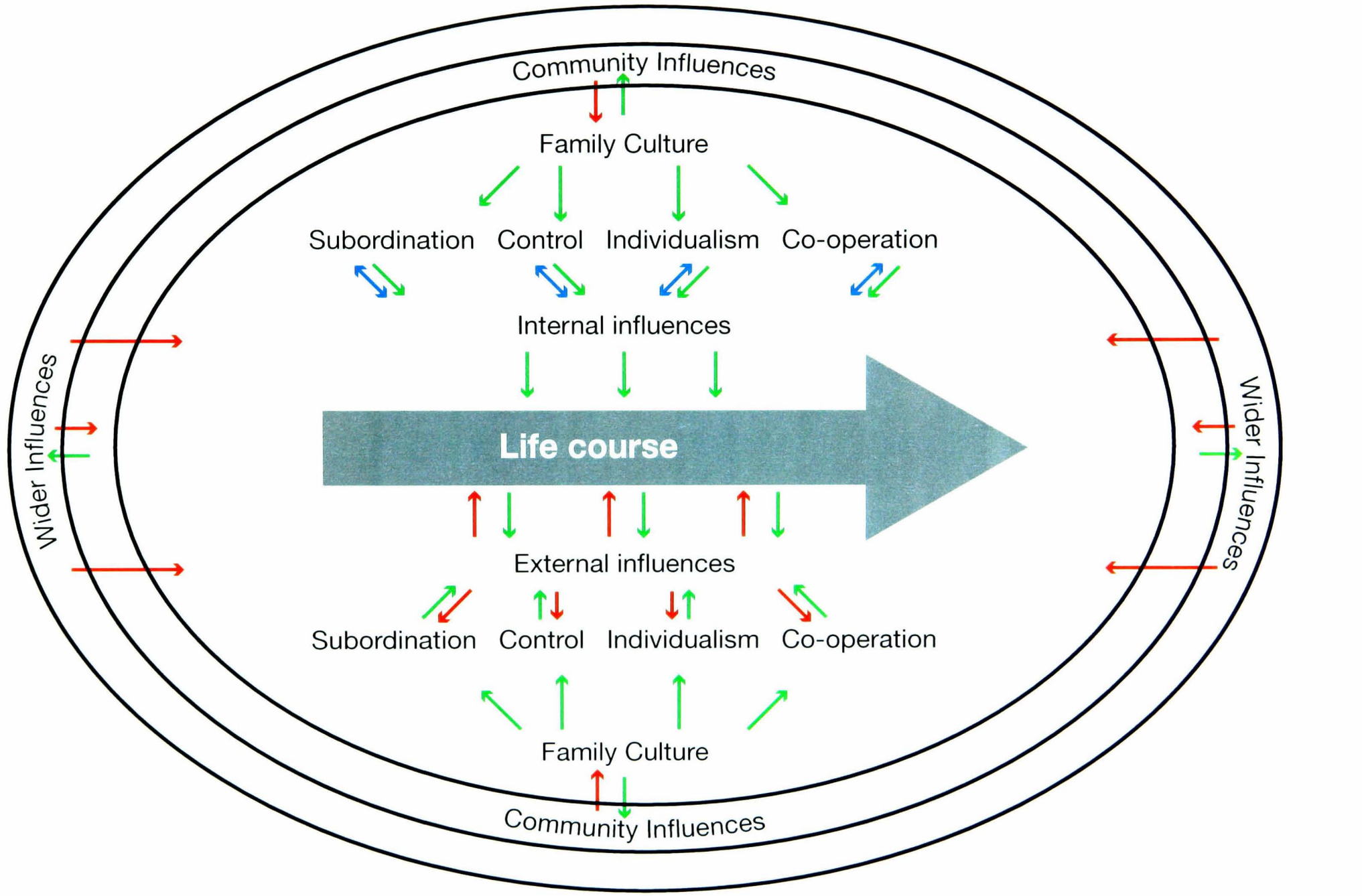
simplified version of this model lies at the centre of the diagram in Figure Eight, which has been developed to include family culture and has been named the 'Life Course and Family Culture' (LCFC) Model.

The influences on eating behaviour from within the family affect the life course and are then in themselves shaped by the type of family culture, be it one of subordination, control, individualism or co-operation. This is a two way process, with negotiation about eating behaviour taking place within the family, which will affect both the family culture and the stage of the life course, as indicated by two way arrows (coloured blue in Figure Eight). However, the family culture is likely to have a powerful effect on the influences on eating behaviour, as indicated by the green arrow between the family culture and the internal influences. This is because although men, women and children all shape eating behaviour to a greater or lesser extent, they live together as a household and function within their particular family culture.

Other influences on eating behaviour from within the family also affect and are affected by the family culture. For example, a parent may attend a cookery skills course and find that he or she feels more confident to cook meals that the whole family enjoy and move from a culture of individualism to one of control, wherein all household members start eating together. Alternatively, a family member may obtain paid employment and due to lack of time move from a culture of control to one that is veering between subordination and individualism, that is 'rushed' because of lack of time.

In Figure Eight, family culture is depicted as encapsulating the life course, in terms of it being a wider sphere of influence on the individual. A still wider sphere of influence includes those identified in Figure Five, such as the community and services provided. Beyond that are the mass media, public policy, industry and the environment.

Figure Eight: The Life Course and Family Culture model



Relationship to eating behaviour

Strong relationship to eating behaviour

Negotiation about eating behaviour

From the responses of many of the couples interviewed, the data suggests that the influences outside the family on eating behaviour, such as finance or material resources, can have a powerful affect on how people experience their life course. For example, attending a local health project may provide a parent with the confidence and skills to get paid employment, which may have a profound affect on their life course, such as deciding the family finances were sufficient to have more children. Similarly, such external influences will affect how the family culture develops. In the previous example, gaining paid employment may mean that the family has to take on a culture of control, in order for the family to eat within a more limited time-scale. The literature review identified the overwhelming effects that structural factors, such as poverty, lack of education, poor housing and the environment have on health and health related behaviours. In Figure Eight this is represented by the red arrows, indicating these powerful influences along the life course. However, to a much lesser extent individuals do shape some of the external factors. For example, if an individual gets involved in community action, such as campaigning to save local amenities, difficulties in access to services may be identified and subsequently improved.

The family, with it's own culture, is not set in isolation. It is set in an ever widening sphere of influential settings, as represented in Figure Eight. The setting closest to the family culture is usually the local community. A family with little involvement in the community may be influenced minimally by its environment. Those involved within their community may be heavily influenced, possibly to the extent to which they behave according to group pressure rather than according to their own belief systems. Others may not only be deeply involved in their community, but be influential within it, so affecting the eating behaviour of others. This is represented in Figure Eight by arrows pointing in both directions between the family culture and community influences. It is an interactive process, which is dynamic and ever changing.

Just as the family lives within the setting of the community, so the community is placed within a wider context. Local service provision, such as the local authority and health authority affect the family culture and life course, as discussed earlier. With regard to

food, for example, the availability of dieticians, the provision of housing which has local food shops or the provision of healthy school meals are potentially significant. At the widest level of public policy, industry and the like profoundly affect the community, the family and the individual. However, at all these levels, there is some possibility of the influence working the other way, for example, community groups campaigning for improved services, or pressure groups lobbying the government for changes in policy. Thus, in Figure Eight, the strong influence of these wider influences is represented by red arrows directed towards families and communities with a green arrow from the community indicating some influence from there to the wider public sphere.

Contribution of the LCFC model to the Knoledge Base

The development of the LCFC model has amalgamated two separate models in a way which provides a unique understanding of the ways families on low incomes acquire different styles of eating behaviour. It allows for family changes over across the life course and provides some understanding as to how differences may change according to the family culture, again, which changes over the life course and is itself intimately bound up with the changes that occur according to life changes. The model developed has provided a possible way of obtaining this information in a useful way to develop the most appropriate methods of promoting health. It identifies the diversity of communities within a small area of a deprived estate, which generally is approached from a view that all low income families in a small estate are homogenous. Families are diverse and this needs to be taken account of if there is any chance of promoting healthy eating. Some of the literature does refer to identifying individual family's eating behaviour (e.g. Charles and Kerr 1983 a, b; Prout 1996). However, this study has used the principles of community development to develop how the model could be developed to use within small communities and so allow a closely identified analysis of the eating habits. The limitations of the study did not allow the LFCF model to be developed in practice, but the possibilities of its use in field work practice is discussed below.

Developing the 'Lfe Course and Family Culture' Model for use in health promotion

The 'Life Course and Family Culture' (LCFC) Model has the potential to be used in numerous ways, such as a tool for assessment, planning and evaluation of individual or family eating behaviour.

The Life Course and Family Culture Model as a tool for assessment of health promotion activities

Analysis of the findings showed a dynamic relationship between the life course and the family culture, in a two way interactive process. In order for health promotion interventions to be appropriate and effective at changing specific behaviours of families, such as eating behaviour, attention needs to be paid to both the stage of life course that an individual is at and the type of culture that each individual or family adopts in terms of understanding the diverse needs within seemingly homogenous groups.

Careful assessment of a family's needs regarding food and eating behaviour is required in order to plan the most suitable health promotion interventions for that particular family. However, an assessment of the wider context within which the family is living is of particular use, because of the important impact of external factors on eating behaviour identified within this study. In the introduction to this thesis, a short statistical profile of the area under study was presented. This provided a basis for understanding some of these external influences, such as poor educational achievement, high levels of public housing and high rates of unemployment. Further valuable insights into the health needs of a community can be gained from talking to local people. However, care needs to be employed when taking account of different people's views. As found in this study, there were two opposing experiences of living in Teams, one being positive and the other negative.

Initially, any community health worker needs to gain an understanding of the health needs of the community as a whole. However, because of the diversity within communities, an individual or family assessment may be the next appropriate step in order to direct that individual or family towards the most suitable form of health

promotion activity. In terms of eating behaviour, the study identified that the stage of the life course was a major influence, particularly on co-habiting and when the children were able to make dietary choices, as was the family culture they adopted. It therefore seems appropriate that to promote healthy eating, assessment should focus on these areas. The LCFC model could be a useful framework for family assessment. This would not be a research tool as used in this research, but a practical tool for assessment, planning and evaluation for field workers.

Assessment of individuals or families can take a variety of forms, from the informal process that takes place during a group interaction to the formal process of a professional worker, like a health visitor, involved in a one-to-one interview. In practice, the way in which the LCFC model could be used would depend upon the worker and family involved. For a health visitor, who is working on a one-to-one basis with the family, it may be appropriate to formularise the model, so that specific questions are asked at a particular home visit. For example, at an ante-natal visit a routine questionnaire could be used for assessment and appropriate information subsequently given. A checklist or pro-forma could be used for such an assessment, such as the one in Appendix Eight, the LCFC assessment questionnaire. This would provide a framework within which to assess changes in eating behaviour over the life course, and to assess the family culture currently adopted. A community development worker could use the questionnaire as a tool for individuals to complete within groups to elicit views and promote discussion around eating behaviour.

The LCFC questionnaire would need to be developed and piloted, which could be done with a variety of local people. The ideal people to do this work would be those who have already been identified as fitting into a particular family culture in order to ensure trustworthiness of the questionnaire. For example, it would need to be confirmed that a family identified as 'organised' through in-depth interviews would be similarly identified using the questionnaire. The extent to which the questions should be open or closed would need to be determined, though it is likely that a mixture would be required. It might be useful to ask families to keep a food diary for the week prior to using the

assessment questionnaire to get a realistic picture of what is actually eaten, given that this research showed that on occasion respondents started the interview describing how they would like to eat, but went on to discuss how they actually ate, which was different.

It would be important to include a question about any changes the family would like to make to eating behaviour at the assessment stage, because a family may be quite happy with how they eat. For example, a family may have made a very positive decision to eat together, sitting round a table and not using convenience foods. Alternatively, a 'quick and easy' family may be satisfied that each member eats what they choose, because that suits the needs of the family and so they do not want to change their eating behaviour. From a community development perspective, it is important to work from where each family is comfortable and to the extent that people want to change.

Training is an important issue for workers with regard to how the findings from any assessment are analysed. It may be that for group work a different questionnaire is used compared to one for one-to-one work. The former might find it more useful to have a scoring system, which will identify where the family is on an LCFC scale, or perhaps an open questionnaire would elicit information which would then be useful as a basis for discussion.

Regardless of the assessment tool used, the aim, from a community development perspective, is to gain insight into where the individual or family is 'coming from'. It is about understanding the background of the individual or family concerned and the contexts within which they live their lives. In some ways, this is similar to the notion of audience segmentation, which is based on social marketing principles (Hastings and Haywood 1991). It is recognised that everyone is different, with the population being composed of people from different backgrounds, ages, social classes and so on. Consequently, they all have different needs. According to social marketing theory, the ideal way of promoting a product or idea is to market it to the unique needs of an individual. Because this is usually not practical, groups of those with similar needs are put together and the appropriate communication strategies are then focused on each

group. This may mean that it would be appropriate to promote healthy eating in one way to 'quick and easy' families who have just had a child and in a different way to 'organised' families who had just started co-habiting.

The Life Course and Family Culture questionnaire as a tool for planning health promotion activities

Planning health promotion activities is a further use of the LCFC questionnaire as a tool for planning health promotion activities. A hypothetical case study could be a 'quick and easy' couple living in Low Teams with a four year old and a two year old child. The mother is involved in group activities at the Family Centre and the father has interests outside the local community. By using the LCFC questionnaire within a group setting, it may be possible to explore why the family has adopted a 'quick and easy' approach, even though this family culture may not be to the satisfaction of the woman. It could be due to the physical circumstances of the house, in that there is not the space to eat together at a table. This may become an entrenched position, in that the male partner assumes a family culture in which the family does not eat together, even though the female partner would like to do otherwise. Use of the LCFC questionnaire within a group may uncover such differences and where they arise from. A consequence could be that the female partner suggests rearranging the living space in order to accommodate a table. This would require negotiation between the partners due to potential conflict over the use of the room and also the potential change in the family culture, moving from a 'quick and easy' style to a more 'organised' approach. Within a group setting, the LCFC model could be used to stimulate discussion and the questionnaire could be advanced as a positive tool in the exploration of such changes in a supportive environment.

A different scenario could be an 'organised' family which is assessed, using the LCFC questionnaire, by a community worker, wherein it becomes apparent that the family want to eat more organic produce. They are satisfied that they eat together and meals are produced from raw ingredients, but feel those ingredients could be healthier. This could be an opportunity for the worker to put the family in touch with the local allotment

society to acquire an allotment to grow their own food, grow organic food with others or develop an organic food co-operative. The family would then potentially move from having an 'organised' family culture to having a 'co-operative' family culture.

The first hypothetical case study suggests a situation wherein a group activity leads to changes within the individual family's eating behaviour. The second hypothetical case study identifies the importance of working with an individual or family using the assessment questionnaire, but then moving into a more community orientated field. Either way, the LCFC questionnaire offers a framework within which to explore these influences directly with families and individuals. It offers a systematic approach to strengthen community development work, because it provides a more focused approach to identifying the needs of households.

Health workers who work in communities, such as community development workers and health visitors, are in a prime position to work with families in this potentially intensive way. The LCFC questionnaire would primarily, though not exclusively, need to be used with individual households, in order to identify where on the grid-group matrix of family culture they are, and where they are within the continuum of the life course, given that it is likely that different strategies to promote healthy eating would be required according to the assessment. This approach would only be appropriate within a community development setting, where workers are focused on a small community, wherein understanding individual households would be feasible. For example, it would be impossible to go into such detail in a wider ranging public health promotion project because of the time commitment required. However, if health promotion workers are aiming to understand the finer nuances of what influences eating behaviour, then the LCFC questionnaire offers a way of doing so.

The Life Course and Family Culture questionnaire as a tool for evaluation

Evaluation is considered a vital element of any health promotion activity (e.g. Nutbeam et al. 1990, Tones and Tilford 2001). The LCFC questionnaire has been suggested as an

initial assessment tool, in order to provide guidance about the most appropriate health promotion intervention. It would provide a snapshot of family life for those couples interviewed but not a longitudinal picture of evolving culture. However, the questionnaire could be subsequently used to evaluate the effect of the health promotion intervention by measuring changes within the family over time. It could also be used to provide the family with feedback about changes in their eating behaviour.

The LCFC questionnaire was developed from an interpretivist perspective, which is concerned with gaining understanding from an individual's point of view. The use of the questionnaire as a form of evaluation for families and workers would be consistent with the principles of community development, as it would remain based on individual or families own perceptions of their eating behaviour and would relate to their own lives directly.

An example of how the questionnaire could be used as an evaluation tool would be subsequent to using it for assessment and planning health promotion interventions. The initial assessment may reveal a family culture which has changed from being one of control, that is, 'organised', before the couple had children to one of subordination/individualism, that is, 'rushed' after they had children. They may have cooked and eaten together when they first co-habited, but once they had children may have been unable to develop routines around mealtimes. An appropriate health promotion intervention might be to introduce them to a food co-operative, where they can buy cheap, fresh food locally, so saving time which can then be used for cooking from raw ingredients. Another option may be a cooking course, which focuses on producing quick and easy meals. The LCFC questionnaire could be repeated after, say, six months and should reveal any changes that have occurred as a consequence of the intervention. Repeating the questionnaire with the family would give an opportunity for feedback, so they could monitor changes themselves. This would provide a way of reinforcing positive changes in eating behaviour and allow for planning of future interventions if appropriate.

Application of the Life Course and Family Culture questionnaire to other health-related behaviours

Although the LCFC questionnaire has been developed in relation to eating behaviour, it could be applied to other areas of health-related behaviour, such as exercise, smoking or alcohol intake. All these behaviours are likely to change according to the life course and will be mediated by family culture, within the wider cultural context. A similar extension of the use of a particular model developed for a particular health behaviour, that is, smoking, and now used in a variety of health promotion strategies is the Stages of Change model as described by Prochaska and DiClemente (1984). The life course and family culture model is more analytical, in that it attempts to understand not just where a family is situated within the model, but also why. For example, with regards to eating behaviour, the model identifies both the changes that have occurred over time and within the present family culture of eating behaviour.

The same LCFC questionnaire could also be used to examine exercise. For example an individual may have exercised regularly before having children, but because the family culture had changed from being 'organised' to being 'rushed' after having children, exercise was considered too time consuming. The assessment questionnaire could be adapted to identify when individuals exercised in the past, what stopped them continuing and then offer an opportunity to develop a plan for developing future exercise, which would fit in with the family culture. This could be evaluated on a regular basis to ascertain how successful the exercise plan had been. A further use of the LCFC questionnaire could be to assess the whole family's exercise levels and develop a plan which involves all family members in activities, such as joining a cycling or walking group or becoming members of the local sports centre. This could have the advantage of facilitating their involvement in the local community.

The LCFC questionnaire may not have relevance to all aspects of public health promotion because much work is completed within a wider arena than the household. However, more locally focused work could inform the broader agenda of, for example,

mass media campaigns in order to enhance the audience segmentation described earlier, so that families with different family cultures at different life course stages are targeted in a more specific way. Furthermore, it could be developed so that it was a more integrated assessment tool in the future, to include other aspects of health promotion and not just eating behaviour.

Summary

This chapter has provided a discussion on the findings of the research study. Initially, the life course emerged as a core category, through using the nutrition career as a framework for exploring this concept. It was found that there were stages across the life course which were significant, in particular, growing up, adolescence, co-habiting and having children old enough to make choices about their food intake.

Family culture also emerged as a joint core category, within which other food choices were made. Families could be divided into 'quick and easy', 'rushed' or 'organised' culture. Following a review of the literature, it was found that this classification fitted into a two-by-two grid-group analysis. This equated with other research, which identified families with cultures of control, subordination, individualism and co-operation.

Recognising that family culture changes over the life course, a model of the relationship between the life course and the family culture was developed: the 'Life Course and Family Culture' model., which was found to be the unique contribution to the knowledge base. It was identified that this model could be used to assess a family, in order to find what health promotion intervention would be most appropriate, given a family's culture and stage of the life course. A potential questionnaire, the LCFC, for practical use was introduced, which could be used for assessment. It was identified that the same tool could be used for health promotion planning and evaluation. It was also recognised that the tool could be implemented with other health related behaviours.

The emergence of the LCFC model as a single mode of analysis reinforces the grounded theory principle of a single core category, despite the fact that during the course of this research this was questioned by the identification of life course and family culture as two separate categories.

The next chapter provides a reflection on the study in order to assess how the aim and objectives were achieved and the trustworthiness of the analysis, before looking at the implications for health promotion interventions and further research.

Chapter Nine

Reflections on the research

Introduction

This chapter consists of a reflection on the research study. It begins with a consideration of the study's aim and objectives to assess the extent to which they were achieved. The trustworthiness of the results is discussed and limitations of the study are identified. A number of recommendations for improving health promotion specifically in relation to opportunities for eating healthier food for low income families are suggested. This also applies more generally to other areas of health promotion. Finally, areas for further research are identified on the basis of the findings of the study.

Were the aim and objectives of the research achieved?

The overall aim of the research was 'To explore influences on eating behaviour in low income households with pre-school children'. From this aim three objectives were identified:

1. 'To investigate gender and family influences on eating behaviour in low income families with pre-school children'.
2. 'To explore parents' knowledge, attitudes and beliefs about the relationship between diet and health'.
3. 'To identify a framework for the promotion of healthy eating in low income families with pre-school children'.

The study design enabled all the objectives to be achieved. The use of interviews and focus groups allowed data to be collected which indicated the influences on eating behaviour, such as the male partner and the children, as well as cost and time. Couples'

perceptions of the relationship between diet and health were explored. Consideration of these influences and perceptions led to the 'Life Course and Family Culture' (LCFC) model being advanced as a theoretical basis for the interpretation of the data. This model provides a novel way of investigating diversity at a family or micro level, rather than at a community or macro level, even if that community covers a very small geographical area. The model was used to explore the potential for producing a questionnaire which could be used as a framework for assessing families and then planning and evaluating the health promotion interventions which would be most appropriate to them.

Trustworthiness of the results

The study was informed by an interpretivist paradigm. From this perspective, validity and reliability are not considered appropriate criteria to assess the analysis of the findings, because no claim is made about them being generalisable to other communities. The results are relevant to the particular area in which the research took place. Instead, trustworthiness of the analysis is sought. 'Triangulation, thick description and reflexivity' (Brody 1992, p. 177) were the major tools used to ensure trustworthiness of the analysis, as discussed in Chapter Three.

Triangulation

Interviews with couples and focus groups were used in order to view the findings from different perspectives. Similarities and dissimilarities between the different phases of the research were discussed in Chapters Four, Five and Six. Where there was agreement in responses between the phases, credibility was increased. On the other hand, where there were discrepancies, explanations were sought to account for these. This supports the credibility of the research process. In particular, Phase Three was developed as a negative case analysis, which involved identifying households which might refute the developing theory (Glaser and Strauss 1967, Lincoln and Guba 1985). The purpose of this phase was to identify if women, whose partners were excluded from being interviewed, were in any way different from the other couples who agreed to be interviewed.

To provide a context for the study, additional data sources were used, particularly with reference to the community profile in Chapter One. The profile was supplemented by the researcher's experience of working in the area, and was based on both epidemiological information and knowledge obtained from local residents, and on the community development work in which the Family Centre was involved. The additional data provided contextual information which was found to be important in understanding the setting within which the research took place.

Thick description

Data was collected, using the qualitative methods of semi-structured interviews and focus groups. The responses were recorded and transcribed verbatim in order to provide thick description. Other details were documented, such as personal information and setting. Context was also provided by the knowledge of the local area and by asking respondents explicitly about their own experiences of living in the area.

Reflexivity

The third tool included reflection on the research process itself. According to the interpretive paradigm, this is important because the researcher will affect the research process. This might be in terms of how the interviewees respond to the researcher and vice-versa, which could vary according to time, individual mood, setting and pre-conceptions of each other. Researchers are often uncomfortable about self-disclosure by the respondent in interviews and aim to maintain a distance, in order not to 'contaminate' the data, and maintain that the researcher is a separate entity to the researched (Atkinson and Shakespeare 1993). Interpretivist research rejects this claim, in that the researcher is interpreting the information obtained and can not do so in a vacuum. As Brechin (1993) states:

> 'realities are created through negotiated meanings rather than through objective measurement' (p. 72)

Field notes were taken by the researcher on a daily basis. These included comments about the respondents and how they engaged in the interview or group. They also included

comments about the researcher's experience of conducting the interview. Some responses were expressive of the difficulty of obtaining the sample in Phase One.

> 'Tuesday: Six visits...no-one in...snow'

Others were quite poignant.

> 'Talked to R for $1^1/_2$ hours about her childhood...she was her mother's [actually her sister's] second daughter, has had anorexia severely, 8 pregnancies [stillbirth at sixteen]...turned the tape off to talk further'

All the respondents in this study were aware that the researcher had worked locally as a health visitor and community development worker. A clear decision was made before the fieldwork commenced about responding to requests for help, support or advice. In the case described above, the researcher allowed the respondent to talk and used listening and communication skills to provide support. The respondent was asked whether she wanted more help and was given names of people she could contact if she wished to discuss issues further or to obtain more support. Consideration of such ethical issues was important throughout the research in order to avoid exploiting or disempowering respondents.

Grounded theory, interpretivism and community development

Three areas of analysis and potential practice have been drawn on within this study, each of which has been useful in the understanding of both the approach and the research: grounded theory, interpretivism and community development. Each have their own offering in the understanding of any piece of qualitative research (Clarke and Pearson, undated).

As discussed earlier, the first paradigm which the researcher engaged with was the interpretivist perspective. This was because the mode of study identified appeared to be appropriate to this philosophical approach and that the research methods were coherent with the aim of the research. It was consistent with the qualitative nature of the research, which was concerned with understanding individual's and couple's own views of the

world, accepting that these may change according to the setting and time of data collection.

The use of the principles of grounded theory were found to be useful in terms of understanding themes, which led to the identification of categories (Glaser and Straus 1967). Grounded theory was an invaluable tool in dealing with the masses of data which needed to be analysed. An interpretive approach to this perspective was adopted, wherein a single core category was identified initially, but a further category was found to be important in the analysis. Instead of Glaser and Strauss' (1967) insistence on finding a single core category, a more flexible approach allowed two main categories to be developed which could then be developed into a single model. (Charnaz 2000).

Finally, the principles of community development were employed throughout the research on a more practical level. This was because, at least in part, the researcher was a community development worker. It is an approach which again is interested in diversity and understanding respondents' different values and differing viewpoints. Although the researcher started the research from this perspective, interpretivism provided a wider philosophical basis for the research. Grounded theory principles fitted with both these perspectives, particularly where analysis was concerned. Community development was then used as a basis for developing the potential applications of the final model.

The Role of the Pracitioner/Researcher

A further aspect of reflexivity includes an awareness of the researcher also being a practitioner. It has already been referred to that any researcher must be aware of any potential prejudices in order to put them aside for the fieldwork and analysis of the research, knowing that it is sometimes an impossibility. In such a case, prejudices need to be acknowledged with honesty and openness, in order for anyone reading a report of the findings can take account of this. This is similar to the problem of health promotion discussed in the previous chapter. We all have some agenda and this should be made explicit (Seedhouse 1997).

It is equally important that the researcher/practitioner is aware of the respondents themselves. Researchers can be in a situation which potentially exploits the respondents. For example, if the subject is aware of the researcher's professional status. This could lead to the former giving the responses he or she thinks is wanted, to ensure they continue to obtain health services. They may also consider the researcher/practitioner to be an 'expert', which may not fit in with our view of trying to redress inequalities (Atkinson and Shakespeare 1993). As a practitioner and researcher from an interpretivist perspective the aim is to reduce inequalities, in order to empower people to develop their own skills and confidence. This can be difficult if the respondent is expecting advice or counseling. Again, openness and honesty is important in identifying the interviewer's role.

A further aspect of the 'insider' role of practitioner/researcher is that he or she is likely to get more information as they may be known by local people. Alternatively, less information may be provided because respondents are conscious of giving too much information, which may then be passed on to other professionals to their own detriment. Assertions of confidentiality need to be followed as closely as possible, with full knowledge that there may be some responses that need acting on, such as child abuse. However, the alternative is that the respondents know the practitioner and feel comfortable to talk about difficult subjects because of trust that has developed with the researcher as a practitioner.

The implications of being a practitioner/researcher need to be explored carefully before any research study is undertaken. Before the study began, the researcher discussed issues of confidentiality and possible exploitation with the supervisors. The key to this examination of the aims and objectives must be in presenting the study with honesty and openness, ensuring that the respondents are clear about the research and that an interview can be terminated at any point. Informed consent is an important tool to use to make this process explicit, as was done in the present study.

To ensure the appropriateness of reflexivity, interviews and topics arising from them were discussed in detail with the supervisors of the research study. A more experienced practitioner was appointed to support the researcher if any problems arose during the research. In the event, this was not needed as any practice problems that arose, the researcher was able to negotiate with the respondent as to what further services were appropriate and they were referred accordingly.

Findings from Phase Four

The interviews were conducted in the couple's homes using the interview schedule developed within the framework of the nutrition career for Phase Three (see Appendix Seven). The interviews lasted for between one hour and one hour and three quarters, with both the male and female partners being present for all or most of the interview.

As in previous phases, in quotation the interviewer is identified (I) and respondents (M: male, F: female) by initials.

Core category. Life course: Influences affecting eating behaviour over the life course

During analysis of the data from the couples in Phase One, it became apparent that the life course was a possible core category. It became clear that the stages of the life course were of great importance in the way people's eating behaviour was mediated. Respondents recognised how this had changed since they were growing up and going through adolescence and leaving home. Co-habitation seemed to be a particularly significant event in terms of eating behaviour, as did having children, once they were old enough to express opinions and accept or refuse food. The focus groups had confirmed that the life course was a suitable concept to explore as a potential core category, but the women only interviews appeared to deny the life course as an appropriate category. As discussed earlier, such mismatch of findings is acceptable from an interpretivist perspective.

Growing up

In Phase Four of the research, the concept of the life course was found to be more pronounced than in other phases. It may have been due to the more focused questions asked using the nutrition career as a framework. However, the same schedule was used in Phase Three and the responses did not confirm the core category of the life course. It can be assumed that if the life course was not relevant to couples in Phase Four, it would have become apparent, and would be rejected as a core category. Likewise, there is no reason to assume the couples in this last phase of the research were not expressing their own awareness of their experiences, which confirmed the importance of the life course.

Couples were asked what kind of things they ate when they were growing up. The predominant response was 'dinners', that is, meat and two vegetables, or 'cooked food', which seemed to mean that it was not ready cooked food from the freezer or bakery.

> 'F: Seven days a week we used to have a dinner'

> 'M: She [mother] used to make all her own soups, pies, everything… she still does'

> 'M: Loads and loads of dinners when I was at my mother's…dinners…salads'

> 'F: Never chips or anything like that…it was always vegetables and meat'

Several individuals seemed quite nostalgic about their mother's (predominantly) home cooked meals, with the implication that such food was superior to what they presently ate or to quickly cooked, convenience food. Many respondents reported to eating other foods, but gave these other foods less importance to 'dinners'.

> 'F: Well, we had occasions when it was quickly prepared…if it was something like fish fingers…but normally it was all cooked'

Most people thought such food was healthier.

> 'F: Make a pan of soup…that would be good for you…good for the bairn [child]'

Only a few considered the food they had eaten when growing up was unhealthy.

> 'M: When I was growing up…all the wrong things…it's all the things that …that to me…I find that most people that were born in the fifties… late fifties…were brought on the same thing… mince…mince and dumplings and things like that…all the fatty stuff'

This was someone who had considered himself overweight and had subsequently started watching his diet and weight training and so was very knowledgeable about food.

Several individuals talked about meal routines.

> 'F: I can tell you what I used to have… I remember on a Monday we used to have, egg, chips and beans… on a Tuesday we used to have shepherd's pie…on a Wednesday we used to have mince and dumplings….on a Thursday we used to have pies and peas, because my Grandad used to come and that's what he used to have and everybody ate the same meals sort of thing …we always had a pudding as well'

> 'M: Set days for set stuff…Monday you have a dinner…on a Tuesday you have chips...on a Wednesday you have a dinner…on a Thursday you have a dinner…on a Friday you have a fry up…on a Saturday you have chips and on a Sunday you have a dinner'

Some couples talked about eating 'junk' food as they grew up, but most referred to eating home cooked dinners. Thoughts about the relative healthiness of the food they ate now when compared to food as they were growing up were mixed. Some couples thought they ate more adventurously, whereas others felt they ate more convenience foods now. Most couples recognised that once the children were old enough to make choices about eating, changes to the adults' diet occurred. Many of the respondents who now allowed their children to make their own choices with regard to eating commented that this was not the way they had been brought up. They had no choice when they were children. Food was provided and they were expected to eat it. So some not only described different foods they ate as they were growing up, but also commented on the different parenting styles.

> 'M: Oh yes... like I was brought up not to back answer, be cheeky... lippy or anything like that...I used to get wrong and my mother used to say 'right, well you're staying in'...she knew that's all... cause I hated staying in...I used to say 'Ah, let me out mam'... but she wouldn't'

A minority of respondents described their bizarre childhood eating habits.

> 'F: Mashed tattie with smarties in it…mashed peas, marmalade and egg sandwiches'

Another woman gave an account of her 'funny' eating as a child.

> 'F: Jam and bread…I lived on jam and bread
> I: That was because that's what you chose to eat?
> F: Yes
> I: But your mam was actually cooking…did the rest of the family eat?
> F: Oh yes…they love all their food…my two brothers can't get enough of their food'

These respondents seemed to have had the opportunity of eating a 'proper' meal, but were allowed to eat what they chose in a similar way to the focus group women. In most households, however, meals were cooked from basic ingredients. This may be due to fast, convenience foods being unavailable at that time.

Adolescence

Many respondents described changing their eating habits when they became teenagers. Predominantly they talked about eating chips, particularly from the fish and chip shop.

> 'F: I used to be out most of the time…you know what I mean…
> I used to eat food from outside…chips from the chip shop'
>
> 'F: We never went into sandwich shops…just go to the chippy every day'

This confirms previous research (Lupton 1996, Caplan et al. 1998) which suggests that adolescence is a time of rebellion. Teenagers are generally aware that fatty foods are unhealthy and seem to choose such foods as a way of asserting their own individuality. There is also teenage culture, which tends to involve 'hanging around' with their friends, away from home and school, which are perceived as institutes of authority (Seymour and Dean 1997). However, this is also a time of self-consciousness, particularly for young women. Concern for body size is common and can lead to eating disorders. Two women described being hospitalised for anorexia when they were teenagers.

> 'F: …I was quite big and I didn't eat for about a year…I ended up in hospital …I ate like…I would eat fruit but that's all I dared eat…fruit and drink water'

Leaving home/living alone

Many couples moved straight from the parental home into a co-habiting relationship and had no experience of living alone. Those who had lived alone principally talked about 'not being bothered' or eating 'rubbish'.

> 'F: I hardly ate on my own…I don't know…I just couldn't eat by myself…I just wasn't bothered about anything'

> 'F: …when I was on my own I didn't eat…very very rare I'd have something to eat'

Take-away meals and pub snacks were mentioned by a few men.

> 'M: …I used to have a pub meal, you know…or have a Chinese…a Chinese or fish and chips or something like that…it was pointless going in the house and, say, doing a couple of tatties, making just enough Yorkshire pudding and, like, a small piece of meat'

> 'M: …a pub lunch of pizza, chips and a pint of beer'

Getting together as a couple

Most couples described a change in eating habits when they began to co-habit, though several could not remember whether or not there had been a change. Some thought their diet was more healthy in consequence.

> 'M: It's really since I met L [partner] and her family…'cause her family's really health conscious and things…and her brother-in-law…he's told me what to eat…the good things to eat and things'

> 'M: A big difference I did find moving in with you [partner]…I found that my parents…especially my mam overcooked all her vegetables considerably…totally overcooked…too much salt…I stopped using salt'

These couples were more likely to talk about eating new foods when they got together. For example, they talked about eating pasta and rice dishes, which they had not eaten when growing up.

> 'F: when I met G [partner] and I changed my attitude to food and I wouldn't dream of eating chilli con carne…I wouldn't dream of eating tuna… and G said try this and try that'

Others talked of not bothering to cook until they co-habited.

> 'F: Well...he moved [in with] me and that's when I started cooking

...cause...like for him and me...but I wouldn't cook just for me'

One woman described how when her partner moved in, he would have fads about certain foods. She would buy and cook whatever his latest craving was until he became fed up with it, and this process repeated itself.

The man or woman in the couple were both likely to introduce changes into the diet. However, it appeared that changes suggested by the woman would only be acted upon if the man approved. The woman was most likely to accept any changes her partner suggested, regardless of her own needs. One startling example of the power differentials in one relationship are evident in the following quote.

> 'F: G [partner] sent me a lovely letter and he said 'I will go out with you as long as you lose weight'...and I have still got the letter today...I will never forget it...I sewed my mouth up and stopped eating'

Many couples said their diet was now less healthy than when they were growing up. This seemed to be related to eating 'proper' food previously and eating convenience food now, such as frozen pizzas, fish fingers, and sausages. Some couples reported eating the same food as they ate when they were growing up. However, on closer examination, several of these couples having started talking about no change in diet, went on to describe differences.

> 'M: I was married when I was 17.
> I: And did what you ate change then?
> M: No...didn't change much...just the same...potatoes, chips, sausages... much the same...
> I: What about when you two [present partner] got together?
> M: Just about the same...it has always been the same
> I: How do you think it compares ...what you eat now to what you ate when you were growing up?
> M: It is probably pretty bad what I eat now...yes...it seemed healthier with all the potatoes and that'

It seemed that it was not something they had considered before. With further probing from the interviewer, they reflected on their eating habits and realised they had changed their diet.

Having children

When a woman gets pregnant, she is in contact with many health professionals: the general practitioner, midwives, health visitors. All pregnant women should receive nutritional advice, which is based on Ministry of Agricultural, Food and Fishing (now called the Department of Environment, Farming and Rural Affairs) guidelines (Health Education Authority 1997), along with more specialist advice about eating during pregnancy. During the present research, no-one mentioned obtaining information during pregnancy nor did they report having changed their diet.

Many couples talked about their eating habits changing when they had children, in that they went out less and had fewer takeaways, which echoed responses from earlier phases of the research.

> 'M: Definitely [changed diet]...especially before we had the kids because we used to go out drinking and it was, like, pizzas for our supper and things like that...whereas now we do not do that...we have a Chinese meal about every three months'

The change in diet was not particularly noticed until the children became old enough to make demands. Once this was the case, most parents allowed children to make their own choices. As discussed earlier, this situation was often in contrast to how they were brought up themselves. The main reason given was that food would otherwise be wasted. Families on low incomes could not afford such waste and most, though not all, found it to be more cost-effective to provide different meals to meet individual demands. Often, however, mothers (predominantly) found ways of making the preparation of different meals easier by producing 'mix and match' meals, for example three or four food types would be prepared and the children would pick the bits that they wanted.

> 'M: Yes [we eat]...at the same time...but just different meals'
>
> 'F: Someone might have some fish fingers... and chips and somebody might have salad sandwiches and chips and ...things like that'

Not only were children given choices, they also had a strong and direct influence on what was eaten, by refusing to eat certain things. Again, giving choices was related to the waste involved in children refusing to eat food.

> 'M: We've made all sorts

F: Everything like that and put it down and they just won't eat it
M: It just gets thrown away'

A few respondents were less accommodating.

'I: With the kids…do you let them choose what they want to eat?
M: Most of the time…but then a lot of the time it is 'you're getting what I'm making and you will eat it"

That children have an increasing influence on food choice is unsurprising, given the changing role of children within society. The change of perspective on how children are perceived has led to children's voices being heard in a way that was inconceivable fifty years ago. Consequently, a culture that is more accepting of children's views will produce children who are more vocal and influential. It is therefore not surprising that within many families, children are given more autonomy and opportunity to influence what they eat. However, the picture of children autonomously participating in decision-making within the family seems somewhat idealised. A reason given by many parents in the present study for cooking what children requested was because there was no point giving them what they did not want, as they would not eat it. This seemed more to do with the fear of waste, than a concern for autonomy, but could be a mixture of the two.

Category two. Routines: eating meals and snacks

Most of the couples interviewed in Phase Four did not eat with their children. This reflected the women in the focus group and in Phase Three, but contrasted with Phase One and the men's focus group. Only approximately a quarter of the families sat down together at the table and ate the same food. There were varying reasons given for this. For several families, house size was an issue. The kitchen was considered too small for a table which would accommodate the whole family, so only the children would eat in there. There was a common response when respondents were asked about where the family ate.

'F: We have to eat in front of the telly because we haven't a table'

'F: We've got to eat in here [living room] at the minute because we haven't got the kitchen done…we're waiting …we've got the table, but we want chairs now'

The most frequent approach to mealtimes, particularly the evening meal, was to feed the children first. The couple would eat together later, when the children were asleep. This would allow them to eat in peace without interruptions from the children.

The following extract from one interview expresses several of the above points.

'I: And do you all eat together?
M: We try
F: Most of the time, we try to
M: It's me mainly that's not... I'm the one that normally doesn't eat with you's
F: Yes...if he's like out...we try to wait but if not I like make the bairns... the bairn doesn't eat with us... most of the time...she does but I try to give her her's before we have ours so, so she's not...
M: So she's not greeding off us [child eating from parents' plate]
F: Greeding off us... or if like...I've got to sit and try and eat mine and feed her at the same time... I give her's beforehand.....
I: But the older one, you eat together?
F: But she eats in the kitchen and we eat in here
M: So will K [younger child] when she gets older
F: Oh yes...K will as well...We'd all eat in the kitchen if we had a table...but that kitchen's tiny and we haven't got a table
M: Definitely, definitely
F: We'd all eat together if we had a table
I: So do you all eat the same sort of things?
F: No
M: No
F: I have to make different meals...most meals I have to make different...'

Within this interview, the couple start by saying that they try to eat together, but quickly go on to give several reasons why, in reality, the child eats separately. Such reasons were because she eats off the adults' plates, the kitchen is too small and there is no table. They then say they would eat together if they could. The couple appear to contradict themselves, but it may well be more complicated. The couple seem to think they *should* eat together at a table, which is why they initially say they do. As they come to reflect on the reality of mealtimes, they recognise that this is not the case, even if they would like it to be. This view seems to express a dichotomy between the ideal and the practice.

The results from Phase Four of the research, which concerned changes in routine at weekends, closely mirrored those from Phase One of the study, as well as numerous other

studies (Murcott 1983b, Charles and Kerr 1988). Many couples did speak of eating less formally on Saturdays, such as going for a take-away or to McDonald's. Sunday dinner, however, was mentioned as a highlight in the week for most families. As in all phases of the research, it was overwhelmingly the most popular meal. It comprised meat, potatoes, a wide variety of vegetables, Yorkshire pudding and gravy. Most respondents referred not only to eating a variety of vegetables, but to eating large portions of vegetables. This appears to contrast with what families ate during the week, as many families reported they did not eat vegetables during the week, as identified in Chapter Four.

Only three couples did not have Sunday dinner, two of them because they could not get round to it.

> 'M: Sunday dinners are like a thing of the past'

Just one couple spoke negatively about it.

> 'M: I think most of the traditional foods is just awful…I cannot stand Sunday lunches. Everyone eats and feels sick immediately afterwards and spends the afternoon sleeping it off'

A few couples responded that they were more likely to go up to his or her 'mam and dad's' house for Sunday dinner, than cook at their own home. This was less common in this phase of the research than for the women in the focus group and in Phase Three. One reason given for visiting their parents was because the Sunday dinner was perceived as a family occasion, which indicates the strong social significance of this meal. It may be valued as the only time that the wider family to get together.

However in a few families, the male partner opted out of sharing the Sunday dinner with the rest of the family. Two women carried a plate of dinner home to him, from her mother's house

> 'M: She goes up for her dinner and she fetches mine down'

Whether this was to do with poor relationships between him and her family or that the man wanted time to himself was not clear. In a few households, men took time out on a Sunday to pursue their own leisure activities: fishing, football, going drinking.

Noticeably, none of the women talked of taking time out for their own leisure activities, apart from seeing the family on a Sunday.

When couples were asked about breakfast, there was a mixed response, with approximately half saying they always ate breakfast and a quarter saying they never ate breakfast. Most referred to eating cereal and/or toast and a few reported eating a cooked breakfast. It seemed that once the children were old enough, everyone was left to get their own breakfast, as has been reported in other studies (e.g. Moore 2000). Lunch, that is the meal eaten in the middle of the day, was quite a moveable feast. Several families talked about getting something like a pie or pasty from the bakery, picking up chips from the fish and chip shop or putting a sandwich together. Several women mentioned not eating anything. Dinner, or the evening meal, was the main meal of the day for most families, and could comprise a wide range of foods.

'F: We eat dinners all the time now, though, don't we...like for the tea'

'M: chips one night and dinner the next'

'F: bit of pizza, yes... chicken burger... something like that'

Most people referred to eating snacks, as in other phases of the research. The kind of foods considered to be within this category included crisps and nuts, pies and pasties, cake and biscuits, sweets and chocolate and pop. One man said he would have an apple as a snack and one woman said she may have a slice of melon. Four couples referred to giving their children fruit, but several were inhibited by the price. In general, snacks were high in carbohydrate and/or sugar. Several people were aware that snacks were unhealthy.

'F: We have it in our heads that it is not good to snack'

Couples were asked about both going out to eat and getting takeaways. McDonald's and other similar fast food outlets were mentioned by several couples, who would go there as a family outing. Only one couple talked of going out to a restaurant together, and this was only occasionally now they had children. However, it was a very different story with regards to takeaways, with all couples reporting buying takeaways. This could be fish and chips (though some clearly did not count getting chips from the fish and chip shop as 'a

takeaway'), Chinese, kebabs, pizzas, Indian, Mexican. Most couples only had a takeaway occasionally, when they had enough money. A few had a takeaway once or more per week, with two couples reporting that they ate them nearly every day. It seems unlikely that they could afford this considering that all couples were claiming benefit. However, perhaps these families had an additional form of income.

A very different form of eating out is school meals for children. There were mixed responses to this provision. Of those who mentioned school meals, some children had their lunch provided at school, whereas others took packed lunches. In some ways, this is surprising, because all the families were claiming benefit and were therefore entitled to free school meals. However, some stigma may be attached to this, so packed lunches are preferred. There were a few positive responses.

> 'M: Them always get a good dinner at school, though…you know what I mean'
>
> 'F: Yes she always has a cooked dinner at school so when she comes in she sometimes doesn't want a cooked dinner'

Another was more guarded.

> 'F: He gets his meals in school…so I don't actually know what he's eating'

The social aspect of lunchtime was mentioned by two parents, whose children complained that they were given little opportunity to eat their packed lunch. Presumably this is to fit in with school timetables.

> 'F: [they] only get 10 minutes to eat their packed lunch'

Category three. Decisions: factors affecting food choice

As in the previous phases, many couples identified the woman as the one to decide what the family would eat. This view often seemed to be based on the fact that the women did the shopping.

> 'I: So, who would you say decides what you eat?
> M: Well, she does the shopping'

However, as identified in the discussion of category two, few of the families in Phase Four ate together or ate the same meals. This suggests that family members were

consulted separately as to their food choices and this was confirmed in the interviews.

The influence of the man was evident

> 'I: What will you cook for tea tonight?
> F: I don't know
> M: Mince and dumplings
> F: Yes
> M: Yes...because I fancy some tonight'

> 'F: I wouldn't just put a meal down in front of him...I couldn't do that...
> he wouldn't eat it'

The woman may make a suggestion, which may or may not be rejected.

> 'F: I tend to say to D [partner] 'I was going to do this...do you want the
> same as what I'm having?' and if he says 'no'...I will say 'well what do
> you want?' and do whatever he's having...and 9 times out of 10 times, I
> end up having what he wants'

In some couples, if the man wants a particular dish, the woman may make it, even though it is not to her own taste.

> 'I: Who decides what you eat?
> M: Me
> I: So do you tell her what to eat?
> M: No
> F: He eats garlic and I don't like nothing like that'

The woman in this couple cooked separate dishes for her and her partner. This couple had been unable to negotiate shared meals because of such differing palates. However, in other couples, negotiation had taken place at an early stage of their relationship, as found in the previous phases.

> 'F: Now, when we first met I think it was like I didn't know what
> he liked or, I think I was more frightened than anything else...
> frightened to experiment on making things...a lot of the time [now]
> I make it and it's put down...cause now I know what he likes and
> what he doesn't like'

Not only was the man found to have a strong influence on the diet, but also the children. As noted earlier, in most families, children were asked what they wanted to eat, and often all children in a household would want something different.

In Phase One, several couples referred to 'fussy' children. In contrast, this was a term rarely used in Phase Four, which seemed to be made up of couples who did not expect the family to eat together. If children are allowed to eat as they choose, problems about enticing them to eat food they are less keen on are less likely to arise. Just one woman referred to having particular problems with her son.

> 'I: Would you ask him [4year old son] what he wants to eat?
> F: Yes, but we were told that was wrong when we were seeing a dietician...we were told we shouldn't ask him...we've just got to give him it but it didn't work...I was...just scared he was starving ... so he chooses his own food'

This woman had identified a problem, but the health professional's advice was considered unacceptable. The mother returned to her original practice, with which she felt more comfortable.

Taste was given as a major influence on eating behaviour. Couples were asked what their favourite foods were. As in Phase One, by far the most popular meal was 'a dinner'. It was particularly enjoyed by men and children. That women were not as keen, may reflect that it was usually they who made it.

A dinner was considered 'proper' food and was often associated with home cooking and healthy eating, though some recognised that there were other foods which could be classed as 'healthy'. Cost was prohibitive for many, who felt they would eat more healthy, 'proper' food had they more resources.

The next most popular food was 'junk' food, particularly with children. Most couples did refer to 'junk' food at some point during the interview, usually recognising it as unhealthy. Chips, 'fatty stuff', lard, dripping, margarine, butter, burgers, sausage, pizza were categorised under this heading. Usually it is high fat content, processed, convenience food. Other foods identified as favourites included salad, surprisingly, by men, although women talked more about salads, and pasta and rice were particularly popular with women.

Category four. Sharing: shopping and cooking

In Phase Four of the interviews, there was less sharing in shopping habits than in Phase One, which was reflected in cooking habits. In Phase One, it was a mixture of the woman shopping with her partner, alone or with a female friend or family member. In Phase Four, if the men did go shopping, they were more likely to go to 'push the trolley'. However, most said that they would pick something off the shelf if they fancied it.

> 'I: And if you saw something that you like… or just fancied…
> would you put that in the trolley?
> M: Oh yeah… probably yeah'

In this sense, the men clearly had some direct impact on what was going to be cooked.

In a more indirect way, the women know what the men like, and shop and cook accordingly.

> 'M: I wouldn't eat it [something cooked he did not like]… but like
> she's… she gets stuff in … she tends to get stuff in that I like'

As noted previously, it seems that earlier in the relationship, food decisions were negotiated. Once they had been together for a while, the woman had found out what the man liked.

As in Phase One, the pattern of shopping was of a major weekly activity at a supermarket in the centre of town – usually Kwiksave, Tesco's and Iceland. Virtually all couples talked of shopping locally in between the weekly main shop. This would be to buy perishable items such as bread and milk, or items the family has run out of. Very often couples talked about a regular shopping process with many of the same foods being bought each week by the woman.

> 'F: No… it's the same really… it's not very often any different'
>
> 'F: It's just routine I think… it is you go and get the same things'

Cost was a significant issue for most families.

> 'F: No, no… cannot afford Tesco's … I go to Kwiksave'
>
> 'F: You have money for $2^1/_2$ days every two weeks… it's not much…
> I go straight to Tesco's and get some essentials'

Cost not only affected certain families in terms of where they shopped but also what they bought, unless the male partner was present.

> 'F: The dole money only goes so far, so… that's why I have to do other things to try and tide us over'

> 'F: He doesn't read the prices of the things… just puts them in the trolley
> M: If I fancy it, I just throw it in the trolley'

Only one couple, however, referred to using a cheaper option, such as the market.

> 'F: Newcastle for my veg… I'll buy in bulk'

Newcastle could be too far away for most couples. Gateshead market is situated close to the supermarkets used by most couples, but no-one referred to using this market. This may be because Gateshead market is an unpleasant place in which to spend time, and has a reputation for poor quality, as well as carrying a residual social stigma.

To avoid the temptation of buying a variety of foods, shopping is limited to certain supermarkets.

> 'F: I used to go to Morrison's and Asda and that...but I over spend, so I just go to Kwiksave ...cause they sell like...like top brand names but they haven't got loads and loads of stuff...so I can't go wild...we're limited to what we can buy basically'

Couples were asked whether they would change their diet if they had more money. Unsurprisingly, the overwhelming majority said they would. Two couples specifically said they would eat out or have takeaways much more often. Others said they would shop at different places.

> 'M: …shop at Marks and Spencers instead of Tesco'
>
> 'F: Maybe more at Tesco'

The supermarkets perceived as more up-market were seen to provide more choice and better quality. Many couples also associated more expensive food as being healthier.

> 'M: … if I had the money I would buy all the good gear… if had… had the money to afford, like fruit, fish… you know…things like these meals that you can make with fish that are good for you…all these fancy meals and I'd do it…But, like… it's like I think the healthy foods are definitely more

dearer…it's as simple as that'

'F: Yes… because it costs too much [healthy eating]...too expensive'

The amount of money couples spent on food varied from £30 to £60 per week, with extra money spent on 'bits' during the week, such as milk and bread. The amount of money spent did not depend on the number of children or whether they were claiming income support or family credit. It is difficult to make any claims about this information without more detailed data. It was clear that people's circumstances differed. In some families, the man worked and claimed family credit, and were presumably better off than those on purely income support, but in some cases, extra income must have been received from elsewhere, maybe from other family members or on the black market.

In confirmation of other studies (Murcott 1983, Charles and Kerr 1988), it was found that generally the woman did the cooking. With two couples, this was a shared activity. In many couples, the man would cook occasionally, mainly if he chose to. In such cases the woman did the 'everyday' cooking and the man did it when he felt like it.

'I: You don't cook very often?
M: Not very often… when I feel like doing it I do it … but otherwise she does it'

'F: He cooks mostly on a weekend… or suppertime'

'F: Yes… he does Sunday dinner most of the time'

In several couples, the man was identified as 'good' at cooking; indeed, two had previously worked as chefs. This made no difference and their partners cooked most of the time. In this last phase of the research, women saw cooking as their responsibility, an attitude supported by the men. The former seemed to see any help from their male partners in cooking as a bonus: men cooked what and when they chose to and that in these circumstances it was accepted that he would cook according to his own liking.

'F: He likes experimenting'

In comparison, women did the cooking most of the time and this was generally about providing fuel for the family to get by with on a day to day basis. Women not experimenting was, again, closely linked with families not wanting wide choices at the supermarket, because it encourages spending. Equally, trying different meals is fraught with the possibility of the family rejecting it the food going to waste.

Couples were asked how they learned to cook. Many learned cooking skills from their parents, or from necessity.

> 'M: Just from watching my mother and father… or helping myself… like making myself some supper'

Several talked about doing cookery lessons in school, particularly the men.

> 'M: Yes… I've got GCSE in cookery'

> 'M: I used to like cooking actually … I used to be in the cookery class 'cause I couldn't read an write right'

In terms of developing cooking skills, it appears that, from this research, cookery classes were useful. They may be enjoyable, especially for boys, but this does not mean that they will then use their skills in cooking for the family. However, the loss of cooking from the school curriculum can only be seen as yet another opportunity lost for developing skills in cooking and healthy eating. This was expressed by one woman.

> 'F: I can't do nothing…when I got to the older school... I took typing and shorthand… and I didn't have the option for cookery… I think all kids should know how to cook… because I can't cook or bake or nothing'

<u>Category five. Food and health : the links</u>

Couples were asked about what they considered constituted a healthy diet. Most had some ideas, as in previous phases, but they tended to be mixed in their attitudes and emotions towards a healthy diet. Virtually all respondents referred to a reduction in fat to be important for health.

> 'F: If you eat fatty things you will put on loads of weight'

> 'M: Watch for fatty foods and food that are high in carbohydrates and things like that… and if you're active, high energy foods… I mean sugary foods and that… try and cut them down or cut them out completely if you can'

This last interview extract shows understanding of the importance of reducing fat and sugar, but not of the relevance of eating unprocessed carbohydrates. This was common to virtually all the interviewees – fat was considered bad for health and most couples referred to grilling food rather than frying, a few mentioned sugar being unhealthy, but only one referred to increasing fibre and decreasing salt as important aspects of healthy eating. Indeed, one person talked of a low fibre diet as being healthy. Clearly some healthy eating issues are being absorbed by this group of people, whereas other issues are not being accepted yet.

Although virtually no-one mentioned fibre, many couples talked about a healthy diet including fruit and vegetables.

> 'I: What do you count as a healthy meal?
> M: loads of veg and stuff like that'

> 'F: Well, pasta and that... plenty rice and potatoes if you don't fry them ... fruit'

It has already been shown how couples considered that healthy foods are too expensive. If they equate eating fruit with eating a healthy diet, then it is understandable that it seems beyond their means, as fruit is a comparatively expensive way of obtaining calories (National Food Alliance 1994).

Other people talked about a 'balanced' diet. These people tended to concern themselves with having a variety of foods, that eating too much of one item was unhealthy.

> 'I: What do you mean by balanced?
> M: Well...
> F: Not pigging out you know...just...
> M: Something that's going to fill you ... but isn't too fatty... that's a balanced diet in my opinion'
> 'M: ...eat too much of anything, it can kill you..'

Another aspect of a 'balanced' diet for some, included eating regularly.

> 'I: What would you count as a healthy eating?
> M: Potatoes, fish, pasta
> F: Eating at regular intervals, having three proper meals a day...most important meal ... your breakfast... knowing what proportions to eat and not to fill yourself up...drink plenty of water and things like that'

This view of a healthy diet is promoted by the Health Education Authority, who produce a guide called 'The Balance of Good Health' (1997), which shows the proportions and types of food needed for a diet which is well-balanced and healthy.

Many couples were equivocal about the importance of a healthy diet. Some said in one part of the interview that it was important, particularly for children, and in a different part of the interview that it was unimportant. It seems that in principle, people think eating healthily is a good idea, but when it comes to practice, it is less easy. Certainly one aspect of healthy eating is the cost, and many couples referred to this as a reason for not eating well. Several couples talked about the importance of a healthy diet for children, but not for themselves.

> 'I: Do you think it is important for the kids to have healthy foods?
> F: Yes... them but not me...I'm not really bothered what I eat as long as the kids...'

> 'F: Oh, yes, I tell her to give him [child] load of stuff that's good for him'

Several people talked about being on weight reduction diets, as in Phase One. This was predominantly women, with just one man discussing weight. The latter was related to weight training. Three women described drastic weight loss as teenagers, to the extent that they were admitted into hospital for anorexia. Childbirth was a reason for weight increase for some women. They talked of particular diets which were reputed to work, but of weight increase when they went off the diet. Self image seemed to be the main reason for trying to lose weight.

> 'F: I got a lovely compliment off him... he said I looked lovely... but I know I'm not happy [about weight]'

Category six. Sources of information: about food and health

As in Phase One, many respondents reported gaining information on eating from the television, especially adverts. Products advertised on television were referred to, in terms of the product itself, but also occasionally on the advert content.

> 'M: ...that Flora advert with...what do you call him...that miserable one in 'One Foot in the Grave''

Several people found food programmes unhelpful. Few said they tried any recipes and they were not perceived as meals appropriate for themselves.

'F: ...most of it's for the 'in' crowd...very posh, you know'

Labels on packets were considered important by just a few.

'F: I always look on the back of packets before I cook anything'

'F: I do now [read labels], yes...there's 23 grams of fat in a bag of crisps... custards only 1.5 grams, so I'm going to have that'

Couples were asked about leaflets, where they had come across them and did they find them useful, but responses were mixed.

'F: You can...get leaflets from the doctor's and things like that... healthy eating
I: Do you read those?
F: Oh yes...but...like it's for them to say that's exactly what you should be eating...how do they know? You know what I mean'
'I: What about things like leaflets at the doctor's?
F: Oh...I look at them if I'm bored...but I don't pick them up thinking 'Oh, there's a leaflet on healthy eating...I'll have a read of that''

In Phase One, friends and families were identified as important sources of information on healthy eating. In Phase Four, they appeared to be relevant, but of less importance to couples. Generally, in this phase, it was unclear where people got information about food from, apart from adverts. They possibly gained it from looking round the supermarkets, in which case advertising, whether on the television or in the shops, is by far the most important source of information on food.

Category seven. 'Typical' Teams

Couples were asked what it was like living in Teams. Responses were quite markedly different. Individuals had strong views. Some loved living in the area, thought there were lots of amenities and, most importantly, that people were friendly. The alternative view was that families were desperate to get out of an area which they considered to be deteriorating at a great pace, and did not want their own children growing up in such an

environment. When asked what a typical family in the Teams was like, again, responses were either very positive or the opposite.

> 'F: It's alright once you get to know people'
>
> 'F: Right gossips...they all are...they want to know everybody's business ...that's why I don't like it'

Family ties were of particular concern to families - both positive and negative.

> 'F: I wouldn't ... move away with nothing...I mean my father lives across the road and L's mother just over there...so...like we're both near each side of the family...but it's horrible when you're living near your family because you've got another side interfering...you can not do anything about it...everyone knows your business'

Some respondents remarked on the positive aspect of having family close to hand, and obviously relied heavily on the social support that this provided. Those new to the area found this close knit community oppressive and felt that they were under surveillance by neighbours and subsequently felt threatened at times.

Of those people who had moved into Teams, several described a significant change in eating habits which had occurred as a result of moving. Two respondents described moving from the country into this inner city area and how they had changed from eating what they described as 'fresh and healthy' food to eating much more convenience food. This is an example of another influence on the life course, wherein geographical changes affect eating habits. Such influence may have a major impact, but they only affect a minority of households, unlike universal life course events.

Couples were asked about the differences between men and women who live in Low Teams. When asked about what men talk to each other about, they said

> 'M: Just about what happens...stupid things on the telly...we play on the computer and then we shout at each other for cheating...or getting beat at a game of cards...what happened in the cards... I don't know...just talk about nothing'
>
> 'M: We don't talk about problems'
>
> 'M: Football...when the football season's in'

Women recognised the same issue.

> 'F: Men don't seem to talk about day to day...you know...like women... men don't seem to sit and chat like that'

> 'F: It's just women are different in everything'

These attitudes reflect the findings from the literature review, which identified the difference between men's and women's attitudes to life, with women being involved in household activities and discussing their experiences, unlike men (Skelton 1988, Brandthe and Kvande 1998). Some people described men they knew who went to the pub in the afternoon, went home for their tea which had been prepared by their female partners and then returned to the pub. These men spent their money and ended up borrowing off whoever they could until they could collect their benefit. Drugs were perceived to be a problem, though less so than alcohol. However, a few respondents linked drugs with crime in the area.

The researcher asked couples about why men were reluctant to speak in an interview.

> 'F: Cause men want to think they're in control'

> 'F: I think the men are too embarrassed ...they say 'I'm not doing that ...sitting talking''

> 'M: Women like talking...men just like...I don't know...just getting on with life...you know...women just like gassing....'

> 'F: Women just like talking ...men ...just quiet and shy'

These extracts from interviews reinforce the traditional stereotypes of men and women in Teams, as perceived by couples, though they did not perceive their own relationships in such a way. This is not surprising, given that these were the very couples who were prepared to be interviewed.

Common themes were drawn from the first phase of the research, and subsequently explored in the further phases. Both similarities and dissimilarities were found across interviews and focus groups. An interpretivist perspective anticipates such affirmations

and contradictions. This paradigm suggests that humans interpret all their experiences, according to their own subjectivity. There are no absolutes or objective truths. In consequence, people will respond differently in different circumstances and with different people. In a similar way, the researcher will interpret the data from his or her own perspective, as discussed in the chapter on methods. However, if themes emerge that have coherence, then these should be explored further. The aim of the researcher is then to represent these findings in the most trustworthy manner.

Further analysis of the key findings

The subsequent sections in this chapter include the similarities of grounded theory, interpretivism and community development. It also includes an overview of the role of practitioner/researcher. Development of a second core category, family culture was identified. The next section explores and draws together aspects of the influences on eating in low income families that were found in most responses within the research. The scope of the research study did not allow for all the influences, both external and internal, as identified by Tones and Tilford (2001). Consequently, areas that were particularly emphasised by the respondents are examined more closely. Finally, variations between the Phase Four findings and the previous findings are identified.

Grounded theory, interpretviism and commununity

Three areas of analysis and potential practice have been drawn on within this study, each of which has been in the understanding of both the approach and the research: grounded theory, interpretivism and community development. Each have their own offering in the understanding of any piece of qualitative research (Clarke and Pearson, undated).

The use of the principles of grounded theory were found to be useful in terms of understanding themes which led to the identification of categoried (Glasier and Strauss 1967). Grounded theory was an invaluable tool in dealing with the masses of data which needed to be analysed. An interpretivist approach to this perspective was adopted, wherein a single core category was identified initially, but a further category was found

to be important in the analysis. Instead of Glaser and Strauss' (1967 insistence on a finding a single core category, a more flexible approach allowed two categories to be developed which could then be developed into a single model (Charnaz 2000).

Finally, the principles of community development were employer throughout the research on a more practical level. This was because, at least in part, the researcher was a community development worker in the area. It is an approach which again is interested in diversity and understanding respondents' different values and differing viewpoints. Although the researcher started the research from this perspective, interpretivism provided a wider philosophical basis for the research.. Grounded theory principles fitted with both these perspectives, particularly where analysis was concerned. Community development was then used as a basis for developing the potential applications of the final model.

The Role of the practitioner/researcher

The researcher is affected by their own subjectivity, the subjects they engage, as well as by the philosophical perspective employed. Anyone can choose to do research, without any training or experience. Indeed, we have probably all experienced being stopped on the High Street or called on the phone by an unknown person seemingly doing 'research'. The reasoning behind these so-called 'market researchers' is to gain information about the types of washing power you use or the newspaper you read. This is not research in any academic sense, but can be perceived as such by the general public. It can have a detrimental effect, if only due to the 'junk' mail which has to be dealt which it may by produced in consequence. It is important that any researcher from an academic or government department have the appropriate identification and show it at any contact with the public.

The implications of being a practitioner/researcher need to be explored carefully before any research study is undertaken. Before the study began, the researcher discussed issues of confidentiality and possible exploitation with the supervisors. The key to this examination of the aims and objectives must be in presenting the study with honesty and

openness, ensuring that the respondents are clear about the research and be terminated at any point. Piloting the interview also provided an opportunity to ask respondents whether they consider any questions inappropriate or offensive. As discussed earlier, informed consent is an important tool in ensuring trustworthiness. To ensure trustworthiness reflexivity is an important tool.

In the present study, interviews and topics arising from them were discussed in detail with the supervisors of the research study. A more experienced practitioner was appointed to support the research. if any problems arose during the research.

It is equally important that the researcher/practitioner is aware of the respondents themselves. Researchers can be in a situation which potentially exploits the respondents. themselves. For example, if the subject is aware of the researcher's professional status. This could lead to the former giving the responses he or she thinks is wanted, to ensure they continue to obtain health services. They may also consider the researcher/practitioner to be an 'expert', which may not fit in with our view of trying to redress inequalities (Atkinson and Shakespeare 1993). As a practitioner and researcher from an interpretevisit perspective the aim is reduce inequalities in health, in order to empower people develop their own skills and confidence. This can be difficult if the
A further aspect of the 'insider' role of practitioner/researcher is that she or he is likely to get more information as they may be known by local people. Alternatively, less information may be provided because respondents are conscious of giving too much information, which may then be passed on to other professionals to their own detriment. Assertions of confidentiality needs to be followed as closely as possible, with full knowledge that there may be some responses that need acting on, such as child abuse. However, the alternative is that the respondents know the practitioner and feel comfortable talking about difficult subjects because of trust that has developed with the researcher practitioner.

Here it seems an appropriate place to introduce the notion of where the idea for the research has arisen. The notion of quantitative research methods was rejected

immediately as inappropriate (Hughes 1990). The reasoning behind the choices made can be found in Chapter Three. However, there are aspects of these choices which are relevant to the role of the researcher/practitioner. Just as knowledge of local people can be effective in obtaining useful information, the same people may know the worker well, they may feel free to provide false information as a 'joke'. More likely is a situation wherein the local residents are enraged by changes in the area and demand that a piece of research to find out the whole estate's views. A community worker can help greatly in the process, but it can be a long process, without a great deal of success. Furthermore, it can be a disillusioning experience, leaving local residents still more resentful of institutions and less prepared to be involved in a campaign.

A further issue can be the other way round, with the respondents questioning the respondent. This could be along the lines of 'why is there such a long waiting list for my hip to be replaced?' by the interviewee. This can be a difficult situation. One could be honest and tell the respondent the true state of affairs, which could then lead to a barrage of abuse. The alternatives are to lie about the availability of beds in the hospital or claim ignorance. Either way, the interviewer is avoiding the openness and honesty referred to previously. Equally, respondents are expecting counselling or medical advice. Again, openness and honesty is important in identifying the interviewer's role.

Second core category. Family culture and eating patterns

Families were found to engage in different family cultures, which had a bias to a particular pattern of eating, and families could consequently be categorised into groups. Approximately half reported allowing each family member to choose what he or she wanted to eat, within defined and accepted parameters. Preference was often for convenience or frozen food and was often eaten at different times, with the children eating when they came in from school and the adults eating when the children had gone to bed. These families could be described as 'quick and easy'. As well as frozen and convenience food, they tended to eat bacon, sausage, egg and, of course, chips, either from the fish and chip shop, home-made or oven cooked.

Another family culture, accounting for approximately a quarter of families, was identified and could be described as 'organised'. These families tended to home cook from unprepared ingredients and were much more likely to eat together as a family at a table. They ate little convenience food and were more likely to eat vegetables.

> 'F: This is what you would call an old fashioned kitchen...when it's... everything cooked'

A further culture, accounting for the final quarter of families, were those who did not have a routine and put together meals as and when it became a necessity. They would cook whatever was to hand or go to the local shop to get food for immediate use. If at all possible, they would offer the children choices, but sometimes the need to eat what was available prevented this. These families could be described as 'rushed'. Several women in this group stated that they often snatched a bite of a sandwich when she got chance, or did not bother eating.

> 'F: He's [child] not a very good eater...and the stuff he leaves...I'd probably pick at'

Some life course changes were common to all three family cultures. For example, men are influential at most times over the life course, but have a particularly strong influence when a couple start to co-habit.

<u>The male influence on eating behaviour</u>

The present research found that men had a major influence on food choice in most families. At one level, it is not surprising that the man's tastes are taken account of, in the sense that people generally want to eat what they enjoy and the woman will provide accordingly. However, the power differences between men and women are demonstrated by women's tastes generally being subordinated to their partner's. Thus, at all levels of negotiation, the man within the relationship had a profound influence on the couple's diet, if not the children's. Women seemed conscious of their partners' choices from early in the relationship and were prepared to accept providing these choices, regardless of her own preferences.

The significant level of negotiation in the early stages of the relationship as to what food was acceptable raises issues about the level of communication that takes place between partners in establishing a relationship, which will be different for all couples. Negotiation within a relationship can reveal communication problems, as identified in the literature review, and may involve vagueness, early anticipation of what the other will say, tactics to avoid conflict, such as refusing to discuss issues or becoming competitive (Sharpe et al. 1996). These differing approaches were identified in different phases of the research. When couples were interviewed in Phase One and Phase Four, anticipation of the other partner's response was common, one often answering for the other and interrupting. The other, less common style involved couples referring to each other and one speaking on behalf of the two. This appeared to relate to the family culture.

It was common for men to be oblivious to the cost of food, much to the annoyance of their partners. If a man did go shopping, he would spend far more money, because he was not aware of the cost of food or would not think of choosing the cheapest product.

Cost: eating on a low income

All families in the study were on a low income and cost was a major influence on food choice, as would be expected. The literature review identified how poor health was linked to poor diet and how this was associated with poverty. The families interviewed in the research were all on a low income and, although the majority of respondents talked about eating what they wanted to, the cost of food was found to have a strong influence on the food people chose to buy. This was given by many as a reason for not eating more healthy foods. Such food, which was identified as including fruit and vegetables and lean meat, were considered expensive and beyond the means of these families on benefit. Lobstein (1995) calculated that families on benefit had only eight pence to spend per day for every hundred calories for a child. At the time, to obtain one hundred calories from fruit or vegetables would have cost at the least twenty five pence and from lean beef or pork it would have cost forty pence. In the poor financial circumstances in which they found themselves, it is unsurprising that these families on low income rely on white bread, pies and pasties, which are considerably cheaper in terms of cost per calorie, for

example, the cost of 100 calories derived from white bread would be three pence (National Food Alliance 1994).

Not all people said they would change their eating habits if they had more money. This seemed to be related to the social and moral ramifications of eating identified earlier. The impression they gave was that they were reluctant to admit to eating a poor diet, as this somehow reflected badly on themselves. However, given the influence of cost, it seems likely that if families did have more money, they would be more likely to eat more healthy foods, which many families conceded to be the case.

Several respondents said that if they had more money, they would shop in more upmarket supermarkets, such as Tesco, Asda or Marks and Spencer. These were recognised as offering a much wider variety of foods, unlike Kwiksave and Iceland, which provide basic foods. The importance of eating a variety of foods has been well documented (Department of Health 1994, Dowler and Calvert 1995). However, most of the couples in the present research did not buy a wide variety of food. They bought similar foods each time they shopped, knowing what they and their children would eat, so as to avoid waste. It has often been reported that families on low incomes can not buy a variety of foods, since they are unavailable to them because of cost and this is seen as another example of inequality (Low Income Project Team for the Nutrition Task Force 1996, Lang and Caraher 1998). In the present study, however, some couples did not want more variety because they would not then be tempted to over-spend.

The literature review identified that many inner city areas have become food deserts in which low income families have reduced access to food. However, in the present research, all respondents referred to doing a main shop, either weekly or fortnightly. Virtually all respondents used supermarkets in the centre of Gateshead. Although only a few of the couples had a car, there were no complaints about the distance of supermarkets, which are about two miles from Low Teams, with a good bus service. As such, it could not be argued that the couples were living in a food desert. However, all respondents talked about getting 'bits' from the local shop, such as milk and bread. The

local shop does not sell fresh fruit or vegetables and the food it does sell is mainly expensive, processed food. Unless fruit and vegetables are easily and locally available, it will always be difficult for low income parents to provide healthy food for their families on a regular basis.

As discussed above, cost had a major impact on diet. Often lack of time was linked to this. Respondents stated that food had to be cheap and quick to prepare.

Time - eating within the constraints of time

Many respondents referred to time restraints which prevented them cooking as they wished. On analysis of the interviews, it was not clear why convenience and speed is of such importance. On the surface, one may imagine that these couples had plenty of time, given that all the women and most of the men were not in employment. It may be because taking the children to school, looking after children at home, shopping and housework are very time consuming activities, especially without a car.

Time was particularly an issue for the 'quick and easy' families and the 'rushed' families. It was especially an issue for the latter, who seemed to dash from one task to another and had little time to spare to prepare food. In consequence, food was chosen because it was the quickest to prepare and often was a snack. The 'quick and easy' families, although more prepared for mealtimes, also reported that lack of time was an important element in their choice of food. In most of these families, different members ate different meals, which obviously had time implications. If several meals are being provided at each mealtime to cater for each family members' tastes, it may be impossible to do so without using convenience foods which will reduce the time spent on preparing each one.

In contrast, although the 'organised' families prepared food from raw ingredients, lack of time was not considered a problem. This could be because they placed more value on food and it's preparation and therefore set aside time specifically in order to cook. In these families it seemed that the importance they placed on food meant that they prioritised time to prepare the family meal. All members of these families were more

likely to eat the same meal as each other, which may reduce the time to prepare food for the family by eliminating duplicate or parallel preparation.

The influences of the male, cost and time also relate to the social aspects of eating, such as how the family behaves, the roles adopted within the home and the subsequent family culture that predominates within that family.

Social aspects of eating

The literature review identified the important social role of food and eating and the findings of the study confirmed this. Many of these aspects have already been referred to, but will be drawn together under the present heading. The social meaning of food was found to be linked to respondents views of 'good' and 'bad'. The findings show how often respondents made judgements about what was good or bad. A dichotomy was often identified between the ideal, that is, what was perceived as good, and the reality, which was how the family actually behaved. This often created difficulties around how they perceived their behaviour, because they may aspire to their ideal but be unable to achieve it. This resulted in cognitive dissonance for many respondents, as identified in Phase One. On finding themselves in this uncomfortable position, couples gave explanations about why they could not achieve their ideal. Examples of this included explanations about why they did not share chores, about why family members did not eat the same food as each other, about why families did not eat together at a table and about why they did not eat healthy food or 'proper' food.

Sharing chores was an area where this dissonance occurred for several couples, which the other examples given above can be related to. The Concise Oxford Dictionary (Thompson, 1995) gives six definitions of the word 'share'. The relevant definition in this context refers to

> 'a part contributed by an individual to an enterprise or commitment' (p. 1273).

It does not refer to the size of the part contributed, yet there seems to be some expectation of equality. When talking about sharing tasks in the household, some couples did express such an expectation, in the belief that there was supposed to be more gender equality

these days, even though they recognised that this was not necessarily so in their own relationship. There appears to be some kind of moral imperative these couples felt, in that they thought they *ought* to share equally, thus expressing another aspect of the dichotomy identified between the ideal and the practice. However, there may well be families who have no interest in an egalitarian relationship. Indeed, any attempt to increase equality may have the reverse effect. For example, in an attempt to encourage men to share with the shopping, supermarkets might be encouraged to be more appealing to men. However, as happened in some families, the man might pick more items of food that he fancied off the shelf, without concern for the cost. This could place an added burden on the woman, who is finding it hard to keep within her budget. A further consequence could be that, given that men have a strong influence on the family diet as it is, if they were to share more in the shopping, they would have an even greater influence.

The findings demonstrate that women do the majority of cooking and shopping. They have been perceived by health professionals as the 'gatekeepers' to the family diet and, in consequence, have been the focus of health education.

> 'Women, especially mothers, are subjected to particular attention by health educators because of their pivotal role in family health care and health maintenance' (Pill and Parry 1989, p. 51).

It seems that women are put in an unenviable situation. They may well know what is healthy for the family, but be unable to provide such food because of the man's preferences. They then get bombarded with health promotion messages about the importance of a healthy diet. To start targeting men on nutritional issues, rather than women, would be a possibility. Keane (1997) found that men, aged 40 -60 years, were more likely to seek information about health if they perceived themselves at risk of a heart attack. These men were more likely to be white and middle class. Young men, particularly those in their early twenties, had a blasé attitude to potential health problems. The men in the present research were predominantly under 40 years old, and likely to be resistant to traditional health promotion strategies, such as one-to-one counselling or the provision of leaflets and so different approaches would be needed to effect changes in behaviour.

Food was described by some respondents as a means of controlling children's behaviour in order to conform to socially acceptable norms. The possibility of using snacks and sweets as a bribe to control children's behaviour thwarted some women's attempts to curb their intake. The cynical display of sweets at the supermarket cash point exploits this problem, by tempting children waiting in the queue. Buying some may be the only way parents feel they can control a potential tantrum. The need to use snacks and sweets as bribes suggests that perhaps some families would benefit from support to help find different ways of rewarding children. Most health professionals advise the use of basic behavioural techniques, which involve rewarding good behaviour and ignoring bad behaviour. The men's focus group responses did not recognise this aspect of the use of snacks, and berated their partners for 'giving in' to children's requests for such unhealthy food. This could well be that they were with the children less, particularly in potentially difficult situations like shopping. Indeed, these men identified one reason for not shopping was children misbehaving.

A further aspect of control included reducing intake of food. A number of women referred to losing weight by reducing calorie intake to be a significant influence on what they ate. There are conflicting views about how women themselves perceive dieting. McKie et al. (1993) found that women were resentful of the expectation of maintaining an ideal body image, whereas Lupton (1996) stresses that women who diet should not be seen as victims, but as people who are taking control of their lives. The present research found that women dieting seemed to be resigned to consistently being on a calorie controlled eating programme, even though it required constant effort. Tackling the potential problems associated with dieting is a difficult topic, given the enormous media pressures placed on women. Robinson (1996) suggest that a holistic approach may be the most appropriate, wherein women are encouraged to address not just the issue of weight, but also the mental, emotional and social aspects of their health. A further potential problem of weight control is the predicament of developing eating disorders as a response to maintaining a specific body image for some young women. Indeed three of the women

interviewed described themselves as having suffered from anorexia as teenagers. This emphasises the importance of understanding the relationship between food and health.

Food and health: understanding the relationship

When asked about the relevance of diet to health, several couples minimised the impact of personal behaviour on health. They had a fatalistic outlook, wherein they considered that they had no control over their health. This was expressed in the idea that they could get run over by a bus any time. Such an attitude to health has been shown to be more common in social classes IV and V (Naidoo and Wills 1994). It seems to reflect a rational response to a situation when there is a lack of choices available. Many couples talked about the absence of healthy eating habits as being due to some reason other than their own choice, such as lack of time or money, or both. A way of coping with such difficulties seemed to be to deny them, in order to maintain their view of themselves as 'good' parents. This finding reflects the literature, which identifies that people on low incomes have standards below which they strive not to fall, such as having a roast joint of meat on Sundays and using butter rather than margarine (Wilson 1989). It also affects where people choose to shop. In addition, it reflects the findings discussed earlier concerning the perceived dichotomy between the ideal and the reality.

One aspect of understanding the relationship between health and food is having the knowledge. This is not the only what is needed, but is an essential part of healthy eating.

Sources of information on food and health

Sources of information about food identified by respondents included television, magazines, leaflets, health professionals and family and friends, as well as labels on tins. Different sources were recognised as being more or less influential than others.

Television provides a range of information, from cookery programmes to documentaries to adverts. The plethora of cookery programmes on television at present would suggest a greater interest in cooking from raw ingredients and developing new cooking skills. However, families on low incomes are excluded from benefiting from such interest

because of the cost. A few respondents referred to watching and enjoying celebrity cookery programmes, but less said they ever tried to cook the meals shown. The need for a host of different ingredients was doubtless a difficulty. Although people on low incomes may wish to try more unusual dishes, they can not afford either the range of raw foods or the variety of spices or herbs required. They may leave ingredients out, but the dish then hardly resembles the original recipe.

Documentaries and news items on the television, the radio and in newspapers were a source of information for some respondents. Although these respondents did not specifically identify the television, radio or newspapers as places where they obtained facts when asked, the knowledge gained from the media was implicitly revealed when they talked about food scares. Several men in particular were bothered by BSE, listeria and salmonella. A few reported to have stopped eating beef as a consequence. The general feeling about these scares was a cynical view of the government, that these health problems had been known for some time, but the government had decided not to let the general public know. Reilly and Miller (1997) identify instances in which the government has reported food to be safe. When later information surfaces to show that this was not the case, it appears that the government had known this for some considerable time. This confirms that lay people are correct in being sceptical about what information is provided via the media.

Health promotion has generally sought to effect change in eating habits by giving information and advice about food via health professionals, leaflets and national campaigns. This has focused on improving the individual's or the family's diet. Some respondents referred to obtaining information from health professionals such as general practitioners and health visitors and those who attended the Family Centre said they had gained information about food there. Given that all families had at least one pre-school child, it is perhaps surprising that health professionals were not mentioned more often, as most families would be in regular contact with the primary health care team. It was not clear whether they had not absorbed any information offered through these sources, had rejected it, had forgotten it or did not have enough for it to make an impact.

Information is just one aspect influencing eating behaviour, but social exclusion was another factor that respondents referred to.

Social exclusion - the experience of living in Low Teams

There was a clear view amongst most respondents that people who live in Low Teams generally live in a traditional, gender divided society. This view was held regardless of how they perceived their own relationship, which most considered generally to be more sharing and equal than was usual in the area. This perception could reflect the likelihood that the respondents recruited for the study were in more companionable relationships than others in the area.

The couples and the focus groups generally described the 'typical' relationship in Teams as one in which men are 'in charge' and expect women to do all the house-keeping and childcare. There was a general view that family relationships are changing, with couples becoming more sharing. However, on the whole, although women are working more, there is little evidence of a major shift to shared responsibility within the home. This is reflected in the literature: young men leaving school today maintain a conservative view of domestic life.

> 'Young men's views of masculinity in some ways conformed to the notion of a 'lad' but also emphasised domestic conformity... The main impression, however, was of the continued dominance of a 'traditional' masculinity rather than of a new version of masculinity which might be more in tune with the requirements of a service-based economy' (Henwood et al. 1987, p. 1).

Part of this 'laddish' culture (Henwood et al. 1987) was described by several respondents in terms of the prevalence of alcohol drinking and drug taking in the area. In terms of anti-social activity, there was a perceived split in the area of Low Teams with one end considered much more prone to crime than the other. Terms used to describe the West end of the area where there was particularly poor housing included 'the Bronx' and 'Beirut'. Those who lived at the 'better' end tended to disassociate themselves as much as possible from the other end. In a small area, such splits have the potential for great social

division, with those in the more deprived areas feeling even more excluded within an already marginalised geographical area (Botes and van Rensburg 2000).

Variations in findings between Phase Four and other Phases

All men in the focus group agreed to being interviewed with their partners in their home. Subsequently, differences were noted between men interviewed together with their partners as a couple, compared to when they were in a single sex group. One man acknowledged this.

> 'M (alone): Some of my mates would say I don't get on with her...but I know for a fact they're different in the house...you know...when you go down their house...it's totally different'

Interviewing the men from the focus group showed that their responses were different when with their partner compared to when they were with the men in the focus group. These couples came across as much more sharing in their attitudes when together, when compared to the men's responses in the focus group, with much less emphasis placed on gender divisions. When the couples were interviewed together, given the present dominant ideology of marriage as companionable (Finch and Morgan 1991), it may be that most couples felt impelled to present a picture of an equal, sharing relationship. The focus groups were single sex and members could potentially be more open, as their partners were not present. They expressed solidarity with their group members, so that the men referred to 'men sticking to men and women sticking to women'. Both couples and group members could have encouraged each other to present a picture of reality which reflects their experience at the time of interview. It also could reflect a dichotomy between the experience of being in a couple and being in a single sex group.

Unfortunately, most of the women in the focus group were not prepared to allow home visits to interview their partners so no comparison can be made. However, the one woman who agreed to be interviewed with her partner did support the difference found with the men. She talked about them always eating together and was one of the only couples to talk about going out together, even though in the focus group, she agreed with

the other women, that men and women have little in common. Again, she provided a different perspective when in a gender specific group compared to when with her partner.

From a positivist perspective, such differences may be interpreted as disproving the validity of the data collection and analysis. One of the disadvantages of focus groups is that they involve group dynamics, which may lead to the group censoring any deviation from group norms (Kitzinger 1994). Equally, it could be argued that the female partner could be censoring the man's response when being interviewed as a couple. However, these differences are not surprising from an interpretivist perspective. Individuals do not live in a static world, but in an ever changing environment, which they interpret in different ways at different times. Thus when the men were together, they perceived themselves as a homogenous group, whereas when they were with their partners, the similarities between the two as a couple were reinforced and acknowledged. The tools of 'triangulation, thick description and reflexivity' (Brody 1992, p. 177) need to be applied to ensure trustworthiness of data collection and analysis in these changing contexts.

A major difference between these Phase One and Phase Four was that women in the latter group were more likely to cook and shop. These families were less likely to eat all together or to eat the same foods, many preferring a 'quick and easy' approach to eating.

Within the continuum described in Chapter Six (see Figure Two), Phase Four couples could fit in alongside the male focus group members, as having companionable relationships, though less so than Phase One couples. However, ideas about the importance of companionable partnerships needs to be explored more closely in the context of domestic life. It already has been identified that over the last 50 years there has been an increasing idea of relationships being more sharing and couples focusing on their partnership rather than on the wider family. However, evidence has shown that women still have the major responsibilities within the home (Oakley 1974, Graham 1984, Blackburn 1991, Brandthe and Kvande 1998). The present study found that the majority of couples did consider themselves to be in sharing relationships, at least to some extent. However, it is questionable to call a couple's relationship more companionable just

because the man sometimes shares the shopping and cooking with the woman. Many of the couples referred to the man cooking occasionally, but generally this was when and what he wanted. However, perhaps it is not the actual behaviour of individuals within a family, but the perceptions that make relationships more personally supportive and rewarding. Phase Three women and the women's focus group members appeared to have no expectation of such a relationship, and seemed to accept the situation they were in.

Some of the differences between the Phase One and Four couples could be due to the recruitment methods used. The former were contacted directly by the researcher. Most couples who eventually agreed to be interviewed at this stage were unknown to the researcher. Given the number of contacts needed to engage ten couples, those who were willing to be interviewed were more likely to be interested in food and eating. In contrast, Phase Four couples were recruited by the researcher, in the context of working as a community development worker, knowing them personally or via a person the researcher knew. In consequence, these couples were more likely to be 'doing a favour' for the researcher or their friend. They may, therefore, be less interested in food. This seems to be reflected in the differences in responses in that Phase Four interviewees considered the provision of food to be a necessary requirement of the daily routine - 'food as fodder'.

The research showed that this cohort of low income families had varying attitudes to eating behaviour, as would be expected from an interpretivist perspective. The attitude of many of the couples was predominated by keeping the family 'filled up' i.e. food that is cheap and palatable, regardless of the nutritional input. But if food is considered simply as food, then it could be imagined that it would not matter what the food is, as long as it filled the individual up. To some extent this was the case the case,

Dissemination of findings to respondents

Initially the researcher intended to contact all respondents in order to disseminate the findings personally. However, it soon became apparent that only a few of the couples were interested. The main reason given was that they thought it was a considerable time between the interviews and the findings being available and many had changed their

circumstances, with children going to school or one or both partners getting work. However, verbal feedback was given to those who were interested and the researcher spoke to local groups about the research findings.

Summary

This chapter has reported on the Phase Four of the research, which involved interviewing 22 couples. Life course was the core category based on influences on eating habits over the respondents' life time and was explored using the nutrition career as a framework for research. Life course is examined in detail in the following chapter. As they were growing up, most couples talked of eating 'dinners'. As they moved into adolescence, the majority of respondents described a change, wherein they would eat chips from the chip shop, away from home, which seemed to be a partly rebellious act. On leaving home, several people talked about not bothering much with food. When first co-habiting, there was a mixed reaction, with some considering they ate a much more varied diet, whereas others referred to eating mainly convenience food.

The majority of couples used convenience food routinely, for speed and ease. Families could be classified according to their cultural bias. Most could be described as 'quick and easy', because they were quite content using convenience food most of the time, to provide the variety of foods the family wanted, and had regular mealtimes. A smaller group could be described as 'rushed', with snacks often replacing meals. Another, small group were 'organised' and cooked from raw ingredients. Family cultural bias was identified and is explored in greater depth in Chapter Eight.

The couples did not describe changes in diet when they first had children, but did when the children were old enough to make their own choices. Most said they provided children with what they wanted, which may entail different dishes for each family member and adults eating separately from children. Despite this, dinners were identified as a favourite family meal, which they may well have during the week, as well as on Sunday.

The couples in Phase Four of the research shared the task of shopping less than those in Phase One. If the man went, it was to push the trolley, though they were likely to pick things from the shop shelves if they saw something they fancied eating. Cost was a prohibitive factor for most. Again, the women mainly did the cooking, with men cooking occasionally and when they themselves chose to.

When asked about health and diet, most referred to fat being unhealthy and fruit and vegetables being healthy, as in the earlier phases. Many couples were equivocal about the importance of a healthy diet and often a compromise was made between eating what was considered healthy and unhealthy. As was found in earlier phases, weight reducing diets were mentioned by several people. Couples referred to obtaining information from television adverts and friends and family. Many were equivocal about the usefulness of leaflets. When asked about living in Teams there were polarised attitudes, with some reporting very positive feelings and others very negative ones. Many felt that general attitudes in the area were gender stereotyped.

Common themes were explored, which included the male influence on eating, the effects of living on a low income, time implications for cooking, understanding the relationship between food and health, sources of information about food and social exclusion. Variations between the findings in Phase Four and the previous phases were discussed.

The next chapter will discuss the two core categories of the 'life course' and 'family culture' and identify a model which could be used for assessing, planning and evaluating health promotion activities.

Recruitment of, and therefore researching men was a limitation in the study, as was interviewing in the home environment, as was discussed previously in Chapter Three. A further limitation to the study was lack of funding for the researcher's post as well as difficulties in disseminating the findings to respondents.

This chapter has reported on the Phase Four of the research, which involved interviewing 22 couples. Life course was the core category based on influences on eating habits over the respondents' life time and was explored using the nutrition career as a framework for research. Life course is examined in detail in the following chapter. As they were growing up, most couples talked of eating 'dinners'. As they moved into adolescence, the majority of respondents described a change, wherein they would eat chips from the chip shop, away from home, which seemed to be a partly rebellious act. On leaving home, several people talked about not bothering much with food. When first co-habiting, there was a mixed reaction, with some considering they ate a much more varied diet, whereas others referred to eating mainly convenience food.

Recommendations for health promotion practice

Based on the findings of this study, health promotion practitioners should be able to design more appropriate interventions to improve the opportunities for families on low income to eat a more healthy diet.

Recognising diversity within communities

Health promotion has hitherto treated families and communities as homogenous groups within certain defined parameters, for example, as disadvantaged, and has not recognised the diversity within such groups that has been identified in the study. Low Teams is an area of high deprivation, which is usually thought of and treated as a unified community. However, the study has shown that it contains considerable diversity of family culture, and that different approaches to health promotion are required for different groups. It is important that those working in such an area are aware of this cultural diversity and the changing requirements at different times of the life course. The LCFC model provides a theoretical framework for understanding some of these differences and the questionnaire, when fully developed, will provide a tool to assess families in order to target interventions around eating healthily, and other health related behaviour.

Within the overall discipline of marketing, social marketing has developed as a method of promoting health (Hastings and Hayward 1991). However, the study identified segmentation on a much smaller scale than is generally used. It could be described as segmenting the 'audience' at a micro-level, rather than at the macro-level of social marketing. It is only by getting the opportunity to understand individual households' perspectives that the similarities and differences to attitudes about healthy eating can be unravelled. At a practical level, this kind of work is labour intensive. However, from a community development perspective, this close engagement with local people is likely to increase participation and empowerment to address their health needs.

Community development work is based on equity, with the explicit purpose of reducing inequalities and valuing diversity. Community development work has been identified as a particularly appropriate way of promoting health throughout this study. However, in order to work in this way, workers require a full understanding of the meaning of truly empowering individuals and communities. Training community workers in the LCFC model and use of the questionnaire could provide a starting point to increase their knowledge and understanding of working with communities. They also need an understanding about the importance of providing appropriate information, in the knowledge that information is necessary but not sufficient for empowerment

Improving information available for families on low incomes

An important aspect of working with diverse communities is ensuring that information is widely available. The research showed that people had differing views of the effectiveness of the promotion of healthy eating via leaflets, television or magazines. A first step in any strategy to disseminate information is to ascertain what is the best medium for each group. It was identified that most people obtained information about food from family and friends. It is therefore most appropriate to focus on where those people meet and so identify local venues, such as community centres and family centres, where information can be disseminated. This will differ according to the stage of the life course that families are at and according to the family culture that has been adopted. For example, the 'co-operative' families may be ideally reached through a community centre.

because they may well already be involved with such a centre, whereas the 'rushed' families may be better targeted via home visits in order to fit in with their hectic lifestyles. Alternatively, 'organised' families may be better approached through health promotion material which is directed at households which cook from raw ingredients or through food co-operatives that provide cheap, fresh food.

The sort of information that is disseminated requires careful thought. From a community development perspective, the process of dissemination must involve the community itself. It is the community which can ensure that information is suitable and relevant. Involving local people will ensure that any written material is in a style appropriate to the target group, which will include paying attention to language and visual content. Ideally, through providing the resources, training and support, workers could enable local people to produce their own information, thus reflecting the empowerment noted above. This would mean that the material produced would be appropriate to the groups targeted, be they teenage single mothers or middle aged married men. A further, important spin-off would be the likely increase in self-esteem of the local people arising from creating their own product and the skills learnt in the process. This kind of activity offers the opportunity to work with others and gain from the benefits of social contact.

Production of written materials can be an important medium for providing information, so long as it is tailored to the needs of the appropriate group. However, there are many other methods of disseminating information on a more personal basis, which may be more effective according to where they are identified within the LCFC model. Such methods include one-to-one contact with professional workers, such as health visitors and dieticians, and may be useful for some, for example the 'rushed' families who could benefit from an individual approach. Alternative approaches could address issues from a collective perspective, which would be in keeping with the principles of community development. Group approaches to promoting healthy eating have been successful in many areas and should be encouraged. Again, working together with other local people creates an opportunity for people to gain skills, obtain information, which is appropriate and useful for them and offers a setting wherein social networks can develop. The 'quick

and easy' and 'organised' families may particularly benefit from such a group approach and the 'co-operative' families may be encouraged to take a lead role in the organisation of group working. This could link into the lay referral systems that are evident in most communities, wherein

> 'most health care work is carried out by lay people either in the form of self-care or caring for relatives and friends' (Nettleton 1995, p. 39).

Promoting healthy eating to children

It was identified in the literature review that diet in childhood is vital to future health. Parents need to know how to feed their children healthy food, but children make demands around what food they will eat and consequently shape family eating behaviour. These two aspects mean that health promotion for this group is important. Work with parents of children should be prioritised, given the strong influence of children on eating behaviour found in the study. The previous section suggests appropriate approaches to providing this information in the most useful settings for families at different stages of the life course and family culture, according to the LCFC model. Use of the assessment questionnaire could provide a further opportunity to work with groups that are orientated towards children, such as toddler groups and family centres. Sure Start initiatives (Department of Health 1998b) which have government funding to promote the health of pre-school children, are in a prime position to promote work around healthy eating.

Schools also offer an ideal opportunity to promote healthy eating to older children and many have developed innovative schemes to do so. The 'Healthy Schools Award' has encouraged schools to focus on the inclusion of healthy eating in the curriculum, to offer healthy options for school meals and to provide fruit rather than sweets and crisps in school tuck shops (Department for Education and Employment 1997). This initiative should be promoted across all schools, in order to develop a commitment to healthy eating as an integral part of policy, particularly given that the study found that several parents were unhappy about the eating arrangements in school.

Improving the provision of health promotion for women

The study has shown how women often have a double burden when it comes to providing food. They may well know what is healthy to eat, but are unable to act on this knowledge because of the demands of their partner and children or due to the constraints of money and time. Workers need to be aware of the potential 'victim-blaming' approach of expecting women to change the whole family diet. The LCFC model could be used to ensure that workers have an understanding of the context that families are in when making food choices, which would avoid 'victim-blaming'.

Expanding the provision of health promotion for men

Men have been shown to have a strong influence on the family diet within the study, so it would seem appropriate that some healthy eating messages should be targeted at them. From a community development perspective, it would be most appropriate to engage local men on low incomes to develop health promotion initiatives. This has happened in a few local community development projects (Robertson and Williams 1997). However, it would require investment in exploring suitable ways of accessing men's networks. The workplace is the arena where most research with men has previously taken place, but is obviously inapplicable to men who are unemployed. It has already been highlighted that the private domain, that is, the home, did not seem to be the most comfortable setting for some men to express opinions about eating behaviour. Other settings need to be explored in order to involve men. Community workers working in family centres and other community settings, which may include pubs, clubs and sports venues, should actively recruit men and encourage participation in family and community life, which would include health promotion initiatives around healthy eating.

Promoting healthy public policies

Throughout the study the lack of availability of cheap, healthy food for families on low incomes was identified as a deterrent to eating healthy food. There are numerous reasons for this, a major one being the lack of a national food policy aimed at reducing inequalities in health. Much health promotion around healthy eating is aimed at individuals and families, but if healthy, low cost food is not available, it is difficult for

even well informed and highly motivated families to make healthier choices regarding their diet. Healthy public policies are about making the healthier choice the easier choice.

The food industry drives patterns of food provision, rather than the government, with low cost being an over-riding factor around the production and availability of food (Caraher 2000). Government strategy at a high level is needed to address this issue. There are far ranging issues involving the Department of Food, Farming and Rural Affairs and the Department of Health working alongside the Food Standards Agency to ensure that food is safe and that policies are developed to provide sustainable farming and fishing regimes, in terms of continuing or developing practices which do not hinder future supplies.

On a more local basis, there are numerous government initiatives that are benefiting local communities, such as Health Action Zones (Department of Health 1998a) and Sure Start (Department of Health 1998b). Many projects funded from these initiatives are directed at improving access to food and information about food. However, short term funding can mean that any potential benefits are largely negated by projects coming to an end. The LCFC model could be used to explain the importance of the local knowledge of a community to gain longer term funding. It could be used to demonstrate that one solution to a community's needs is not enough. A community is not homogenous. Instead the diversity of any community must be explored in order to make any health promotion initiative appropriate to the needs of that community.

Suggestions for further research

The findings of this research study should help health promotion practitioners to develop interventions that meet with the diverse needs of households on low incomes. Although social marketing provides segmentation as an approach to offer health promotion to targeted client groups, the study provides evidence that more detailed work is required to appeal to the hard-to-reach group of families on low income. Previously communities with high deprivation have been considered as a whole, without recognition of the diversity within such communities. In consequence, marketing segmentation needs to be

more sensitive to the micro-level differences than has previously been accepted. The LCFC model offers a theoretical framework within which to do this. The proposed questionnaire offers the potential for the practical application of the model and will be of use in all of the following suggestions for further research.

Researching men living in families on low income

During this study, it proved extremely difficult to recruit men on low incomes to take part. This is a problem encountered in many research studies and this hard-to-reach group remains under-researched in relation to eating behaviour. There is a need to reach this group of men in order to understand their lives and so develop the most appropriate methods for promoting their health. This is particularly the case given that this group is a section of the population which suffers particularly poor health. Using community development approaches to promote health for men on low incomes has proved successful in some places and research in such settings may be useful in engaging this group.

The use of incentives, either in the form of cash or rewards in kind, could be helpful in involving men in research, given that these men are on low incomes. However, they may then provide the answers they think the researcher wants, in order to receive the incentive, rather than express their own views. Other, more innovative methods may be to address men in the more public arenas that they visit, such as the local pub or club or sporting venue. It may be more appropriate to employ male researchers in these settings.

In the present study, not only were men found to be influential, but children also affected eating behaviour in many families.

Researching pre-school children living in families on low income

The research study interviewed men and women, but not children. The study did not have sufficient time or resources to explore children's views of eating. However, pre-school children make their views known from an early age. The results from the study found that children from a young age were capable of expressing their approval or otherwise of

different foods by refusal to eat. Pre-school children can be very articulate from at least 18 months onwards (Bee 1985). Future research could examine pre-school children's views, using imaginative methods such as drawing and playing games.

Many families had older children as well as one or more pre-school children who would be likely to have opinions to offer, particularly around advertising, peer influence, school meals and school health promotion, as well as suggestions for changing eating habits.

Action research to explore healthy eating with families on low incomes

At the outset of the study the interpretivist perspective was identified as the most appropriate approach to the research. Action research, using participatory inquiry techniques, would be a particularly useful approach to researching households from a community development perspective (Thesen and Kuzel 1999). However, constraints on resources did not permit for this type of research to take place.

Proponents of action research method argue that a positivist paradigm, which aims to uncover an objective reality, is inadequate. Instead, they make no assumptions about universal truths, believing that there are multiple truths, all of which are relevant and appropriate (Lincoln and Guba 1985, Addison 1999). However, researchers doing participatory action research go beyond merely embracing an interpetivist perspective, which believes that research should be done 'with' people, and not 'on' people. Instead, the people to be researched should be involved in the research process itself and all participants should be involved on an equal basis.

Despite problems with participatory action research, such as lack of interest from local people or the risk of professionals taking over the process, it remains a potentially positive approach to understanding issues relevant to a community: exploring the micro-level differences between families, and the similarities in terms of life course and family culture as described in the LFCF Model. This is consistent with the aims of community development to reduce inequalities and empower both individuals and communities.

Researching other groups

The respondents in this research study were in the process of bringing up at least one young child. The nutrition career concept, however, could be applied with people at later stages in their life, for example, with people who are retired. Significant events for them could be children leaving home, changing jobs, having grandchildren and retirement. Another group could be single people, for whom other influences are importance. For example, they may move in with friends when they first leave the parental home, then buy their own flat, wherein the influence of others is reduced, in contrast with the couples in the present study. People from different ethnic backgrounds may well have different significant life course events affecting their eating patterns, such as seasonal variations in the availability of food or religious practices.

Summary

This chapter has addressed the aim and objectives of the study and found that they were successfully achieved. Methodological issues were reflected on, which focussed on the trustworthiness of the results and the limitations of the research process. The findings of diversity within a small geographical community implies that general health promotion strategies aimed at low income families are not specific enough to recognise that households have different cultures and are at different phases of their life course. These need to be identified through small scale research which recognises these differences. The LCFC Model and associated questionnaire offers an opportunity to do this. The implications and scope for future research are recognised and recommendations suggested which will inform health promotion practitioners of ways to improve targeting their audience appropriately, using the techniques and practice of community development and use of the LCFC Model and questionnaire.

Overall conclusion

The study has demonstrated the difficulties of researching the lower income sections of society. Women on low incomes were found to be relatively open to be interviewed,

whereas men in the same circumstances were much less prepared to be involved in the research. This could be due to the women gate-keeping the men or men's reluctance to be interviewed. Different methods need to be explored to engage this hard to reach group for future research.

The male influence on eating behaviour is strong and needs to be taken account of when health promotion initiatives are considered. Likewise, the influence of children needs to be addressed. Any health promotion activity also should be aware of the diversity of communities. Presently, an area of recognised deprivation is considered as a homogenous community, wherein single answers will address particular problems. The study has shown that within a small geographical area there are several different attitudes to eating.

Two core categories were identified that expressed these different attitudes, the life course, wherein people change their eating habits according to their circumstances and the family culture that they adopt, which also may change across the life course. This lead to developing a theoretical framework, the LCFC model and a consequent prototype questionnaire. This could be developed as a planning tool which could also be used for evaluating health promotion interventions. This provided a novel approach to addressing health promotion around healthy eating in families on low incomes.

Appendices

Appendix One

Gateshead Healthcare Logo

Bensham Clinic
Liddell Terrace
Whitehall Road
Bensham
Gateshead
NE8 1NB

Tel: 0191 477 2177

Client Consent Form

Title of study:

Gender influences on diet and eating behaviour in families with pre-school children on low incomes

I have read and understand the information sheet.

I have had the study explained to me.

I have had the opportunity to ask questions about the study. I have received answers that satisfy me.

I understand that I can withdraw from the study at any time, without giving a reason. This will not affect health services I use in the future.

I agree to participate in the study.

.....

signature of client

Appendix Two

Gateshead Healthcare Logo

Bensham Clinic
Liddle Terrace
Whitehall Road
Bensham
Gateshead
NE8 1NB

Tel: 0191 477 2177

Information Sheet

Title of study:

Gender influences on diet and eating behaviour in families with pre-school children on low incomes

I am doing a study in Low Teams for the health authority. It is looking at what families eat and why. This may help us provide better information about what people eat, for future work with families. I hope to talk to several couples about this in interviews lasting between 30 and 60 minutes. I would like to tape record each interview, with your agreement.

Any information you give me will be treated in confidence and anonymously. Your name and address were obtained, in confidence, from health authority records.

If you do not wish to take part, you may refuse without giving a reason. If you want to withdraw from the study, you may do so at any time, without giving a reason. This will no affect any health services you may wish to use in the future.

Please feel free to contact your own health visitor, or myself on 261 2517, if you would like more information or have any concerns about this study.

Catherine J. Mackereth
Research health visitor

Appendix Three

Gender influences on diet and eating behaviour on families with pre-school children

Interview schedule one

Introduction
Explain research
Obtain written consent
Introduce tape recorder

Personal details
Gender
Family members and children's ages
Length of time together as a couple
Does anyone in household work?
Previous job if unemployed
In receipt of benefit? For how long?

Health
In general, what is your health like?
- good /bad things about your health

What do you think affects your health
What about the health of other family members?

Food and eating
In general, what kind of food do you eat?
- favourite foods
- examples of meals: weekdays
  Saturdays
  Sundays

Who decides what you eat? Why?
Have you ever changed your eating habits? Why
Who do you eat with?
- partner
- children

When do you eat?
Where do you eat?
- at table: when?
- in front of TV: when?

Do you eat the same food?
- as partner
- as children

If no, what are differences?
Do you eat snacks? What? When?
Do you have treats? What? When?
- partners
- children

Who cooks? Always?
Who shops?
- how often?
- where?
- how much money spent?
- who decides what to buy?
- if you had more money, would you shop differently?

Do you eat takeaways? Where? When?
Do you eat out? Where? When?
Do you eat out?
- at extended family home
- at friends

Health and diet
In your opinion, what is a healthy diet?
Do you think you eat a healthy diet?
Is it important?
- for you
- for your partner
- for the children

Do you think what you eat affects your health? How?
Where do you get information about food from?
- TV
- magazines
- health workers
- leaflets
- adverts
- school

Is it good/useful information?
What, if any, kind of information on food should be available? From where?

Appendix 4

Gender influences on diet and eating behaviour on families on low incomes with pre-school children

Focus group outline schedule

Introduction

General description of phase one results and their response

About them - families, income levels

Family Centre - attendance

Personal health

Favourite foods

Eating habits

Changes in eating over life course

Cooking

Shopping

Health and diet

Information on health

Teams - place, gender relationships

Appendix 5

Gateshead Healthcare Logo

Bensham Clinic
Liddell Terrace
Whitehall Road
Bensham
Gateshead
NE8 1NB

Tel: 0191 477 2177

Dear

I am conducting a research project in Low Teams entitled:

Gender influences on diet and eating behaviour in families with pre-school children on low incomes

It involves interviewing male and female partners of couples identified as living in the area. I have enclosed an interview schedule for your information. I anticipate that each interview will last 30 – 60 minutes. Names have been obtained from child health records. The following family/ies on the practice list have been identified as fitting the research criteria:

Ethical approval has been given for this study. However, if you have any concerns about my visiting this family/ies, I would be grateful if you would let me know at the above address. If I do not hear from you to the contrary, I intend to begin interviewing on (date three weeks hence).

Yours sincerely

Catherine J. Mackereth
Research health visitor

Appendix 6

Gateshead Healthcare Logo

Bensham Clinic
Liddell Terrace
Whitehall Road
Bensham
Gateshead
NE8 1NB

Tel: 0191 477 2177

Dear

I am doing a study in Low Teams for the health authority. It is looking at what families eat and why. I would like to talk to you and your partner about this. The interview will last between 30 and 60 minutes.

If you would be happy to do this, I will call round to your home on:
at:

Any information you give me will be treated in confidence.

If you do not wish to take part for any reason, please contact me at the above address or on my home phone number: 261 2517. If you want to withdraw from the study at any time, you are free to do so. This will not affect any services you wish to use in the future.

Your name and address were obtained in confidence from health authority records. Please feel free to contact your own health visitor if you would like more information, or myself at the above number.

I look forward to meeting you.

Yours sincerely

Catherine J. Mackereth
Research health visitor

Appendix 7

Gender influences on diet and eating behaviour on families with pre-school children on low incomes

Interview schedule 2

Introduction
Explain research
Obtain written consent
Introduce tape recorder

Personal details
Gender
Family members and children's ages
Length of time together as a couple
Does anyone in household work?
Previous job if unemployed
In receipt of benefit? For how long?

Health
In general, what is your health like?
- good /bad things about your health

What do you think affects your health
What about the health of other family members?

Food and eating
In general, what kind of food do you eat?
- favourite foods
- examples of meals: weekdays
  Saturdays
  Sundays

Who decides what you eat? Why?
Have you ever changed your eating habits? Why? When? Over what period?
What did you eat when you were growing up?
Who cooked when you were growing up?
Did your eating change when
- you became a teenager? How? Why?
- you first left home? How? Why?
- you met your partner? How? Why?
- you and your partner started living together? How? Why?
- you/ your partner became pregnant? How? Why?
- you had the children? How? Why?

Who do you eat with?
- partner

- children

When do you eat?

Where do you eat?

- at table: when?
- in front of TV: when?

Do you eat the same food?

- as partner
- as children

If no, what are differences?

Do you eat snacks? What? When?

Do you have treats? What? When?

- partners
- children

Who cooks? Always?

Who shops?

- how often?
- where?
- how much money spent?
- who decides what to buy?
- if you had more money, would you shop differently?

Do you eat takeaways? Where? When?

Do you eat out? Where? When?

Do you eat out?

- at extended family home
- at friends

Health and diet

In your opinion, what is a healthy diet?

Do you think you eat a healthy diet?

Is it important?

- for you
- for your partner
- for the children

Do you think what you eat affects your health? How?

Where do you get information about food from?

- TV
- magazines
- health workers
- leaflets
- adverts
- school

Is it good/useful information?

What, if any, kind of information on food should be available? From where?

Teams

How long have you lived in Teams?

Where else have you lived? How did it compare with Teams?
What is it like living in Teams?
- good things?
- bad things?

Has it changed at all? In what way?
How would you describe a typical family living in Teams? Who makes the decisions?
Are you like that?

Appendix 8

The 'Life Course and Family Culture Questionnaire'

Life course - how has your eating behaviour changed over your life?

There are times when some people's eating habits change over their lifetime.
Have you ever changed your eating habits? Why and when?

What did you eat when you were growing up?

Was it different to how you eat now?

How was it different?

Did your eating change when

- you became a teenager? How and why?
- you first left home? How and why?
- you met your partner? How and why?
- you and your partner started living together? How and why?
- you had children? How and why?

Family culture - how do you eat now?

What are your favourite foods?

What are your partner's favourite foods?

What are the children's favourite foods?

What kind of things do you eat during the week?

- on Saturdays

- on Sundays

Do you all eat at the same time or separately?

- partner and children	Daily	Every 2-3 days	Weekly	Rarely
- children earlier, with partner later	Daily	Every 2-3 days	Weekly	Rarely
- all different	Daily	Every 2-3 days	Weekly	Rarely

Who decides what to eat?

- everyone separately	Always	Sometimes	Occasionally	Never
- male partner	Always	Sometimes	Occasionally	Never
- female partner	Always	Sometimes	Occasionally	Never

Do you all eat the same food at mealtimes?

Daily Every 2-3 days Weekly Rarely

What kind of food do you usually use?

- Frozen	Daily	Every 2-3 days	Weekly	Rarely
- Tinned	Daily	Every 2-3 days	Weekly	Rarely
- Fresh Ingredients	Daily	Every 2-3 days	Weekly	Rarely

What affects what you eat? Please number the following in order of importance:

Taste
Preparation time
Cost
Health
Other (please state)

Are there any changes you would like to make about what you eat?

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Food consumption in low income families with pre-school children

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Abstract

Healthy eating advice aimed at families has been traditionally targeted at women in the belief that it is they who make the decisions about food consumption within the family unit. This article reports the findings of a study which explored the influence of other family members on food consumption in low income families with pre-school children. Ten couples were interviewed at home. The findings reveal that women's decisions about food consumption within these families are influenced primarily by their partners, but also by their children. The findings suggest the existence of a 'nutrition career', whereby food choices and preferences are renegotiated as personal circumstances change, e.g. when cohabitation begins or on becoming a parent. During these key transition points patterns of food consumption may be voluntarily reshaped thus providing an opportunity for community practitioners to target healthy eating advice more appropriately.

The Government's *Health of the Nation* strategy (Department of Health (DoH), 1992), highlighted nutrition as a key area for health promotion. This emphasis on healthy eating has been reaffirmed in the Government's Green Paper *Our Healthier Nation* (DoH, 1998). Dietary intake is an associated risk factor in diseases such as coronary heart disease, stroke and cancers (World Health Organization (WHO), 1990), and is therefore of vital interest to those concerned with health promotion. The *Health of the Nation* strategy (DoH, 1992) recommended that men, in particular, should to be targeted for health promotion activity because of their increased risk of contracting these diseases.

Many studies have examined dietary intake by asking people what they eat (Tomlinson and Warde, 1993; National Food Survey Committee, 1994). Research has also examined people's knowledge, attitudes and beliefs about food (Charles and Kerr, 1988; Blackburn, 1992; DoH, 1992), but these studies have mainly focused on women or women's perceptions of men's knowledge, attitudes, beliefs and practice concerning healthy eating. Few studies have addressed the issue from a male perspective. In most previous studies of family food consumption, it has been demonstrated that women believe they have prime responsibility for the provision of the family's diet and do most of the shopping and cooking though they may be influenced by their children's food preferences (Murcott, 1983; McKie and Wood, 1991). Consequently, much healthy eating advice intended for 'the family' has been directed at women (Wilson, 1989).

Individual eating patterns begin to be laid down from birth. Families with young children have consistently been viewed as an important target group for the promotion of healthy eating (Birch, 1993). There are also clear differences in food consumption patterns between socioeconomic groups. Families in socioeconomic groups IV and V eat less wholemeal bread, polyunsaturated margarine, semi-skimmed milk and fruit than families in socioeconomic groups I and II (Calnan, 1990). This makes lower income families with young children a particular priority for healthy eating advice.

An important and obvious influence on family food provision for those on low incomes is cost (Dobson et al, 1994). Healthier foods are perceived to be (and often are) more expensive and may therefore be outside the reach of many low income families. Such families are also less likely to have private transport and may be obliged to shop locally, rather than at out-of-town supermarkets, which may mean still higher prices and fewer choices (Graham, 1984).

The presence of a male partner in a household may influence eating behaviour. A study by Charles and Kerr (1988), indicated that women (especially in socioeconomic groups IIIb, IV and V) cook according to their male partner's preferences, with their own beliefs about healthy food and personal preferences having low priority. Male partners may exert an influence on family diet, even though they do not become actively involved in shopping and cooking. Male unemployment may mean

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'An added problem for low income families, is the risk that children may refuse to eat new foods which means that there is a financial risk involved in buying food that will not be consumed. Food that is familiar is bought in the knowledge that it will be consumed, and this food is often chosen by children...'

that men spend more time at home and could therefore be more active in food purchase and preparation. Morris (1987), however, states that:

> 'Male unemployment is likely to carry with it a resistance on the part of the man to any suggestion that he should take over domestic chores.'

This finding is in contrast with middle class notions of the 'new man' (Murcott, 1983; Gillon et al, 1993), as gender differences in men's and women's domestic roles appear to be less apparent in socioeconomic groups I and II (Buss, 1993; Tomlinson, 1994).

Children also influence family eating. A baby has little choice over what he/she eats — 'milk is the food' (Birch, 1993); however, children are soon able to express their distaste by refusing food. In general, new and different foods are often rejected. Repeated exposure is likely to lead a child to learn to eat the new food, and enjoy it, but often parents accept a rejection before the child has had the opportunity to become accustomed to the new food (Birch, 1993).

An added problem for low income families, is the risk that children may refuse to eat new foods which means that there is a financial risk involved in buying food that will not be consumed. Food that is familiar is bought in the knowledge that it will be consumed, and this food is often chosen by children rather than being the mother's choice (Calnan, 1990).

It is intended that findings from the study being reported here will provide the necessary information to develop a more appropriate framework for the promotion of healthy eating in low income families with young children. The aims of the study were:

- To explore parental knowledge, attitudes and beliefs about the relationship between diet and health in low income families with pre-school children
- To investigate family influences on food consumption in low income families with pre-school children.

Methods

The research was conducted in an area of Gateshead in northeast England which has been identified by Phillimore and Beattie (1994) as the 14th most deprived ward in the Northern Region. A defined geographical area of approximately 2000 households was identified as meeting the key characteristic of high deprivation required for the study. The other criteria for inclusion in the study were that the household:

- Had a low income (defined as claiming benefit, including income support for low paid work)
- Contained a man and woman who were living as a couple
- Contained at least one pre-school child.

The sample in this research comprised 10 couples. A list of households (drawn from the Child Health Record Department) which met the selection criteria was used to identify potential research subjects. An essential aspect of the research was to obtain the views of both men and women on diet and eating behaviour within the household. McKee and O'Brien (1983) comment that: 'there is no ready-made sampling frame of fathers'. Clarke and Watson (1991) suggest that obtaining the views of men in socioeconomic groups IV and V is difficult. There was some difficulty in obtaining a sufficient number of couples to take part in the research because of an apparent reluctance of male partners to be interviewed. Eighty-eight initial contacts were made in order to secure interviews with 10 couples.

There is no information on the families who declined to take part in this research. These families may form a distinct subgroup within the target population. Consequently, the research sample may have consisted of more 'cooperative' couples who may be unrepresentative of similarly structured families who did not take part in the study. This limitation should be taken into account when the implications of the results are considered.

All couples in this small-scale qualitative study were interviewed by the first author (CM) to ensure consistency. As this was a qualitative study, reliability and validity were sought through discussion of the data with the research supervisors. Approval was sought from the local Research Ethics Committee. Their only concern was the safety of visiting couples at home. They were reassured that this was normal community nursing practice and that colleagues would be aware of where the researcher would be visiting. A consent form was signed by all interviewees and included an explanation of the research, assurance of confidentiality and a clause to allow the interviewee to terminate the interview at any point.

The interviews were held in the couple's home and, on average, lasted 45 minutes. The couple were interviewed together. The interview schedule is outlined in *Figure 1*; all interviews were audio-taped and then fully transcribed. The interview transcripts were analysed using a grounded theory approach to the data, which entailed categorizing the information into themes, using open and axial coding. This uses a systematic approach 'to develop an inductively derived grounded theory about a phenomenon' (Strauss and Corbin, 1990). A summary of the data is presented under the five key themes identified.

Interview schedule

Introduction
Explain research
Obtain written consent
Introduce tape recorder

Personal details: gender, family members etc.
Family members and children's ages
Length of time together as a couple
Does anyone in household work?
Previous job if unemployed
In receipt of benefit? For how long?

Health
In general, what is your health like?
— good/bad things about your health
What do you think affects your health?
What affects the health of other family members?

Food and eating
In general, what kind of food do you eat?
— favourite foods
— examples of meals: weekdays
Saturdays
Sundays
Who decides what you eat? Why?
Have you ever changed your eating habits? Why? When?
Over what period?
Have they changed since
— you met your partner? How? Why?
— you had the children? How? Why?
Who do you eat with?
— partner
— children
When do you eat?
Where do you eat?
— at table: when?
— in front of TV: when?
Do you eat the same food?
— as partner
— as children
If no, what are the differences?
Do you eat snacks?
What? When?
Do you have treats?
What? When?
— partners
— children
Who cooks? Always?
Who shops?
— how often?
— where?
— how much money spent?
— who decides what to buy?
— if you had more money, would you shop differently?
Do you eat takeaways?
Where? When?
Do you eat out?
Where? When?
Do you eat out?
— at extended family home
— at friends

Health and diet
In your opinion, what is a healthy diet?
Do you think you eat a healthy diet?
Is it important?
— for you
— for your partner
— for the children
Do you think what you eat affects your health? How?
Where do you get information about food from?
— TV
— magazines
— health workers
— leaflets
— advertisements
— school
Is it good/useful information?
What, if any, information on food should be available?
From where?

Figure 1. Interview schedule used to explore gender influences on diet and eating behaviour in families with pre-school children.

Results

Profile of respondents

Respondents were asked some general questions about themselves and their families in order to get the interviews started. The 10 couples had been together for 3–12 years and had 1–4 children. Four of the men worked but still needed to claim family credit.

Analysis

The results were coded according to a number of themes, such as decisions about food, food purchase, ideas about 'healthy' food and 'junk' *vs* 'real' food. However, on further analysis, an underlying theme emerged around the concept of life transitions. Different attitudes, influences and behaviour were identified as people moved through their life cycle. Growing up, leaving home, meeting partners, setting up home with partners and having children were identified by the majority of respondents as times in their life when they had reflected on their eating patterns and often changed them.

Growing up

Many interviewees talked of their mothers cooking 'proper dinners' when they were growing up. Invariably this would consist of meat, potato and another vegetable. This was often compared to the present diet, either positively or negatively:

> 'Now I just have dinners now and again and have Sunday dinner round at my mother's...but brought up on dinners.'

> 'Dinners. Me mam used to always cook for us. We hardly ever had chips when we were little...but me dad'll not eat chips...well, I cook chips and that, whereas me mam wouldn't.'

> 'Well me mam used to make broths, dinners...I mean, when I was a kid, my mam always made me eat my greens, sprouts...and I used to say "I don't like them"...but I have changed my diet because I eat rubbish now.'

'Several people commented on how much they enjoyed their Sunday dinner. Many families enjoyed a wide variety of vegetables and this appears to contrast with what some families eat during the week.'

Although eight couples eat differently now compared to when they were growing up, all couples had 'Sunday dinner' as they grew up and continue to do so regardless of their low incomes. For nine couples, this meant a roast joint of meat, potatoes, a variety of vegetables, gravy and Yorkshire pudding. Sunday dinner seems to encapsulate the social role of food and eating.

> 'Time when a family's supposed to get together.'

Several people commented on how much they enjoyed their Sunday dinner. Many families enjoyed a wide variety of vegetables and this appears to contrast with what some families eat during the week. Some of the families reported not eating vegetables during the week, but eat lots on Sundays. This has potential implications for health promotion because it is not vegetables in themselves that are rejected, but the way they are presented at different times of the week.

Early adulthood

When asked about what they ate as teenagers and as young adults leaving home, many interviewees talked of their changing diet. Typically this consisted of rebelling against the family diet and asserting their independence. This was highlighted by the following comments:

> 'I got my own flat with my sister, we used to just binge sandwiches and pork pies with crisps and we never really eat healthy...chip shop or Chinese.'

> 'I used to go to the Chinese.'

> 'I don't eat as much fatty stuff as I used to eat. I used to eat loads of fatty stuff when I was younger but I don't as much now.'

On cohabitation

Couples talked about changes in their eating habits when they moved in together. Many of them were working at this stage in their lives and therefore had more disposable income and few responsibilities.

> 'We used to go out a lot...to restaurants.'

> 'We used to always have takeaways... Chinese...but now we're basically in the house now. If we have a takeaway now, it's mainly a luxury. On a Saturday night we would go down the road and we would get a jumbo sandwich at the pub...at the minute we never have much out...we had a kebab the other day, but it is very far and few between.'

This was a common pattern, of eating out or getting takeaways when a couple did not have children. For most families, this changed on having children because of the cost.

On having children

At this stage, many couples talked about further changes:

> 'We seemed to get more of a family when [name of child] came. We seemed to have more responsibility when he came so we started to act a bit more sensibly.'

This was the time when patterns of family eating were established, but it was a more complex issue than appeared on the surface. Most couples initially claimed that it was the woman who made the decisions about the provision of food for the family. Further probing, however, revealed that such decisions usually involved negotiation between the couple. The woman implicitly or explicitly sought approval from her partner for her choices. Occasionally, the man might object to the woman's choice or he may request a favourite food.

> 'If I say I like that (frozen meal)...she knows to get some more the next week.'

> 'Well, when we go shopping...he picks what he likes...and I cook it.'

If a woman cooked something her partner did not like:

> 'He wouldn't eat it...so its, like, a waste.'

The following quotes were typical responses:

> 'I know what he likes.'

> 'We all like what each other likes.'

These remarks suggest previous compromises around family eating habits.

At other times, decisions about food consumption seemed to be primarily the man's domain. When one man was asked who decides what they eat, the answer was 'I just say what I fancy', another said an unequivocal 'Me'. Three men were critical of their

'Most people at some point referred to eating 'what they wanted'. This, in many ways, seems an obvious point, but there appears to be a tension for some people between eating what they want to eat, what they feel they should eat, what they feel the children should eat and/or eating to lose weight.'

partner's choice of food for the children:

> 'Junk food, she feeds them on junk.'
>
> 'She seems to make just...chips...just like the chip shop.'
>
> 'I tell her to give him loads of stuff that's good for him...not bad for him.'
>
> Female: 'I'm not really bothered (about healthy eating)...'
>
> Male: 'What will happen when you die when they (children) are six?'

One woman said that if they could not decide between them what to eat, then her partner usually won:

> **'I mean if I done something and he didn't want it he wouldn't eat it anyway'.**

In this study, children also influenced what was eaten. Although most couples said that the family usually ate the same foods, reasons for not eating the same food included 'fussy' children and the children's preference:

> **'Well, as I say, I've got to fight at times to get meals down him...if he won't eat a meal I'll say well...he's had nothing, give him a bag of crisps...at least he is getting something.'**
>
> **'There's no point giving them something they're not going to eat.'**

Most people at some point referred to eating 'what they wanted'. This, in many ways, seems an obvious point, but there appears to be a tension for some people between eating what they want to eat, what they feel they should eat, what they feel the children should eat and/or eating to lose weight. A moral dilemma between 'want' and 'should' often exists:

> 'I mean as I said, if I want to eat it I'll eat it and if I don't I won't. It's as simple as that, but as long as they're getting their nutrition I'm not bothered what we get...well, as long as the kids are all right, that's all that bothers me.'

Nutrition career

The concept of a 'nutrition career' fits in well with the study findings, i.e. an individual pattern of eating behaviour which may be laid down early, but can be overlaid and reshaped as the person progresses through his/her life and as his/her personal circumstances change. Key transition points such as early adulthood cohabitation and having children may provide an opportunity to promote healthy eating as they are likely to be associated with change in a number of areas in the person's lifestyle, at a time when he/she is in a position to reflect on the need to change certain behaviours, such as food consumption.

Discussion

The results from this study show some of the complex influences on food consumption in low income families. In particular, they reveal more negotiation between family members with regard to eating patterns than many earlier studies suggested (e.g. Douglas, 1982; Charles and Kerr, 1988). In this sample women may still appear to have the main responsibility for purchasing and preparing food, but their male partners and children have a strong influence on what food is actually provided for the family.

The data suggest an emergent concept of a nutrition career, i.e. the development of individual eating patterns, which are influenced by key life transitions through the process of reflection, negotiation and subsequent change in behaviour. One of the most important life transitions for an individual occurs when the household becomes a family. The person who has the most power within a relationship is likely to gain most from negotiation.

In this study male partners seemed to have a high degree of influence on eating behaviour within the family. Children were influential, but less so than men. Most of the couples interviewed seemed to have come to a compromise of some sort. It may be that, early in relationships, ground rules are set by the behaviour of the male partner in terms of what food is acceptable and what is not. This is then further negotiated when children become vocal in expressing their preferences. The family then moves into a more established pattern of eating behaviour.

Since this study was completed, Kemmer et al (1998) have published the results of their study which was set up to examine food consumption patterns before and after cohabitation. The results partially support the findings from the Gateshead study, in that they found a similar division of labour between couples,

Key Points

- **Healthy eating advice aimed at families has traditionally targeted women in the belief that it is they who make decisions about family food consumption.**
- **In this small study couples on low income were interviewed in their homes to explore the influence of family members on food choices.**
- **Partners had a predominant influence on women's decisions about food consumption and children also influenced such decisions.**
- **On further analysis, a 'nutrition career' was identified, whereby food choices and preferences are renegotiated as personal circumstances change throughout the life cycle.**
- **Transition points could provide an opportunity for community practitioners to effectively target health promotion activities around food choices.**

Shopping and cooking were done, either by the woman, or as a shared activity between the couple and there was 'a great deal of negotiation and adaptation in food choice' after cohabitation commenced.

The women in Kemmer et al's (1998) study, however, appear to have more influence over food consumption than was found in the Gateshead study. This contradictory finding could be explained by a sampling bias which was identified in Kemmer et al's study. Kemmer and colleagues surveyed couples drawn predominantly from the higher socioeconomic groups. The women in these couples seemed to be more assertive than their female counterparts in the Gateshead study in respect of their food preferences and choices.

Conclusion

If the findings from the Gateshead study hold true for other similar families, attempts to promote healthier eating in these families may be ineffective if initiatives are targeted at women without recognizing the influence of male partners and children on food consumption within the family. There may be a need to specifically target other family members in such households in order to promote healthier eating.

Strategies are needed to educate and target families as a whole, such as family group work in settings such as family centres which are aimed at the whole family, food cooperatives, and community cafes (National Food Alliance, 1994). Schools provide an appropriate access place to target children. To date, little work in this area has been undertaken with men. However, Robertson and Williams (1997) describe a number of successful projects, from well-man clinics to community-led projects, e.g. the Danny Morrison health project in Glasgow.

Life transitions, such as leaving home, beginning to cohabit or becoming a parent, would seem to present an ideal opportunity for the promotion of healthy eating. It could be more effective to offer targeted healthy eating messages during the key transition stages in the individual's nutrition career, e.g. at school in preparation for leaving home, at parentcraft classes and in the early years of parenthood.

The findings from this research will enable practitioners to map out opportunities for the promotion of healthier eating with these different target groups. The researcher intends to further explore the influences on family eating, using the nutrition career as a tool for researching nutrition in greater depth. ●

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