Food, Caring and Illness in the Family Setting

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2000
This study explores the processes by which people in families manage the experience of chronic illness, specifically in relation to dietary recommendations for medical reasons. The two medical conditions chosen to represent chronic illness were coeliac disease and coronary heart disease. Adults in 41 families were asked to talk about organising and managing the special diet within the family setting. Most participants were married or living as married at the time of the interviews, but a few were widowed or divorced. In half of these households one spouse was diagnosed with coeliac disease, and in half one spouse was diagnosed with coronary heart disease. The study was designed so that within each medical condition equal numbers of men and women had the condition. Participants were interviewed on two occasions approximately three to four weeks apart. The study used in-depth interviews conducted using a framework drawn from previous research but allowing for the emergence of new and unanticipated data. The interviews were taped, fully transcribed and analysed using a process of detailed general coding and then focused coding for emergent themes.

At the outset it was assumed that gender would be a significant factor particularly in the organisation, production and consumption of food and meals. The position of the 'home manager', that is, the person mainly responsible for food and meals in the family, (usually female) was the main focus of the study.

Analysis of the data revealed: Gender remained a significant factor in the ways that the families organised and managed domestic tasks and activities. However, the nature and meaning of the family relationship was seen to be equally important as a process by which social life was created and reproduced on a day to day basis. The intrusion of chronic illness into the family relationship, although disruptive in both consequence and significance, was absorbed and managed, usually by wives and mothers, in ways which sought to minimise perceptions of the burden involved. An emphasis upon the natural and the ordinary was conveyed by participants which lead to a sense of stability yet flexibility reflective of Gidden's term 'ontological security'. The desire to 'lead a normal life', expressed by some participants and implied by others, provided a key overarching theme.
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Introduction

Background. The aim of this study has been to examine the everyday experience of living with a diet-related chronic illness within the family setting from the perspective of those family members responsible for the production and consumption of food and meals. The central focus has been the attitudes towards and management of food and meals in the light of a family member being required to follow a special diet. The starting point for the study has been that activities that take place within the family have meanings which go beyond the functional and provide a means by which social life is constructed and understood. The juxtaposition of the often mundane activities of organising food and the frequently distressing experience of dealing with the consequences of a chronic illness highlight the range of responsibilities which fall within the remit of family practices. The expectation that the family setting is the 'natural' and 'proper' location for these caring tasks to be undertaken will be a major theme drawn out in the literature and evident in the data analysis.

The origins of this research came from work already undertaken on diet change in families as part of the Nation's Diet Research Programme, funded by the Economic and Social Research Council and completed in 1995 (Henson et al. 1998, Gregory 1999). The study examined the impact on the family of one member's change in diet and focused upon three broad types of diet: vegetarian, slimmer and medical. It was noted, amongst other things, that there were interesting similarities across what appeared to be very different types of changes in diet, in terms of how the participants construed the family setting, as well as the meanings they associated with food and meals. The idea for this study came from aspects of the original study that could not be addressed in the depth required.

The decision to focus specifically upon the experience of chronic illness was based upon a number of factors. Chronic illness increasingly forms a large part of the work that the medical profession has to treat, but, unlike acute illness, is likely to require some form of attention which will continue lifelong. The consequences of this attention are most likely to be felt in the home, and in ways very different from those experiencing acute illness. Whilst acute illness is likely to demand concentrated care, whether in the hospital or the home, there will usually be an assumption of an endpoint to that care. The experience of chronic illness, for patient and for the rest of the family, is, quite literally, a lived experience. The prevalence of chronic illness and the need for it's consequences to be accepted and absorbed into the family setting suggested a topic for enquiry valuable both in policy terms and as a means by which everyday social meaning could be examined in depth. It was the latter which made a qualitative approach most appropriate, using open interviews with those members of the family most associated with the organisation of domestic tasks and activities.
The study focuses upon two specific medical conditions: coeliac disease and coronary heart disease. The former is a relatively rare condition which involves the non absorption of the gluten in food which, if not avoided, results in the lack of absorption of necessary nutrients, and which results in a range of potential symptoms. The treatment is purely dietary. The latter condition is a major cause of deaths in both women and men in most Western societies, as well as a widespread cause of demand for medical treatment, from angina to major heart surgery. The treatment includes recommendations of lifestyle changes including diet. These conditions were chosen partly because they have characteristics that seem very different, which, it was hoped, would provide a useful range of potential responses to the illness experience (these characteristics are discussed in detail in the methodology section). They were also chosen as conditions which have the potential for patients to return to what tends to be described as 'a normal life', relatively easily, provided the medical recommendations are followed. Thus a tension might be created between living a normal life, which tends to be construed as an absence of illness, and the requirement to follow medical advice, which implies a questionable health status.

There is considerable evidence that the process of producing meals which the family consume together is used by many as an indicator of the nature of the family itself (Mucott 1998, 1983a, DeVault 1991, Charles and Kerr 1988). The Nation's Diet project revealed that providing food and meals in families, whether or not the diet was part of an illness treatment, conveyed special meaning for those giving and those receiving. Notions of healthiness formed an important part of what could be achieved through 'proper' food consumption (this included the way that food was consumed as well as the content of meals). Meals were also viewed as a means by which family life could be seen to be shared and endorsed. Thus bringing together the sociology of food and the sociology of health and illness within the context of the sociology of the family would provide a valuable and unique contribution to social research and social theory.

Literature. The literature which will be presented in the first three chapters of this thesis draws upon studies and theoretical discussion from the three areas of sociological enquiry to provide a framework for and to inform the themes which have been identified in the data analysis. Thus, the work cited is not a comprehensive exposition of the full range of literature available within all three sources, but rather an indication of the key debates which are relevant for the analysis that has been undertaken. It has also been selected in order to make the required links between these three areas in a form which has not been achieved in quite the same way elsewhere.
The literature on the family will show the strength with which notions of 'the family' have endured, despite considerable change in the ways that everyday social lives are organised. It will be argued that, as well as providing a location within which basic (and more sophisticated) human needs may be catered for, it also generates activities through which identities, both individual and group, are constructed and reconstructed on a daily basis. The value of traditional beliefs about 'family life' as structural norms and as everyday contingency will be discussed, with particular reference to the use of 'the natural' as both a basis and a consequence of those beliefs. Significant are the implications for a form of biological determinism which conflates sexual function with gendered identity and so identifies the home and family as the appropriate responsibility of wives and mothers. Gendered assumptions about the family through an ideology of 'caring as natural' will be used as a vehicle for examining the invisibility of certain aspects of caring in the home. The distinction between notions of 'caring for' and 'caring about' is identified and provides a major theme which runs through the literature and informs the analysis.

The literature on diet, food and meals focuses upon the processual nature of family practices. The sociology of food has, amongst other things, offered an effective way of examining the lived experience of family life and the meanings constituted through everyday tasks and activities. The ordinary and the everyday have been notoriously difficult to bring to centre stage within much of sociological enquiry, particularly medical sociology, other than when in comparison to the dramatic and the unusual. Social research on food and diet has been important in the development of understanding about how relationships within families are established and maintained. Again, the role of gender has been found to be a significant factor in this. Gender roles and responsibilities in the family are shown to be acted out through food activities which represent and could be said to constitute 'the family' as it is understood in contemporary Western culture. In particular, attention is drawn to the ways notions of 'the natural' can be seen to have masked the complex negotiation which takes place within the family setting as part of this process.

The literature on health and illness draws attention to the uncertainty with which the distinction between 'health' and 'illness' can be understood, both in terms of definition and in terms of perceptions of individual health status. Responses to chronic illness are seen to be involved as much in creating a sense of continuity of identity as they are to ensuring that medical advice is followed. The experience of chronic illness in the home is seen as likely to affect all members of the family, who are likely to be drawn into a number of potential strategies used to deal with the consequences. In many cases the impact can be seen to be major and negative, although a positive approach to the situation in which they find themselves is reported by
many others. However, although the impact of the illness has been well documented, and the process by which that impact is dealt with widely theorised, there can be seen to be a neglect of theorising 'family' as constituting meaning for the illness experience.

**Methodology:** The participants originally to be recruited to take part in this study was the 'home manager' (the person responsible for domestic tasks) in 40 households where there was a married or co-habiting couple. Half of these households were to have one spouse diagnosed with coeliac disease, and half were to have one spouse diagnosed with coronary heart disease. Within each medical condition equal numbers of men and women would have the condition. (The numbers of participants actually recruited and interviewed are discussed in the Methodology chapter). The interviews were taped and transcribed and analysis was undertaken at a general level and then by tracing specific dominant themes which were reflective of the ideas which formed the basis of the original proposal for the research. The research design utilised two interviews with each set of participants, three to four weeks apart. The interviews incorporated descriptions of family food practices over time, including the participants' childhood as well as across their adult relationships, which allowed a sense of beliefs and practices over time to build up. Thus, although the illness experience formed a central feature of the enquiry, it could be viewed within a long term context.

The data collection process was conducted with the aim of participants talking about their experiences and beliefs rather than in response to set questions. These 'guided conversations' attempted to draw out the ordinary as well as the momentous, the everyday process as well as the significant event. It was felt, therefore, more appropriate for the consideration and presentation of the data analysis to remain as close as possible to the processes from which it has been drawn. Thus, rather than fragment the data into abstract conceptual groupings, however broad, attempts have been made to retain the context, in terms of location, time and individual meaning, as far as possible. This approach has made use of, where felt necessary, detailed background of the participants lives, and extensive extracts from the transcripts. In this manner it is hoped that the atmosphere and the influences to which the participants were subject would be evident.

**Data analysis:** The examination of the data drew out four main abstract concepts which formed the core of the analysis: 'relationship'; 'caring'; 'negotiation'; and 'selfhood'. Definitions of these terms, for the purposes of this research, will introduce the final discussion chapter in order to distinguish them from alternative ways in which they may be used. Briefly, 'relationship' means the bond established over time, between a group of people related by marriage (or similar) and/or birth, which allows expectations of love, affection, care and support to develop. 'Caring' incorporates the linked but separate notions of *caring for*
and caring about which bring together the instrumental and the affective aspects of family relationships. 'Negotiation' denotes the process by which people within families communicate their needs and expectations to each other in ways which may not always be clear and straightforward and may be incomplete and misunderstood. 'Selfhood' is the most difficult to define, in that rather than a distinct entity, it is intended to convey the sense of identity, both individual and group, that emerged from the negotiations around caring within the family relationships which were part of an ongoing process that was 'family'. In many cases the meanings of these concepts may be indistinguishable from the ways they are used elsewhere, but it is felt important to establish that, whilst they may be terms in common use, they have a specific meaning for this study.

The family relationship provides both the backdrop for and the process through which the data analysis is presented, but each chapter focuses upon a different aspect of that experience. The first data analysis chapter focuses upon the embodiment of 'caring' within the family relationship through notions of the family meal and by examining the lived experience of 'caring for' and 'caring about'. The second data analysis chapter examines this experience within the context of gendered roles and territories which enact the process of 'doing family'. Whilst the impact upon women of caring responsibilities was (in this group of participants) very clear, there was also evidence of the complex process by which gendered tasks and activities constituted the relationships within which they operated. The third analysis chapter locates the experience of illness within the process of 'doing family' in order to highlight the constitutive relationship between the two. Strategies and negotiations used to facilitate initiation of the special diet provide the focus for this. The management of the illnesses to which the participants are subject weaves through all of the analysis chapters, but becomes a direct focus of the final analysis chapter. In this the blurred boundaries between notions of health and notions of illness are demonstrated through the processes of negotiation family members undertake to deal with the medical conditions, whilst preserving the sense of normality that living in families demands.

Conclusions. It is suggested that, by examining the experience of illness in the family setting through the processes involved in conducting domestic tasks and activities, (specifically those around food) insight into the constitutive nature of 'the family' can be achieved. The final discussion chapter draws out the main themes which run through both the literature and analysis chapters to illustrate the nature of 'family' as process, and the meaning that notions of 'normality' have for the construction and reconstruction of family life, day to day and over time.
The major contribution of this thesis has been to enhance understanding of the processes by which people make sense of everyday life within the framework of social norms and expectations. This has been achieved through the detailed examination of the mechanisms for dealing with two contrasting chronic illnesses, specifically in relation to food and diet within the family setting. It has the particular worth of contributing to the understanding of the experience of illness, for both patient and family members, for clinical, political and lay benefits.
Part one
Literature review
Chapter 1. The family as a site for gendered care

Introduction

'The Family' as a concept and as a lived experience remains an enduring institution for academic study, for political manipulation and for everyday human existence. The term 'the family' is recognised across many cultures, not just those limited to the West, as the setting within which most people, at some point in their lives, live and conduct the private, personal aspects of their lives. Criticism has been levelled at a narrow functionalist Parsonian inheritance which confines the definition of 'the family' to a North American middle-class, white, heterosexual, married couple with children (Bernardes 1997. VanEvery 1995). Even a more realistic definition of a heterosexual once-married couple with children has been recognised as representing only a small proportion of the general population of most Western cultures (Bernardes 1985, 1986, 1987). Nevertheless, it is increasingly the case that groups of people who do not fall within the definition given above (such as: lone parents, foster or adoptive parents, same sex couples, co-habiting couples and remarried couples with step-children) may describe themselves as 'families' (Morgan 1996, VanEvery 1996, 1995).

This chapter will review (mainly) sociological literature which defines, discusses and interprets the concept known as 'the family' in terms of the theoretical foundation upon which current understandings of 'the family' are based. The gendered nature of family practices will be examined specifically in terms of day to day social life through the lifecourse. An emphasis will be placed upon the processual nature of 'the family' as a means by which the family relationship can be seen to be negotiated and developed over time. The perspective taken for the purposes of interpreting and understanding the data presented in later chapters is that of social construction. By this is meant that the meanings through which people comprehend their lives as indisputable facts may be constructed out of common understandings of what is 'normal' and expected. To construe the world as constructed is, in Gergan's words:

the attempt to place one's premises into question, to suspend the "obvious", to listen to alternative framings of reality, and to grapple with the comparative outcomes of multiple standpoints. For the constructionist this means an unrelenting concern with the blinding potential of the "taken-for-granted". (1999 p50)

It is assumed that the everyday lived experience of the people who agreed to participate in this study provides a dual role for them. Whilst undertaking the tasks and activities which have allowed each family's lives to proceed functionally, each family member's contributions to
their daily routines also provided a day to day construction and reconstruction of the meanings that the family generally, and their roles within the family specifically, have for them. Thus, there will be an emphasis upon the level to which the literature can be seen to provide evidence for this perspective.

Definitions, theories and family ideology

Definitions of 'the family' draw upon assumptions about location, relationship and 'a mutually created shared reality' (Backett 1982 p35). Notwithstanding the range of relationships mentioned above, members of which are willing to describe themselves as 'a family', the process of 'being family', that is, the day to day activity and communication is rarely in dispute. This is a process which has been defined by Morgan (1996) as follows:

'family practices' incorporates sets of practices which deal in some way with ideas of parenthood, kinship and marriage and the expectations and obligations which are associated with these practices (p11)

The term 'family' has been used within '...a constellation of words - house, home, household, maison, maisonnee...' (Bourdieu 1996: 19) when trying both to understand and to prescribe the activities which people undertake within the private world of personal relationships. The words 'kin' and 'marriage' might also be added to that list to show the kind of terms used to try to define a form of relationship entered into and experienced routinely by most people without the need for explanation. Bourdieu goes on to suggest that the normal family, 'while seeming to describe social reality, in fact constructs it' (p19). The following brief examination of the potential meanings behind these terms provides a starting point for an examination of the potential for such a claim.

The term 'household' implies geographical location (address) and material assets as much as membership and, Morgan suggests, reflects an apparent simplicity over the term 'family' (1996), and which may explain its popular use in large scale surveys such as the General Household Survey. 'Family', in contrast, spills over into neighbourhood and beyond, geographically, also bringing with it both past and future in terms of generation. The term 'kin' takes the problem of containment of definition found in 'family' to new levels by introducing notions of duty and obligation through a sense of reciprocity which must be negotiated (Finch and Mason 1993, Finch 1989). 'Marriage' would seem to be the most straightforward of terms, in that either religious and/or legal contracts define and describe an event witnessed by others than the participants and which leads to a status in law. In addition,
attached to the term 'marriage' may also be found the legitimate location for the social consequences of romantic love and sexual intimacy more explicitly than to that of 'family' (Dunscombe and Marsden 1999). The term 'home' is, perhaps, the least easy to define, and, according to Morgan (1996), the least explored. It returns us to a sense of physical location but as a setting for a specific relationship and the potential for permanence in the cultural memory as well as the current situation (Giles 1997, Malos and Hague 1997, Finch and Hayes 1994). Nevertheless, 'home' brings together the location of household and the relationship of 'family' into a space, place and time in which family life is acted out. 'Doing home' and 'doing family' have been examined in a special issue of *Womens Studies International Forum*, 'Concepts of Home' and have revealed the complex ways these have been construed and lived (Bowlby et al. 1997). These terms, to a greater or lesser extent, all continue to be used routinely by those who wish to refer to an arrangement within which they chose to conduct their private personal lives. However, the term 'family' is the one which leaps most swiftly to the lips of those who wish to share or to prescribe activities which are associated with notions of caring, when located within the private sphere of the home.

What does seem clear is that what has been described as 'the standard sociological theory of the family' (Cheal 1991), certainly in America in the post World War II years, of 'an urban middle class ....remarkably uniform, basic type of family' (Parsons1971 p 53 quoted in Bernades 1997) is far from the everyday experience of the late 20th and early 21st centuries. The restructuring required following the disruption of two world wars in the 20th century generated a functionalist approach to the understanding of social life, as it did in the material and economic response to the widespread disruption of war. Thus the idea that the 'modern family as a relatively isolated, small unit specialising in the functions of socializing children and personality stabilisation of adults' (Parsons and Bales 1955 p16 quoted in VanEvery 1995) provided a useful vessel for a number of post war dilemmas. A significant aspect of Parsons' work was the identification of a dualism in human behaviour, the division between the expressive and the instrumental roles (Cheal 1991,1999, VanEvery 1995, Morgan 1985). This attributed the expressive role to women, and located it in the home, whilst the instrumental role was seen as most appropriately situated with men in the world of paid work. Cheal (1991) explains that Parsons (1964) 'claimed that the conjugal or nuclear family is the only type of family that does not conflict with the requirements of an industrial economy' (p5), whilst, at the same time, explaining that the gendered assignment of roles could be attributed to the biological fact of childbirth (VanEvery 1995). The movement of the understanding of the nature of the family from 'institution' to that of 'relationship' (Burgess and Locke 1945 in Cheal 1991) may have anticipated a Parsonian interpretation or followed
it, either way it conveniently enhanced a view of the family which was useful for governments as well as attractive for many of those within families.

The functionalist view of 'the family' proposed by Parsons and his contemporaries during the immediate post war period was concerned to draw together within one grand theory a description of its form and function. This goal haunts its use today, despite successful challenges mounted from a range of sources, the most effective of which originated within the women's liberation movement and provided the building blocks for contemporary feminism. Cheal explains that Parsons saw 'the differentiation of the sex roles [into husband/father in paid employment and wife/mother providing emotional support for the family] [as] necessary because otherwise competition for occupational status would undermine the solidarity of the marriage relationship'(1991 p5). VanEvery points out that the expressive - instrumental divide, at the time, was seen by Parsons as important to an 'adaptive capacity necessary to industrialisation' (1995 p6). This had the effect of contributing to the justification of the ideological split between the public and the private spheres specifically upon gender grounds and, as VanEvery suggests, makes this not only a theory of the family, but also a theory of gender. Cheal comments that the usefulness of this split to the creation of a familial conservation within the context of patriarchy 'make[s] a virtue out of necessity' (Cheal 1991 p72). In the UK during the post world war two period, there was some recognition of the impact of family breakdown and the impact of bereavement in the Beveridge Report, by introducing financial support for people suffering the consequences of these. Nevertheless, this initiative was always seen as a 'safety net' for those who could not expect to rely upon family support in the first instance.

This formal endorsement of a gendered division of family roles generated a notion of complementarity demonstrated by, for example, 'the symmetrical family' espoused by Young and Willmott (1973). Gender roles in this family setting were seen as equal but different and were promoted ignoring the power dimension which underpins family life, based upon a paid 'breadwinner' role and an unpaid 'housewife' role. This 'companionate marriage' approach allowed for a level of paid work undertaken by women which has, in fact, taken place, but assumed a contribution by men to domestic tasks which has never achieved truly complementary levels (Finch 1989, Finch and Summerfield 1999). Nevertheless this theoretical perspective has been of particular attraction to those who prefer to construe 'the family' through a systems theory approach. This employs the assumption (drawn from engineering and applied to human beings) that interacting and interdependent elements act together to achieve an equilibrium within the home and maintain a protective boundary between the unit (the family) and the outside world (Cheal 1991). Cheal (1991), for example,
describes three functions of 'families' generated by this rather optimistic approach: (i) family controls, which assumes a self-monitoring feedback process subject to family rules; (ii) family boundaries, which assumes a flexible separation from the environment responding to changes through the lifecycle; (iii) family development, which again assumes progress through the lifecycle via a form of positive adaptation.

Whilst attractive as an abstract theory which could both describe and explain 'the family' as a social institution, and as a practical target for use by psychological and other practitioners, the systems approach generated more questions than it answered. It had the effect of setting up an ideal type of family behaviour which either ignored the potential for variation in terms of family experience, or identified alternative lifestyles as deviant. A theme of morality was an inevitable if unintentional accompaniment to this theoretical stance and was particularly directed at the role of women within families. The conflation of the female expressive role with a biological essentialism attached to childbirth not only assigned care for the whole family to wives and mothers but, by default, censured women who behaved differently. The biological basis of explanations for the feminisation of the family and of domestic tasks and activities usually undertaken by women in the home attracted assumptions of 'naturalness' and 'universality' which persist, despite well argued criticism. Bernardes has described this as 'family ideology' in which '[e]very day actors, everyday organisations and institutions clearly do define 'the family' in an abstract, universalistic and ideological manner' (1986 p597). As such, this belief system implies group or shared organisation, which nevertheless supports notions of individualism reflected in the clear demarcation between the roles of the component members - mother, father, child (1991). This theme will be developed further later in the chapter.

**Critiques and criticisms of 'family' as function**

Functional/ structural critiques of theories of the family such as those described above can be found largely in the feminist literature, but also from all theorists who demand that attention be paid to the 'process' by which family members negotiate the different needs and demands of each member within the context of the day to day lived experience of family life. Rather than assuming a mutuality of viewpoint (power) and of goal (moral values) within the family as a unit, attention has been drawn to the complexity of negotiated realities created by and for family members, and the potential for differing needs, demands and power. As early as 1972 Bernard noted the existence, within any one marriage, of 'his' marriage and 'her' marriage suggesting that 'men and women experience marriage in different ways and often report their
experiences differently' (Cheal 1991 p16). At the same time Berger and Kellner (1971 cited in Bernardes 1997) saw the experience of marriage as contributing to a sense of certainty and identity which could be said to form a shared sense of reality through a process of construction, mediated through language. Backett (1982), in her work on parental behaviour, saw family life as a process of communication and negotiation emphasising that her participants expressed the desire to 'understand' the behaviour of their children. Gubrium and Holstein (1990) noted the negotiation necessary between family members for the construction of 'the family' as an image of 'the social constructed world [which] must be continually mediated to and actualized by the individual' (Berger and Kellner 1970 quoted in Gubrium and Holstein 1990 p40). Nevertheless, they go on to criticise the potential reification of 'the family' as a concrete and independent entity evident in much of the theorising about 'the family'. Gubrium and Holstein (1990) have used Burgess' notion of 'the family as superpersonality' (Burgess 1926 in Gubrium and Holstein 1990 p38) and Reiss's notion of 'the family paradigm' (Burgess 1926 in Gubrium and Holstein 1990 p41) to illustrate a 'self-contained familial entity [which] is signalled by an internal-external demarcation of what it is and isn't' (p42). This image of boundedness draws upon a sense of unity and orderliness which Gubrium and Holstein question through a criticism of the homogeneity of "the-ness" (ie: the family). They point to a construction of the 'private image of the family' generated by social scientists, practitioners and family members themselves which is culturally compelling but ultimately 'a kind of collective myth in search of its own experiential bearings, diversely realized in place and time' (Gubrium and Holstein 1990 p56).

Important to these theorists and many of their contemporaries has been the notion of process which requires behaviour and responsibilities to be negotiated and re-negotiated over time (Bernardes 1997, Ribbens 1994). An emphasis upon meaning over form has allowed theorists to examine the process by which understandings of how members of families negotiate and construct their lives as families. Whilst some of the theorists mentioned so far still imply a mutually agreed understanding of the reality of their family lives, others have recognised the outcome of a negotiated process which embodies a fundamental inequality, a biologically based but socially constructed notion of gender. The conflation of pregnancy and childbirth with childcare and housework has contributed to a socially constructed notion of not just what 'the family' is, but what it ought to be, particularly in terms of what women's roles should be (see, for example, the Polity Reader in Gender Studies).

Feminist scholarship has been the most significant source of theorising which challenged assumptions of 'the natural' inherent in many theories of 'the family' (Bernardes 1997). Addressing issues of inequality through the subordination of women, the lack of
problematising the invisibility of negative aspects of family life (such as domestic violence) became a significant feature of feminist theorising (Charles 2000). This was achieved by turning on its head the theoretical goal. A parallel might be drawn with Foucault's alternative approach to understanding human nature as explained by Rabinow (1984) who quotes Foucault as follows:

...the real political task in a society such as ours is to criticise the working of institutions which appear to be both neutral and independent; to criticise them in such a manner that the political violence which has always exercised itself obscurely through them will be unmasked... (Foucault quoted in Rabinow 1984 p6).

In a similar manner, rather than attempting to identify an overarching shape and form which explained 'the family' in terms of structure and function, feminist theory has been used to question the value to wider society, specifically patriarchy and/or capitalism (depending upon the perspective), that such a construct could be 'created and carried by particular social groups whose interests it serves' (Cheal 1991 p10, Barrett 1980). Cheal comments that 'Some...argue that...we think about 'the family' as an active social unit...because of the ideological aura of sanctity that surrounds family life in capitalist societies', and quotes Rapp (1978 p281) 'the concept of family is a socially necessary illusion' (p13).

Once the assignment of domestic roles according to gender began to be problematised (Oakley 1974) it was possible, from a theoretical point of view, to draw attention not only to the power relations within the home which created inequalities, but also to examine the process by which everyday activities could be seen to constitute that power relation. Many of these challenges to existing theories of the family have drawn attention to the simplification necessary to uphold them. For example, Connell (1987) suggests that '[t]he very ideas of 'the housewife' and 'the husband' are fusions of emotional relations, power and the division of labour' (p125). VanEvery (1995), in her work on anti-sexist living, identifies two central organising principles to the feminist critique, firstly the artificial separation of instrumental and expressive tasks and secondly the division between the public and the private. The former ignores instrumental (organisational, managerial) components of domestic work usually identified as 'women's work'. It also has denied the place of the expressive within paid employment, undertaken by both men and women, but often restricted to occupations largely undertaken by women as a consequence of a gendered occupational segregation (Leonard and Speakman 1986). This denies the blurredness of boundary between the public world of paid employment and the private sphere of domestic life, which allows aspects of the public to intrude into the home, and also the supportive nature of the private to prop up and cement the vulnerabilities of the public (VanEvery 1995, Ribbens 1994, Finch 1983). It is certainly the
case that '[Public]'[legal and popular definitions of marriage and family life revolve around routinely understood [private] differences between women and men and constructions of sexuality' (Morgan 1999 *my italicised insertions*).

As early as the 1970s Ann Oakley pioneered work which problematised the interpretation of work within the home and family as 'non-work', and women in the home being seen as wives and mothers but not 'houseworkers', with working mothers seen as 'a problem' (Oakley 1974). The biologically based 'naturalness' which underpins these assumptions has been severely undermined through a process of de-construction which has separated out the images which had been combined into a socially constructed, politically convenient view of gender divisions. The artificial separation of 'the public' and the 'private', which is convenient for economic purposes, as described above, had allowed 'the family' to be construed as a 'black box' only legitimately open to public scrutiny when seen to experience 'problems' (Morgan 1999, 1996, Cheal 1991, Brannen and Wilson 1987).

*Family as process: 'doing family'*

Oakley's work triggered research aimed at opening up this black box and critically examining the divisions and alliances, the negotiations and processes and, most importantly, the power relations which take place within the home and family. For the purposes of this study my literature review is focusing upon those issues which assist the understanding of the processual nature of family life. Research on the family has increasingly stressed the value of recognising the potential for movement, progress and transformation embodied in the notion of process used to describe the dynamic nature of relationships within families. By this is meant that the negotiations, however conducted, which take place between family members do not take place just in order to achieve a specific concrete end, such as, which house will be purchased for the family to live in, or who will cook the dinner at the end of each day. Each interaction negotiates, as well, the meaning behind that house purchase or that family meal, in terms of individual identity and group reality (negotiation, in this context, may be unspoken and tacit rather than a formal transaction). Thus Gubrium and Holstein, in challenging the reification of the notion of *the* family, put forward as an alternative the notion of *being* family, which generates a more active negotiated process (Gubrium and Holstein 1990). Duncombe and Marsden (1995) have drawn attention to the absence of theorising around the emotion work which forms a large part of domestic activity, describing the process of "doing intimacy" necessary to maintain the couple relationship itself '(p150). And West and Zimmerman (1991) began speaking of 'doing gender' to describe the way that '[w]ithin the
private world of the family, it is in what women do, and to an extent in what men do not do that these gender roles are evident' (Gregory 1999 p61).

The idea of process has been most usefully embodied by Morgan (1996) within a concept of 'family practices', which encapsulates the multifaceted nature of 'the family', a term which remains widely used and understood, despite the shortcomings outlined earlier. It is, perhaps, useful here to make a comparison between the term 'family practice' and the alternative term family or household 'strategy', in order to stress the importance of using language which will successfully communicate the dynamic and constitutive nature of family life. Within the discipline of 'the family', the term 'strategy' denotes a more active status, particularly in relation to economic negotiations, which implies the potential for setting goals and weighing alternatives (Cheal 1991). Cheal notes that, as a term, it has a particular use when attempting to analyse decision-making at significant moments through the lifecourse. Crow (1989) has examined the use of this concept in a number of contexts, not just the family, citing Pahl's work identifying potential household strategies adopted by household members together or individually in order to get work done. He suggests that the term has utility in that it recognises the uniqueness of individual households but also allows patterns to emerge, particularly in relation to processes of social reproduction and social change.

Nevertheless, Crow finds a number of criticisms of the term 'strategy', for analytical purposes, such as the widespread use which attracts too wide a range of potential interpretations. Morgan (1989) has added to this analysis by recognising the value of 'strategy' as a sociological tool for the 'examination of the interplay between agency and structure' and also recognising the 'place of temporality and reproduction' (p26). However he also offers a note of caution by highlighting a number of difficulties and ambiguities. He suggests that 'strategies' require 'resources' and resources are subject to both power and structural constraints and can both influence and be influenced by strategies. He adds that without a component of rationality, which is not always easy to identify, the notion of strategy falls down. For the purposes of this study it is that very notion of rationality which could be said to be its main shortcoming. It is the implication that family members overtly negotiate a course of action which is then undertaken in a mutually agreed form and through an agreed pathway to produce a conscious and identifiable outcome which is questioned (Morgan 1996). The notion of 'naturalness' which permeates understandings of 'the family' can also be seen to be implicated in the ways that decisions, practices and compromises are conducted within families. For example, the food preferences of individual family members may be 'negotiated' via the observation, over time, by the person responsible for food (usually wife
or mother) of what other family member's do or do not like to eat. The following extract is an extreme example of how the process can be conducted:

Charles and Kerr, in their study in the north of England show, in the following quote, an extreme example of male food preference taking priority:

_Husband: There was once where you made something I didn't like - I remember that._

_Wife: O yes, I forgot about that._

_H: Yeah-But apart from a broken plate and a rather dirty wall there was no other damage._

_W: I forgot about that altogether _

_H: Yeah, I threw it at you didn't I? Do you remember? _

[Int: Did you? _]

_H: Yeah, O dear me, I think I said something like, 'Shove that fucking muck' - Oh, sorry the tape's on isn't it? I don't want to be rude. That was when we'd just got married wasn't it and you thought that was an acceptable standard of nourishment._

_W: I thought it was nice, it tasted nice _

[Int: That was right at the beginning of your marriage?] _

_H: That's right, yeah. She's never given me any of that rubbish again so that's all right._

(1988 p73)

The authors comment that under these circumstances it is not surprising that a wife would want to cook according to her partner's taste. What is, perhaps, equally as notable is the ongoing negotiation that seems to be taking place within this interview. The husband, years after the event is continuing to assert his authority over food choice - in this case in front of a third party and a stranger: the interviewer. The wife is minimising the effect of the violence of what is being said, by asserting more than once that she had forgotten the event, even though, once reminded by her husband, she could even remember that, in her opinion, that the food tasted nice.

The opening up of the 'black box' of the family by observing the intricacies of the activities which take place within offers the opportunity to compare the lived experience against a Parsonian ideal type. In particular, _feminist_ research has identified the differences, compromises and inequalities which are lived by people within specific social settings and which have theoretical relevance. The everyday experience of people in families, Morgan, for example, has noted, has a significance for the wider sociological theory:
If a central sociological concern was the relationship between individual and society, between agency and structure or between micro- and macro-structures, then an analysis could not end at the boundary of any particular unit selected as a theoretical whole, whether this unit be an organization, a theoretical institution or a household. It was important to see how particular outcomes were produced, thus avoiding possible dangers of reification. Households might well be seen, theoretically, as greater than the sum of their parts but *this did not mean that the parts were unimportant.* (1996 p26 my emphasis)

As an alternative to 'strategy', Morgan (1996) sees "'family practices" [as having] a theoretical status and part of this status includes a recognition that things could be viewed otherwise..' (p191). Despite the fact that this term 'family practices' is rarely used colloquially, he stresses a number of qualities from which this theoretical stance benefits. From the perspective of an appropriate understanding of behaviour and activities which take place within the family, he suggests that the use of this term 'convey[s] a sense of the active', and, as such, embodies 'the everyday' (p189), 'the taken-for-granted' in daily life. It also 'conveys a sense of regularity' which assumes continuity and repetition, but at the same time incorporates 'a sense of fluidity' (p190) which means that any one set of practices may be seen or described in more than one way. From the perspective of the researcher, this approach 'combine[s], in ways which may not necessarily be harmonious or completely congruent, the perspectives of the actor and the observer' (p188) which incorporates 'a sense of flow between the perspectives of the observer and the observed' (p189). This line of reasoning informed the meaning behind the term 'doing home' employed by Bowlby et al. just a year later:

Whilst males and females may be 'doing gender' at the same time family members are 'doing home'. Shopping and cooking may be demonstrating a woman's female gender identity, but identifying a meal that all of the family likes, ensuring a time when they are all available to eat it, and expecting 'Dad' to carve the roast, might be seen as demonstrating the household's family identity, and contributing to the group's concept of 'home' (1997 p346).

It would seem, therefore, that the category 'family' may be identified, and, more importantly, understood, not just by its membership or by its legal or religious legitimacy, but by the process by which its members conduct their day to day interactions. This process may be seen as incorporating intentionality, but not necessarily predictability, relying upon a 'negotiated' coming together of the roles and goals of distinct individuals. Understanding this
process requires attention to be paid not just to the intricacies of daily life or to the overarching cultural norms which inform and influence that activity, but the interaction between the two.

**Caring as a family practice**

Research into the nature and meaning of 'the family', as has been noted, pivots upon the activities which take place behind the closed doors of the family home, and which are inextricably identified with women, and what it is to be a woman. The private domain of the home and family has been consistently seen as the 'natural' location of tasks and activities which are predominantly undertaken by women (Sevenhuijsen 1998, VanEvery 1997, Morris 1990, Oakley 1981, 1974). Whilst gender is clearly a crucial factor, the process of conducting domestic tasks and practices within the home incorporates the construction of roles which take their meanings from the nature and character of the family relationship, as well as that of gender. Studies on same sex relationships (Oerton 1997, Weeks et al. 1999) have drawn attention to issues raised by the commitment to long term co-habitation and emotional involvement which challenge explanations of behaviour based simply on gender.

Nevertheless, activities in the home, which fulfil the everyday practical needs of family members, support the world outside the home, and also enable leisure and entertainment interests to take place, may be summed up within the term 'informal caring', which is strongly linked to notions of gender (McKie et al. 1999). Within that term can be found a very wide range of tasks and duties, many of which are concrete and material, with others which are less clear-cut or tangible. Graham has described caring as 'an unspecific and unspecifiable kind of labour, the contours of which shift constantly (1983 p26). Fundamental to 'doing home' and 'doing family' is 'deeply enmeshed with giving and receiving care, with notions of gender and identity and hence with relations of power' (McKie et al. 2001 forthcoming). The ambivalence with which caring work undertaken in the home is borne out of the combination of pleasure and drudgery that work entails. The opportunities for men to become involved in caring work in the family, whilst not absent (Duindam 1999, Brandth and Kvande 1998, Arber and Gilbert 1989), are not widespread. There is evidence that male involvement in tasks within the domestic sphere has increased over the last two decades (Arber and Ginn 1999, Morris 1999, Arber and Gilbert 1989). However:

....none of the data seems to warrant any suggestion that the traditional female responsibility for household work has been substantially eroded or that male participation
has substantially increased. This does not mean to say that it has not *significantly* increased (Morris 1990 101-2 original emphasis).

The work undertaken within the home which is the most easily identified is that known collectively as 'housework', which may or may not include childcare. VanEvery (1995) in her study into non-sexist division of domestic labour identified three types of 'housework': childcare, activities related to eating, and cleaning. She does not seem to have attached differing values to each of these 'housework types' and construes them as work which, but for active negotiation to the contrary, women are expected to undertake as a consequence of their subordinate status within the home. Nevertheless certain types of domestic work are valued more highly than others, and it is likely that, when men do become involved in domestic work, they tend to chose more pleasant or more creative, tasks over others (Van Berkel and De Graaf 1999, Duindam 1999. Gregory 1999, Baxter and Western 1998). For example, a study examining fathers' experience of parental leave has found that the men focused upon caring for the child during the parental leave, taking very little part in housework (Brandth and Kvande 1998).

The work of Finch (1989) and Finch and Mason (1993), although concerned with family obligations between kin located both within and *beyond* the confines of the household, nevertheless highlights the complex nature of care and support in families. Janet Finch's interest was how family members construed the exchange of assistance and support and the influence of duty, obligation and responsibility upon the process which translated *ought* into *action* (1989). Her work with Jennifer Mason revealed, amongst other things, that there were no precise norms or rules of obligation, rather a process of interaction in relation to care and support which they define as 'developing commitments' (Finch and Mason 1993). An important theme which can be identified in their work is the ways in which everyday activities and interaction *constitute* relationships over time. By this is meant that rather than caring being a consequence of relationships, in fact the act of providing care, especially if repeated routinely over time, *creates* the relationship. This echoes Graham's explanation of the association made between caring and femaleness. She suggests that it is not simply the outcome of the domestic division of labour but, *in fact, a category through which that division is decided* (1983). Thus agency can be said to create structure as much as structure can be said to contain agency (Finch and Mason 1993). This theme is being emphasised in order to provide an indicator of the direction in which the analysis of the data to be presented will take. Finch and Mason's study explicitly, and other studies mentioned here, implicitly, demonstrate the power of the social meaning behind 'caring' as a gender identity and as a socially constructed institution:
[R]esponsibilities' [for caring and support]...are the product of human agency and not an external property of social structure over which individuals have no control. But there is a sense in which they become structural features, in that they both constrain and facilitate future actions (Finch and Mason 1993 p173).

The form that caring takes within the home is, perhaps, easier to identify and allocate, but the nature of caring becomes more illusive. There is an interconnecting duality to be found within the notion of caring when couched in terms of 'caring for' and caring about'. These distinctions have been pinpointed explicitly in a number of studies, but can be detected implicitly in many others. Ungerson (1983) identifies 'caring about' with affection, affinity and emotion, whilst she sees 'caring for' as associated with servicing needs, specific tasks, obligations, and Parker's term 'tending' (1981). Morgan suggests that these terms differentiate between actual tasks (work) and emotional meaning (love) (1996). Arber and Ginn (1999) draw upon Graham (1983) and Thomas (1993) who suggest that whilst both women and men 'care about', it is women who carry the responsibility for 'caring for'. They also conclude that men are more involved with 'caring for' than has been formally acknowledged, but note that there are gender differences both in the kinds of caring for undertaken by men compared to women, in that men are less likely to undertake personal and intimate care (Arber and Ginn 1999, Arber and Gilbert 1989).

Thomas' review of the caring literature in the early 1990s drew attention, through a process of deconstruction, to the problematic nature of the notion of 'care' for research:

The meaning of care is usually taken as given and often presented as comprehensive in its coverage of caring activity, when in fact the concepts of care employed are partial representations, or segments, of the totality of caring. Definitions of care are constructed such that boundaries are differentially drawn around what constitutes care, with the effect of excluding or including sets of social relations in definitions of caring relationships (Thomas 1993 p649).

Thomas goes on to deconstruct care into seven dimensions - the carer; the recipient; the interrelationship between carer and recipient; the nature of care; the social domain; the economic character, and the institutional setting - which may be combined in different ways to construe care as a concept. Her concern is for a re-conceptualisation of the notion of care which adequately addresses the diverse nature of the concept. She concludes that the construction of a single unified theory of care would be inappropriate for a concept which is fundamentally descriptive rather than explanatory. Nevertheless, she confirms its usefulness as a concept, particularly if, for the purposes of any one research project, it is recognised to be
partial, and clearly defined and identified as such, in that 'care means different things to
different researchers' (Thomas 1993 p667). For the purposes of this study, it is 'the nature of
care' that is significant, which, according to Thomas (1995) poses difficulties related to the
dual meaning of care:

a feeling state (emotion, affection, love) - 'caring about someone', or an activity state
(work, tasks, labour) - 'caring for someone' (p652)

These two aspects of caring combine significantly within the context of the family, where
notions of 'the natural' place responsibility in the hands of women. A process of 'being with'
(Graham 1984) which allows (wives and mothers usually) a level of low key monitoring of
the everyday, brings together 'caring for' and 'caring about'. This can be seen in the notion
of the 'alert assistant' (C. Williams 2000, Charmaz 1991) which provides a useful device for
examining how this duality is manifested, and will be developed in chapter three in more
detail. Thomas, (1993) uses Graham's (1983) analysis of 'the labour of love' in the home,
and Parker's (1981) notion of 'tending' to argue that:

The nature of caring is tied up with the socially constructed qualities of the feminine and
the socially constructed location of women within the 'intimate relations' of the family
within the domestic domain (p658)

Whilst all of these theorists, and others, acknowledge the significance of the home and family
as a location for care, the constitutive nature of the family for gendered caring is rarely
addressed.

**Doing 'normal' family life**

The emphasis must, therefore, for the purposes of this study, be placed upon the meaning that
lies behind the negotiation of care within the home, whether this is simply how domestic tasks
are allocated, or how major organisational disruptions are dealt with, rather than the structure
and form of that negotiation. This is not to say that how people organise caring and support in
the home is not of significance for this study. It is, in fact, through the organisation,
negotiation and construction of normal everyday activities that the meaning that care has for
the family is manifested and sustained. It is assumed that:

[through day-to-day activities, each woman] produces a version of 'family' in a
particular local setting: adjusting, filling in, and repairing social relations to produce - quite
literally - this form of household life (DeVault 1991 p91).
DeVault goes on to say that:

[b]ecause this work of social construction is largely invisible, such efforts simultaneously produce the illusion that this form of life is a 'natural' one (p91).

The assumption that the family is the 'natural' place for informal care, justifying non-intervention by the state in all but crisis circumstances, could be said to be part of a patriarchal system which constructs 'women's desires to nurture and care for children' (Cheal 1991 p11). Certainly the family, in Graham's words, whilst remaining undefined 'features...as a kind of catch-all category which embraces those forms of care which the state does not (or should not) provide' (1984 p17).

Feminist scholarship has revealed the strongly gendered nature of 'the family', and the caring which takes place within it, which is now widely accepted, but which also is recognised to be complex and multidimensional. Morgan, noting the demands that men are seen to be able to make upon women for 'emotional servicing' suggests that 'its most complete expression is found within domestic contexts and that this has a high degree of public legitimacy' (1999 p33). Ribbens, in examining the process of 'becoming a family', identifies the mother's task of creating the family, through processes of internal cohesion and external demarcation. Leonard and Speakman (1986) echo Graham's suggestion (that when public policy places the responsibility for children's health in the hand's of their 'parents', this means their 'mothers' (1979)) when they suggest that 'the family' is used as a synonym for 'women'. The responsibility for anticipating and catering for the emotional needs of family members in terms of gender divisions has also been examined by Duncombe and Marsden (1999). They draw upon the notion of 'the civilising process' which ensures that the social regulation and management of emotion remains concentrated within the nuclear family.

Thus emotional need is both assigned to and contained within the home, and subject to what Hochschild (1983) has termed 'feeling rules', an ideology of feeling which prescribes how people 'ought' to feel. Graham (1983) has made the point that although 'caring' may be a universal need, 'only certain social relations are seen to facilitate the giving and receiving of care' (p15). The social relations in question are those within the private domain of the family and undertaken between women and their families. She goes on to say that caring is only seen as legitimately associated with the public domain of paid work within occupations which are seen as part of a caring profession and where the workforce tends to be primarily female. She suggests that the close association between caring and femaleness, rather than a product of the domestic division of labour, in fact constitutes that division (Graham 1983).
Commenting upon the informal sector of welfare, Graham (1999) notes that 'the informal arrangements made for the care of dependent people emerge out of, and are embedded within, the routines through which families are reconstituted both day by day and generation by generation' (p287). In doing so she draws attention to the level to which the formal welfare sector relies upon support of unpaid work for the prevention of illness and care during illness undertaken within families. An examination of the nature, form and meaning of care specifically related to health and illness will be made in chapter three of this literature review. This chapter will now just examine the ways in which a policy emphasis upon the care related to health and illness can eclipse the everyday 'caring about' work which constructs and reconstructs 'normal' family relationships.

**Doing normal caring**

It is clear from a range of studies that the work that women undertake within the home and family continues to be seen as 'non-work', not just because it is not paid, but also because it is seen as born out of love and affection and contained within duty and obligation (for example see Morgan 1996, Leonard and Speakman 1986, Graham 1983, 1984). In the same way that spending time with the children can be construed as play and love, rather than a necessary task, the bringing of family members together for the family meal can be seen as 'doing family' rather than an event requiring a wide range of skills and abilities (Bowlby et al. 1997, DeVault 1991). Equally, the tasks associated with ensuring the health, or responding to the illness of family members, can be subsumed within assumptions about the caring nature of the family setting. The ideology of the 'natural' attached to definitions of 'the family' encompass caring activities which take place in the home and contribute to a 'feminisation of the family'. That is, those characteristics which have been seen to define femininity - caring, support, emotion - are also attached to definitions of 'the family'.

Graham (1984) identifies five types of responsibility for health within the home: providing health; nursing sickness; teaching health; mediating with health professionals and dealing with health crises. She suggests that the health promoting nature of family activity is often obscured by the language used to provide it, using as an example the 'socialisation of children'. This term is usually taken to mean learning the appropriate social interaction to be able to function normally in society, but, in fact, she suggests, also involves many aspects which ensure children's health and survival. Graham (1984) notes that informal health care is seen by the State as not within its remit. Similarly, McKie et al. have noted, more recently, that public policy generally:
locates what takes place in the household, specifically the family, [as]...private responsibility and morality - from education to crime, from health to sexual behaviour.

They suggest that:

Government seeks to shift State responsibility away from ensuring 'appropriate' behaviour in these areas, and towards helping families to help individuals to take responsibility for behaving appropriately....[whilst remaining] silent on issues of gender equality in the home. (McKie et al. 2001 forthcoming)

Thus, this invisibility of purpose is not restricted to just family health goals but can be seen to be the product of a conflation of 'care' and 'family' mediated through notions of 'the natural' which applies to all aspects of family life. Much of the social interaction which takes place in families may be construed as love and affection, but is at the same time ensuring the well-being - emotionally, physically, psychologically - of family members. This conflation is made possible through the role played by caring in the home in contributing to gender identity. West and Zimmerman suggest that:

It is not simply that household labor is designated as 'women's work', but that for a woman to engage in it and a man not to engage in it is to draw on and exhibit the 'essential nature' of each (1991 p30)

Whilst Finch (1989) quotes Graham as follows:

Caring is 'given' to women: it becomes the defining characteristic of their self-identity and their lifework. At the same time, caring is taken away from men: not caring becomes a defining characteristic of manhood (1983 p18)

However, Morgan puts forward the notion of:

'a caring nexus' both constituted by and constituting the ideas of family and gender. Thus, women may be found to be engaging in caring practices within the home and elsewhere, but it is also the case that the identities of women and gender are constructed and shaped within the caring process (1996 p111 my emphasis).

It is this last interpretation of gendered caring in the home that comes closest to conveying the interactive process by which, within the context of the family, agency can be seen to inform structure whilst, at the same time, structure can act as a stable frame for agency. The strength of this relationship is not only powerful but reassuring even in time of potential crisis. The intrusion of the unexpected and the unwelcome, such as illness or disability, can mean
considerable disruption to family life, sometimes permanently. There is no doubt that this represents major influences upon family practices which can impact upon social networks and family relationships resulting in considerable change (Bernardes 1997). Nevertheless, what is interesting is the level to which families, faced with adverse contingency such as these, will attempt to maintain the characteristics of their 'normal' family life.

This will be explored further in chapter three specifically in relation to care for the ill, but can also be identified in ordinary everyday family relationship negotiation. For example, Ribbens (1994) found that, when talking to women about managing family life, they varied considerably in the ways that they incorporated notions of 'family' and 'individuality'. This created tensions which could 'appear at times as inconsistencies and contradictions' (p47), but which could, in fact, be essential in order to deal with the complexities of family life (1994). Duncombe and Marsden (1999) cite a study undertaken by Brannen and Moss (1991) in which working wives who saw themselves in companionate marriages would 'condone, excuse or even misreport their husbands' inadequate sharing of domestic tasks' (p94). Brandth and Kvande (1998), in a study which focused upon fathers who used parental leave, looked at how they incorporated the experience of care-giving into their construction of masculinity. They found that both fathers and mothers contributed to a process of negotiation and reconstruction of gender which gave masculinity a higher status, which the authors interpreted as a 'process of reproducing masculinity as the norm' (p293).

The tension between 'family' and 'individual' (the latter a very Western product as Ribbens (1994) points out) if examined closely, draws attention to the way that each contributes to the construction of the other. The former has been examined in detail already. The 'individual' can be construed in two ways: as a unique entity with consciousness and bodily characteristics, but also as a universal 'person' which crosses (but is interpreted variably) different cultures and histories (Lukes 1985 cited in Ribbens 1994). The family harbours the conflicting pressure to create both. An example of this tension is usefully described by Ribbens (1994) as embodied in the arrival of a new baby. She describes the child as the 'essential ingredient' in the creation of a family. Nevertheless her participants also spoke of their satisfaction in observing the unique and individual nature of each of their children, indeed seeing their duty, as part of the childrearing process, to help develop their unique personalities. Thus these two core elements of Western society, of 'family' and of 'individuality', can be seen to be both polarised and intertwined. Put more simply:

Whilst we all like to think of ourselves as somehow 'special', we also like to think of ourselves as essentially 'normal'. Some part of that personal sense of normality comes from our own understandings of 'normal family life'. (Bernardes 1997 p54)
VanEvery commenting upon the heterosexual imperative associated with family life, quotes Rosa:

...if we are in a heterosexual relationship there are many other social conversions we are then expected to follow that are built upon it: marriage, house owning, children, tax incentives, dinner parties, social success and being 'normal', being able to join in everyday conversations (1993 p1 in VanEvery 1996 p40).

It is the assumption of 'naturalness' which allows these assumptions and contradictions to remain unquestioned, reduces the potential for legitimate difference and generates a moral component which condemns alternatives (VanEvery 1996, Ribbens 1994). The role of the State in perpetuating this assumption has already been mentioned and should not be underestimated. There is a vested interest for governments to construe 'the family' from the narrow perspective of the heterosexual nuclear family which will not only care for itself under all but extreme circumstances, but also act as a form of surveillance against potential alternatives less able or willing to do so (McKie et al. 2001 forthcoming). Nevertheless, the maintenance of the powerful image of family life cannot be left just at the door of governments who wish to contain society without having to maintain it. Much of the staying power of the notion of 'family' is its contribution to individual personal identity, particularly in terms of its reliance upon gender as both origin and consequence. A narrow biological definition of family allows simple biological assumptions about gender to have an 'obvious' location. Morgan suggests that it is impossible to think about family without thinking about gender, whilst the reverse is less obvious (1996). More recently he has suggested that 'Legal and popular definitions of marriage and family life revolve around routinely understood differences between women and men and constructions of sexuality' (1999 p30).

**Being normal - doing structure**

Whilst most theorists would agree that 'gender' and 'family' as concepts are inextricably linked and thinking about one means making assumptions about the other (Bernardes 1997, Morgan 1996, 1999), more importantly, they would stress the need to examine the link itself (Connell 1995, Morgan 1999). The link between notions of gender and notions of family stems from the biological basis with which they both continue to be defined, but that link is sustained through the everyday lived experience by which those concepts are acted out. In Goffmanesque terms, it is the management of the social interaction that is of significance rather than any underlying ultimate truth, 'people [are] role-playing creatures in a scripted
social world' (Tucker 1998 p77). As such these are skilled, informed agents operating in a world which is complex and not always reliable. Tacit and informal rules and norms provide stability through a process of social routines. Giddens suggests that the routine and affective experience of being involved in daily life events means that people do not ordinarily reflect upon themselves as actors. 'In fact, they adopt an 'as usual' approach to social life' (Shilling 1997 p742), or in Bourdieu's terms, they 'experience a particularly comfortable sense of place' (Tucker 1998 p68). The normality of the ordinary and the everyday is a consequence of the individual actor making sense of the world constrained by structural assumptions which allow social meaning to emerge through day to day activities, rather than as a product of 'discursive consciousness'.

Personal identity as individual, as gendered, as family, is established and sustained through an ongoing process of interaction. Individual identity as such is very powerful, in that there are significant social forces - the state, the media - built around (and so maintaining) fundamental social institutions such as gender and family. It is also very fragile, in that to sustain identities they must be negotiated and recreated on a daily basis. These acts of construction and reconstruction constitute family and gender identities through everyday activities creating a continuous sense of normality. Giddens has developed a concept of 'ontological security', which Shilling defines as the need to maintain 'a sense that the world is as it appears to be, and that the view of the self is stable' (1997 p742), and Tucker describes as 'a belief in the continuity of self identity over space and time, and the reliability of social life' (1998 p83). Giddens suggests that ontological security is achieved through social conventions, that is, taken for granted awareness of social rules and norms. These conventions may seem simple but embody culturally specific knowledge which is complex and non discursive. By this is meant that, as well as a reasoned explanatory understanding of social intercourse, people also use a practical but non-articulated consciousness which orients them in social situations to the cues and nuances of particular social contexts (Tucker 1998). So people monitor themselves and others, not just through taking part in everyday activities, for example, a family meal, but also by the knowledge they have of, in this case, their family meals generally, and interpretations of the behaviours being given off at any one family meal.

The acting out of specific family events and activities routinely 'serves to construct and reinforce a sense of 'being family" (Bernardes 1997 p90), and, as well, being male or being female, and being normal. This routinisation seems natural and normal and so renders invisible the 'consciously crafted structure of family life' (DeVault 1991 p78). Fundamental to this process are assumptions about gendered divisions of labour. The interplay between
gender and family, as well as between identity and normality, is evident in the examples from the following studies:

Lydia Morris, in her examination of the household in relation to the effects of economic change visits the issue of 'role swap' as a potential consequence of male unemployment. She found that the lack of viability for this in either of the two studies in question, however possible in theory, was expressed in terms of the 'naturalness' which stated, or implied, an expectation of 'normality', for example:

Well it's not normal is it? We're brought up to believe in work. It's what the man does; the man's the breadwinner (Unemployed man in Hartlepool (Morris 1987b p98) [in Morris 1999].

Finch and Mason's study of the process of negotiating care and support in families described cousins who, in helping each other with jam making, described this as 'just natural, normal everyday things' (1993 p2)

DeVault's participant conveys a sense of normality when describing her complex shopping routine to cater for her family's different food preferences: 'It's not a hassle. I mean I don't think it's outrageous. It's not - there's nothing eccentric about it. I mean, you know, everybody has food preferences' (p87)

Arber and Ginn (1999) commented that, whilst the level of male involvement in informal care was greater than is generally acknowledged, their involvement in personal care (such as personal hygiene) was subject to norms of appropriate masculine behaviour.

These studies set out to examine very different aspects of family life but have a common theme of, often explicitly, revealing the desire of participants to demonstrate the normality of their choices.

The attraction of normality is at its most potent when associated with the notion of 'mothering'. In the same way that the 'individual' can have two modes of meaning, as discussed earlier, 'mother' might be said to have meanings both personal and universal. As such 'mother' can be seen to be a core component of the meaning of 'family' (Morgan 1996 Ribbens 1994). Whilst it is increasingly the case that women's gender identity stretches beyond the boundary of the family, 'mother' is still seen to be at the heart of the family (Ribbens 1994). Father as full time parent at home with the children is still rare and 'househusband still has an unfamiliar ring' (Morgan 1966 p81). In fact, Ribbens suggests that 'while a woman may strive to create a sense of individuality for her children as well as a
sense of family, 'starting a family' may be the very moment at which she loses her own sense of individuality' (1994 p71).

A central feature of the emergence of 'the individual' as a concept in modern Western society has been its gendered nature. Individuality relies upon constructions of sexuality which can be prescribed and contained. Notions of normality and deviance can be seen to essentially define an individual's sense of personal identity. Thus sexuality is implicated in constructions of family, as it is to individual identity. Gender and gender relations are reproduced from early childhood socialisation, through life times and over generations (Connell 1995). Giddens describes a 'sequestration' of sexuality - a privatisation which designates the 'legitimate' location for the formation and development of gender identity to be within the nuclear family. He sees this process as concurrent with the invention of ideologies of motherhood and domesticity (Tucker 1998), and so further legitimises the family, as both the origin and consequence of gender relations. Despite awareness of concerns over this mythologising of the female role and an evident lack of problematising of male sexuality, Giddens suggests that a sexuality 'freed from the needs of reproduction' can be recognised as "free floating" and socially created'. A significant consequence, he proposes, offers the opportunity for the development of 'the pure relationship'.....as it is entered into for its own sake and is founded on the mutual emotional satisfaction of partners' (Tucker 1998 p205).

This rather optimistic view compares with a more circumspect view from Foucault and others, whose concern is over the normalising consequences of a focus upon sexuality as a core basis for personal identity. They draw attention to the power implications for sexual identities which posit strict demarcated characteristics, whatever form they take (male/female; gay/straight) in that they regulate both behaviour and options (Tucker 1998). The structure-free implications of this 'pure relationship' neglects the vested interests of using sexuality, particularly when located within the family, as a means for surveillance and regulation. The use made of social regulation, whether malign or benign, places both sexuality, or rather conventional heterosexual gender, and family firmly within the context of social structure. Nevertheless it does reflect a notion of 'romantic love' with which relationships within families are routinely associated. As such it provides a useful support to the expectation that the 'good family' will remain constant over the lifecourse. Thus, 'ontological security' is more successfully sustained where: sexuality is legitimised through a narrow heterosexual setting which locates romantic love, and negotiated commitments and is accompanied by morally censured alternatives.

This discussion allows a return to the Bourdieu quote at the beginning of this chapter having provided a range of evidence that 'family' constructs itself as much as it describes itself, but as
a lived experience as well as a social reality. Bourdieu suggests that the family sees the
domestic unit as active agent:

endowed with a will, capable of thought, feeling and action and founded on a set of
cognitive presuppositions and normative prescriptions about the proper way to conduct

Family members recognise the constraining structural framework that 'family' represents, but
are also aware of the day to day process of continuous creation through what Bourdieu sees as
'obliged affections and affective obligations' (conjugal love, parental love, filial love) (p22)
which require constant maintenance work, much like the emotion work described by
Duncombe and Marsden (1999). Bourdieu points to 'the practical and symbolic work that
transforms obligations to love into a loving disposition and...endow[s]... member[s]...with a
'family feeling' that generates devotion, generosity and solidarity' (p22), comparable to the
negotiated commitments described by Finch and Mason (1993). He acknowledges the main
recipient of the responsibility for this work to be women (1996). He also points to '[t]he state .[which]...performs countless constituting acts which constitute family identity as one of the
most powerful principles of perception of the social world and one of the most real social
units' (Bourdieu 1996 p25).

Summary

The literature discussed in this chapter suggests that the notion of 'family' is ambivalent and
politically dubious, but widely recognised as a social institution and so acts as a useful term
for research purposes, provided the limitations are recognised. It is also proposed that an
examination of the nature of meaning in terms of 'family' is more useful than that of form and
function within the context of grand theory. The 'standard theory of the family' is seen to be
very limited in its usefulness, despite its resonance for lay interpretation, as are other
functional or systems approaches.

Much of the literature presented, which takes a constructionist form, emphasises a processual
notion of family interaction as the most valuable way of understanding the meaning of
negotiated realities for people in families. The use of the concept of 'family practice',
suggested by Morgan (1996) attracts a sense of the active and everyday, the taken-for-granted,
the regular and continuous yet flexible, which sums up a context of on-going re-creative
process, which the author and colleagues have described elsewhere as 'doing home' (Bowlby
et al. 1997). Nevertheless, the term negotiation, as a way of construing decision-making and
role allocation within families, cannot be seen to imply equality or agreement, and requires a recognition of power relations. In fact the interplay between social identities attached to family and gender and everyday family activities and interaction might even be seen to constitute power relations.

The notion of the 'natural' is key to the social identity of 'family' and 'individuals' within the family setting. An artificial separation of affect and instrument as well as the division between public and private creates a simplification which contributes to the notion of 'naturalness'. Bernardes has demonstrated eloquently the part played by the use of 'naturalness' to support an ideology of the family as natural and universal which has been particularly useful for public policy (1987). Fundamental to the creating and shaping of the 'natural' or 'normal' family is the location of intimate caring (both caring for and caring about) within its remit. Caring has been recognised as a concept which is difficult to define in totality and which is often emphasised in terms of its instrumental role, over affective activities, thus 'caring about' (affection, love, emotion) remaining illusive and invisible.

Leading a 'normal life' might be seen as the embodiment of 'caring about' but has also been identified as a fragile entity requiring day to day construction and reconstruction for family members to be able to maintain an ongoing sense of security in, not only the identity of the family itself, but their individual identities as well. The giving and receiving of caring (both for and about) can be seen to play a significant part in this process. This desire for a continuity of stability (termed 'ontological security' by Giddens (1979)) can be seen to identify an agency - structure interface which acts as an appropriate location for theoretical debate about nature of 'family'. That is, as individuals, family members have a need for a sense of security or continuity of self-identity which allows for an agentic contribution towards the structuring of social structure.

The notion of normality can be found to be located at the junction between agency and structure in that normality grows out of day to day interaction, which is subject to the contingency of both the expected and the unexpected (for example: marriage; illness/health; divorce) and informs overarching expectations of social institutions, such as gender and family. These become formalised into norms over time and come to be seen to be natural, given, taken for granted, normal. This process is embodied within the processes of negotiation conducted on a day to day basis by individuals within a family framework which describes and prescribes their roles and their responsibilities. Morgan uses the metaphor of the kaleidoscope to illustrate the movement and complexity of family life:
With one turn we see a blending of distinctions between home and work, family and economy, and the idea of the household moves into sharper focus. With another turn, the apparently solid boundaries of the household dissolve and we see the family and kinship, and possibly other, relationships spreading out across these fainter boundaries. With each twist of the kaleidoscope we see that these patterns are differently coloured according to gender, age and generation and other social divisions (1996 p33).

This chapter has examined the theoretical background to concepts of the family with a view to highlighting literature which supports a processual perspective in understanding how people live their family lives. It has identified key components for defining the process of 'doing family', drawing particular attention to the way that ongoing creating and re-creating activities are essential for this. Emphasis has been placed upon the normal and the everyday as fundamental to the notions of process by which 'family' is acted out. After childcare, it is the preparing and sharing of food and meals that most embody the combination of affect and instrument which constitutes the family relationship. The next chapter will examine literature which illustrates the background of, and meanings that the production and consumption of food and meals within the family have for social life.
Chapter 2. Food, meals and eating in families

Introduction

The previous chapter presented literature that describes the theoretical basis of explanations of the family, focusing particularly upon work which examines the day to day lived experience as a means by which family life may be understood. Attention was drawn to the multilayeredness of meaning which can be drawn from ordinary everyday activities, which negotiates identities, relationships and securities of reality, through and alongside the basic needs and desires of twenty-first century family life. These needs range from the humdrum maintenance of the family home which ensures health, safety and hygiene, to the love, education and care of children from birth to the onset of adulthood and often beyond. They also include planning, provision and consumption of food and meals for and by family members individually and collectively. Specific family activities (outlined in the last chapter) range from the simple to the complex, from the pleasant to the mundane and sometimes the offensive, but have the combined raison d’être of 'doing family'.

The role of looking after children provides a clear and unequivocal example of the coming together of the notions of 'caring for' and 'caring about' discussed in the previous chapter. There is no doubt that the tasks of providing for the nourishment, cleanliness, education and safety of children are assumed to be conducted through a sense of love and affection, even by those who are paid to do so, but especially by those joined by bonds of kinship. Tasks associated with the provision of food and meals tend to be construed in a more instrumental mode by those undertaking and receiving them. The affective meaning behind, for example, cooking a special birthday cake, or taking part in the family Sunday roast dinner, is not unacknowledged by those who take part. However, these acts of 'caring about' are frequently missed in the busy everyday run of the mill business of getting on with life. Relationships between members of families are most evident in what people do rather than how they feel. That is, the expression of feelings is often through ordinary everyday monitoring and 'being with' activities (Graham 1984). That 'missing link' between the embodied and the feeling which both drives and responds to in-the-world events (Williams and Bendelow 1996) remains particularly invisible in the family setting. This ignores the significant role played by food and meals as a process by which family life is reproduced on a daily basis. Activities around food, whether the practical aspects of producing family meals, or the communal aspects of eating a meal together as a family, fulfil two roles. Firstly, they are a convenient way for people to achieve regular nourishment, and secondly they provide the means by
which family and individual identities are produced and reproduced on a day to day basis (DeVault 1991, West and Zimmerman 1991)

The aim of this chapter is to bring together a range of literature which illustrates the special meaning that is attached to activities related to food and meals for the construction of everyday family life. The chapter will begin by presenting literature on the theoretical stances which have contributed to the development of a sociology of food and eating, specifically in relation to family life. Attention will be paid to work which examines the meaning that activities around meals and eating have for the formulation and maintenance of identity, both individual and family. This will incorporate discussion about the role of surveillance, drawing upon Turner and Foucault, as a means by which people find themselves contained within socially prescribed pathways. An examination of the creative and re-creative relationship between understandings of home and family on the one hand, and expectations of responsibilities for food and meals on the other, forms the central theme of this chapter.

Research in food, diet and eating in the social sciences

The place of food, diet and eating in the understanding of social life has been recognised across the social sciences. Psychologists have concentrated upon individual taste and its effect upon food choice and preference (for example Shepherd 1990), whilst psychoanalysts have tried to shed light on 'abnormal' eating behaviour (see Lawrence 1987 and Orbach 1978). Economists have examined food choice from the perspective of costs and benefits from a range of view points, including that of government (Henson 1993), whilst geographers have recognised the place of food and eating in the context of social space and movement (Valentine 1999b). Sociologists came relatively late to the recognition that examining beliefs and behaviour around food and eating practices provides a crucial part in the understanding of how people negotiate and explain their social worlds (Mennell et al. 1992).

Social anthropologists, to a degree, pointed the way for this area of enquiry, a major contribution coming from Mary Douglas (1997) who drew attention to the role of food in the rules and rituals of everyday life in both small-scale and contemporary society. Levi-Strauss (1966) saw food preparation as an 'indicator of civilisation', whilst Stephen Mennell (1987) has followed Elias (1978 in Mennell et al. 1992) in tracing a 'civilising process' through history which allowed attitudes towards behaviour around food to reflect wider social changes, but also strongly influenced individual and group identity. Fieldhouse (1986) in examining the place of food and nutrition in custom and culture, has highlighted the tension
between conscious and unconscious concerns about social life generally. Sociology has, over
the past twenty years, generated a vigorous literature on the meaning and manner of food in
society much of which, perhaps not surprisingly, is located within home and family, and
which will be examined in this chapter. Interestingly, issues of health and illness have not
been a central feature of the sociology of food and eating.

Nutrition. A purely nutritional approach to understanding the importance of food and diet in
everyday life has a practical and common-sense credibility which might be said to be both
attractive and comforting. The growth and development of nutritional science, which is
discussed in more detail below, has provided evidence for an instrumental view which
incorporates anatomical functioning and genetic predisposition as a basis for a sociobiological
perspective (Kohler et al. 1999, Feildhouse 1986). Fundamental to such an approach is the
notion of a 'naturalness' which tends to be attached to explanations and which contributes to
prescriptive conclusions which can hint at moralistic undertones. So nutritionists often couch
explanations about eating behaviour in terms of 'good' and 'bad' behaviour, but they rarely
examine in detail the dynamic nature of social life within which the food related behaviour
takes place.

Anthropology. Many of the early anthropologists, taking functionalist/structuralist approaches
to understanding and explaining social life, frequently saw the everyday activities of preparing
and consuming food as a part of a range of activities that provide a language or code within
which could be found inherent rules, adherence to which maintained social order (Lupton
1996, Douglas 1984). There have been challenges to a simple functionalist perspective but,
nevertheless, the notion of a code-like pattern linking everyday agentic action with an ongoing
structural frame of reference has been acknowledged as providing a valuable way of
examining social behaviour, especially that of eating in the home. It is a theme which has
retained a robust character and contributes to a number of theoretical stances which will be
drawn upon in this review.

Many anthropological descriptions of food practices, from Levi-Strauss onwards, have
centred on the need to separate 'nature' from 'culture' in order to construct and reproduce
cultural identity, for the individual and across generations (Mennell et al. 1992). The
inappropriateness of creating such a dichotomy has also been recognised. Attention has been
drawn to the part played by ideas of 'nature' in formulating notions of 'culture' (Sydie 1987),
not the least in definitions of 'family' and the gendered division of domestic labour, addressed
in the previous chapter and which continue in this chapter. These explanations have allowed
food and eating practices to be located within its social setting, but they do not address the
interactions, negotiations and constructions which generate from and contribute to the form and function of those activities.

A number of theorists have attempted to build upon and go beyond a purely functionalist/structuralist approach. Mennell et al. (1992) propose a harmonising of views which they describe as 'developmentalism' which recognises 'the power of the symbolic meanings of food in shaping and controlling social behaviour' (p14), as well as the link between nature and culture. At the same time they draw attention to their own and other work which overturn many common-sense explanations (Harris 1986, Simoons 1961, both in Mennell et al. 1992), as well as, and more importantly, show how the macro events of the social, the political and the economic impact upon the micro experiences of everyday social interaction (Goody 1982, Mennell 1987, both in Mennell et al. 1992).

The Nation's Diet. The most significant acknowledgement of the place held by social research on food and eating has, in Britain, been a programme of research funded by the Economic and Social Research Committee which took place between 1993 and 1996 and involved sixteen projects drawn from across the social science spectrum. A representation of these projects can be found in the publication The Nation's Diet: The Social Science of Food Choice edited by Anne Murcott (1998). In her introductory chapter, Murcott draws attention to the range of ways in which food, diet and eating have been of both concern and fascination, suggesting that a key question for the 1990's has been 'why do we eat what we do?' As well as explaining that the book is a showcase for the research programme and emphasising the multidisciplinary nature of the projects, she also stresses the diversity with which the term 'food choice' was interpreted by the chapters' authors. The notion of 'food choice' is, in fact, one coined originally by food economists, but which has had wider currency since the launch of the Nation's Diet programme. It has come to act as a shorthand used when enquiring into 'why do we eat what we do?' Thus the use of the term 'choice' has become far more arbitrary (Murcott 1998)

Whilst aware of the biological relevance that food has had for a number of these studies Murcott makes clear that all agree that 'food is not just something to eat' (p14). The diversity of discipline and of emphasis represented in the volume is an indicator of the significance that activities around food has for social life and, in the editor's words, 'represents a first, not a last, word on the social sciences of food choice offering a broad set of shoulders on which researchers are urged to stand' (p21). This broad range of topics is a clear indicator that food, as part of social life, means many things. For the purposes of this study, it is those projects which explore food within its social and cultural context, particularly the home and family, which have been the most valuable (Caplan et al. (1998), Henson et al. (1998), Kemmer et
al. (1998)). A number of these studies will and have been drawn upon for the purposes of this review.

Sociological studies about food, meals and eating

Many of the studies about food, meals and eating have illustrated the gendered nature of social settings and have also examined the ways in which power and patriarchy can be seen to prescribe the lives of women, limiting their life choices (DeVault 1991, Charles and Kerr 1988, Kerr and Charles 1986, Murcott 1983a, 1983b). Some studies have indicated that women view with ambivalence the roles that they are expected to assume as wives and mothers, dealing as they do with a dynamic setting and sometimes contradictory processes of negotiation and compromise. Tasks which constitute domestic labour often invite mixed feelings of both pleasure, boredom and frustration (Baxter and Western 1998, Graham 1983, 1984). After childcare, it is providing food and meals that are most likely to attract these feelings.

Anne Murcott (1983a) was the first to draw attention to the significance of food and eating for social life from a sociological point of view, by bringing together a series of papers addressing the relationship between food and eating practices, specific and significant aspects of social life, such as culture, health, generation, and the household. The Sociology of Food and Eating includes chapters which look at the nature of food itself, chapters which discuss how people manage food and meals, particularly in the family setting, as well as chapters which examine social differences, such as ethnicity, age and class. Although there are aspects of all of the chapters which have a bearing upon this current enquiry, it is the second of these groups of chapters, how people manage food and meals, that has particular relevance. Macintyre's (1983) and Homans' (1983) work on food in pregnancy point up the contradictions that can be identified, either to do with women's everyday experience of food, or the suspension of traditions at times of transition. Blaxter and Paterson's (1983) and Pill's (1983) two studies draw attention to the symbolic importance of food, and how it can have different meanings in different settings, for working class mothers and for people across generations. Burgoyne and Clarke (1983) show how eating and mealtime practices contribute to the identity of the individual and of the family, and Murcott herself begins to address a theme she has pursued in later publications: the nature of the meal, how it is construed within the family and the effect that construction might have for the members.
Further work by Murcott (Mennell et al. 1992, Murcott 1983b) and others (Henson et al. 1996, 1998, DeVault 1991, Charles and Kerr 1988, Kerr and Charles 1986) has also examined the place of food, diet and eating within the family. It is clear that meals are routinely construed as a pivot for family activity (even if coming together for a meal is not always regularly achievable) and that food itself conveys meanings that go well beyond that of sustenance or notions of health and illness. The view that a 'proper' family might be seen as one that regularly eats together, has been termed 'commensality' by Mennell et al. (1992). They have drawn attention to the fact that this way of eating together not only reaffirms membership of the group, but helps endorse the 'naturalness' of its form. The desire for commensality together with the gendered nature of family practices can be seen to prescribe and shape the roles undertaken by women in families (Mennell et al. 1992).

The ways in which women feel about and respond to the pressure of these kinds of messages is complex and not at all straightforward. Murcott reports on women who, despite the burden placed upon them in terms of whether they cook, what they cook, and for whom, assert that 'it is a pleasure to cook for him' (1983b p89). Charles and Kerr (1988), in their study in the north of England, describe an understanding from respondents of what a 'proper meal' should consist: cooked meat with two vegetables (also identified by Murcott in her study in South Wales 1983a), and learned through trial and error of what family members are prepared to tolerate (as will have been noted from the extract quoted in the previous chapter). They suggest that these kinds of food practices contribute to the reproduction of patriarchal families and, as such, endorse the principles of capitalism. DeVault, in her study in Chicago, draws attention to the multiple aims that 'feeding the family' might have for a wife and mother. She suggests, after West and Zimmerman (1992), that to engage in domestic tasks, and especially the preparation of food, can be construed as a woman not only fulfilling a female role, but also actively endorsing, on a day to day basis, her gender identity. Henson et al. (1996) and Gregory (1999), looking at the impact of a change in diet by a family member, found that families negotiated roles and rules around food and eating in convoluted ways that rarely involved formal discussion. Factors related to the diet itself, the person changing diet and the structure of the family interacted to influence how people responded to change. These factors reflected notions of how legitimate the new diet was seen to be and the status of the person within the family, in terms of influence and control over changes in diet. The structure of the family, the level to which it followed traditional lines or challenged family or gender traditions, also contributed to the ways that food and meals were construed. The sociological literature on food and eating provides the detail which illustrates the ordinary everyday processes which constitute family life discussed in the previous chapter. It is through the
wide range of often mundane tasks which go to producing meals and mealtimes that people constitute and reconstitute their identities as family members on a day to day basis.

Social developments leading to new perspectives on food and eating

Attitudes towards and research about food and eating practices have developed through a number of parallel and co-incidental events and changes historically, politically and culturally.

Nutritional science: the first development which contextualises this study historically is the relatively recent and rapid rise of nutritional science that has had a direct effect upon the everyday lives of twentieth century populations, especially those in the west. Emerging around the mid-nineteenth century, it has provided a growing knowledge of the constituents of organic life in terms of its effect as sustenance, particularly for human beings. Complaints often heard, particularly in the media but also in academic studies, about the contradictions and inaccuracies of dietary information (McKie at al 1993) are as much a consequence of its rapid development as of its incomplete or flawed science. Nevertheless nutritional science has provided a concrete basis upon which institutions (such as government bodies) who wish to impose strong recommendations about lifestyles, can rest their claims about prevention of medical conditions and the maintenance of good health (Wilson 1989, Graham 1979).

Specific historical events were often the vehicle for nutritional discovery. The poor health of fighting men needed for two world wars was associated with poor nourishment, and early surveys, conducted at the turn of the nineteenth/twentieth centuries, of the lifestyles of the poor in Britain, by Charles Booth (1903) in London and Seebohm Rowntree (1902) in York, provided further evidence of the link between health and diet. Legislation followed intended to improve the position of the poor and equalise health differences. Nevertheless, official advice related to food and diet has always been cautious not to displace action seen as appropriately undertaken within the home (Leat 1998). This has been particularly the case in recent years, with public policy reflecting an individualistic turn, focusing upon advice on lifestyle change rather than on government legislation or investment (see for example the Health of the Nation document, Department of Health 1993). Information is now provided about the nutritional content of foods, together with recommended maximum and minimum intake, with requirements that food manufacturers provide this on packaging. The 'informed choice' this offers consumers takes no account of their economic status or intra-household differences in food preferences, power and control. The nature of food has changed considerably, particularly since the second world war, in that it tends to be judged as much by
its chemical composition as its taste or appearance. This generates the need for 'scientific' knowledge when purchasing food and constructing meals (Lupton 1996). At the same time people are exhorted to take personal responsibility for their health by changing their eating (and other) habits to prevent the onset of diet-related medical conditions. Lifestyles are now seen as indicating the emergence of 'diseases of civilisation' (for example heart disease) stressing the need to change individual attitudes, and implicitly, behaviour, rather than a need to examine the activities of external agents (such as the food industry) through the state (Lacey 1992, Abraham 1991, Hunt and McEwan 1980).

This trend in both medical advice and government health policy has been, effectively, aimed at the prevention of potential illness and maintenance of good health, rather than the cure of existing conditions. These preventive health strategies, however neutrally expressed, carry implications for the actions of individuals within society and the roles they play within particular groups. As noted in the previous chapter, despite changes in patterns of paid employment outside the home, particularly since the second world war, there has been no real indication of significant and lasting changes in the domestic division of labour (Bernardes 1997, Morris 1990, Leonard and Speakman 1986, Oakley 1974). Consequently, recommendations concerning diet as an element of healthy lifestyles are likely to be seen, both formally and informally, to be the responsibility of those most closely concerned with caring, that is, wives and mothers (Ribbens 1994, Wilson 1989, Graham 1984).

Medical science: The next historical development which situates this study, and is linked to changes in nutrition, are changes in notions of health and illness. Sociological perspectives on this topic will be developed theoretically in the next chapter, so here will appear just a brief introduction to the relevant issues. Mortality and morbidity, as related to the incidence of disease, has improved dramatically since the end of the nineteenth century. At the same time there has been a growth in the technical capability of medical treatment allowing people to presume greater and greater expectations of the medical profession for successful recovery from any illness. In fact this may be as much to do with prevention as with cure, as indicated by McKeown (see Hart 1985 and Stacey 1988, Blane 1987), who suggested that improvements in health status of the general population through the early part of the twentieth century were more to do with improvements in housing, sanitation and nutrition, as well as the reduction in family size. Thomas (1995) has added that an unrecognised contribution to improved health status has been the invisible domestic work conducted in the home by women. This informal care is key, she suggests, 'to the creation of the material prerequisites and the immediate tangible and the intangible conditions for the daily and generational reproduction of embodied individuals'(1995 p347). Nevertheless, the development of medical
technology, in terms of detecting existing or potential disease, together with the discovery of medical interventions to prevent or cure specific conditions, at pre-symptomatic stages, has provided a firm basis upon which a powerful medical profession has been built.

Also important to this study has been an increasingly individualistic nature attributed to the medical encounter. The notion of the 'sick role' was first theorised by Talcott Parsons (1951, 1975) as a way of understanding behaviour around illness, and assumed certain rights and responsibilities for that sick person. These expectations centred around specific behaviour of the individual, whether s/he conformed to 'rules', and their social consequences. Parsons' theory of the experience of illness has been challenged in terms of its overly functionalist perspective (Freidson 1970), as has his theory of the family as discussed in the previous chapter. More recent theorising has placed the health and illness discourse within a context which, although real and experienced, can also be said to be socially constructed (Nettleton 1995, Stacey 1988, Hart 1985). This literature will be discussed further in chapter three.

The meanings associated with food and constructions of health and illness can be seen to be closely intertwined on a number of levels. In the previous chapter, and earlier in this chapter, attention has been drawn to assumptions of the 'individual' which underlie the establishment and maintenance of self identity (Ribbens 1994, Gubrium and Holstein 1990). Expectations about 'appropriate' behaviour, whether mothers in families, or sick people in families, assume an independence of choice and ignore the constraints and demands of the social setting. Food is often used as an indicator of appropriate behaviour. Lupton (1996) has suggested that food can be seen as a source of illness - 'bad' food being interpreted as 'unhealthy' food - but can also be seen as a form of medicine, by being health-giving or illhealth-preventing. A 'healthy diet' has come to mean something beyond its component properties, by implying behaviour which is in balance and in moderation.

Family life. The previous chapter has already examined home and family as significant features of contemporary life, and views and beliefs about 'family' provide a significant contribution to the evolution of attitudes towards food and eating. Oakley (1974, 1985), when reporting on her ground breaking study of housework, commented that funders and institutions alike found it difficult to comprehend the need to conduct such a project. Since then studies (see especially Morris 1990), many taking a feminist stance, have, by reporting on and theorising about activities which take place in the 'private' domain of the family, drawn this area into the centre stage of sociological enquiry.

As discussed in the previous chapter, much of this research has shown how the 'public' world of paid work has been seen as primarily male, whilst the 'private' world of home and family
has been construed as female (Gamarnikow et al. 1983). This is never more evident than in views about food, meals and eating within the context of the family, which see the female nature of the household embodied in the concept of 'the housewife' (DeVault 1991, Charles and Kerr 1988, Oakley 1974). Caring for children and for the elderly and infirm has, more recently, been recognised to be a process of negotiation which is informal and intricate, but remains of special significance for women (Ribbens 1994, Finch 1989). The preparation of food and meals in families, equally, remains a severely gendered task. The preparing and consuming of meals has been shown to act as an important but complex basis upon which assumptions about responsibility and control, and gender identity within the family setting are understood (DeVault 1991, Charles and Kerr 1988, Kerr and Charles 1986, Murcott 1983b).

Food, diet and meals as social identity and social control

In this section I move from the background and the influences upon the sociology of food research to literature which informs understanding about the social organisation of food tasks and activities within the home. The previous chapter has already discussed the value placed by governments upon home and family as the appropriate site for the formation and maintenance of 'proper' social behaviour. It is within the family setting that social values such as morality, caring and duty are assumed to be learned and practised, with public condemnation when this is found to have failed (and, of course, the only occasion for public intrusion). However, it was also suggested that the State may also be reflecting a need for social institutions within which individual identities may be established and renewed. The family provides a powerful location within which the ordinary and the everyday can rub shoulders with the emotional and the caring. Goffman (1963) drew attention to the means by which society categorises people in order to ensure the smooth running of social interaction. A 'complement of attributes felt to be ordinary and natural for members of these categories' (p11) establishes social identity - bringing together personal attributes, such as 'honesty' and structural attributes, such as 'occupation':

We lean on these anticipations that we have, transforming them into normative expectations, into righteously presented demands (Goffman 1963 p12).

The construction of these anticipations (demands) is achieved, not just through major social events, such as birth, marriage, divorce (although these can be seen to be signifiers marking processes of continuity and change), but also through a daily display of 'normality'.
Food and gender. The previous chapter has drawn attention to the gendered nature of the family setting and the part played by assumptions about caring in identifying domestic work as women's work. A number of the studies mentioned earlier in this chapter have highlighted the relationship between women and food specifically within the home and family in Britain. Those conducted by Murcott and by Charles and Kerr in the 1980s (Murcott 1983b, 1998, Charles and Kerr 1988), and Henson et al. and Kemmer et al. in the 1990s (Henson et al. 1996, 1998, Gregory 1999, Kemmer et al. 1998a, 1998b) indicate that little has changed in terms of the domestic division of labour. In many of these studies there was strong evidence of male food preference taking priority over that of women or children. Only Kemmer et al. (1998a, 1998b) observed that less deference to male food preferences was made by their couple participants, who were interviewed three months before and three months after setting up home together. It is speculated that the absence of children, and also the female partner being in full time employment, may have had an influence on this. In America Schafer and Schafer (1989) found that, at all levels of the lifecycle, husbands and wives agreed that food selection and preparation was the domain of women, and an edited collection from the Nordic countries, Palatable Worlds, also reveal consensus on the feminisation of food (Furst et al. 1991). Furst (1991) proposes food as a metaphor for gender, with men and women being identified differently with specific foods, in terms of types and of status. She suggests that this is the case in both small-scale societies and modern Western countries. She draws a parallel between cooking and mothering and the nature/culture duality, suggesting that both tasks have been interpreted as transforming uncontrolled nature into socially acceptable culture.

The associations between women and food are evident in the studies mentioned above and others; it is also clear that it is an association which is taken as given, rather than questioned by the institutions (whether public organisations or private homes) within which it flourishes. Wilson (1989), commenting upon preventive health policy, has pointed out that because gender difference tends to be reflected within structural formations, such as the family, rather than overtly, health policy can be devised in gender neutral terms, implying equal capacity to respond. Thus:

the social construction of gender makes food a woman's sphere in most households. Men are not expected to take responsibility for diet and are thus constrained into more traditional attitudes than women (p183).

There is little evidence of change from this statement at the turn of the millennium. The 'naturalness' with which domestic tasks generally, and food tasks specifically, are seen as
primarily women's responsibilities remains, despite changes in employment of men and women outside the home. The home and the kitchen particularly continue to be viewed as female territory. Caplan (1997) advises that 'In the West, gender...is...achieved through 'performance'......[and] would include not only practices of food and eating, but also the preparation of meals (and the clearing up afterwards)' (p9). The 'naturalness' with which these assumptions are made and understood implies a sense of the normal which remains largely unquestioned and unchallenged by most of the participants of the studies cited.

**The family meal as signifier and unifier.** Family meals provide an opportunity for family members to come together and act out their own (gender and family) identities within the context of 'a normal family life'. Concern has been expressed about the gradual disappearance of 'the family' meals as a routine and regular family activity (Murcott 1998). This loss has been couched in terms of crisis with the implication that the demise of the family meal signifies the loss of family unity. The notion of the meal as a social event, has been imbued with considerable significance for social meaning:

A meal may signify unity and sharing, but it does more, it enacts or effects this sharing of the not...shareable...It not only says 'we share', it operates the actual sharing, being mediated by its various foodstuffs (Otnes 1991 p105).

Makela (1991) draws attention to its role as a form of language, communicating meaning in terms of who people are and their social location, whilst Ekstrom (1991) sees food as an 'utterance of culture' which contains an encoded grammar, implicit but decipherable, which conveys rules of 'right' and 'wrong', but also of power and subordination. She draws upon Bourdieu's notion of 'habitus' - a system of dispositions within a specific social milieu, where food is an expression of taste. The distinction between 'taste' and 'appetite' parallels the comparison between culture and nature, in that taste is seen to be 'culturally shaped and socially controlled' (Caplan 1997 p1). Appetite, like nature, is seen as raw and unformed, and requiring transformation into the socially acceptable. The home and family, as a location for individual and collective consumption, is part of a process of transformation of social facts into social meanings. These meanings are negotiated, often contested, but ultimately produce family identities and relationships (Valentine 1999a, Lupton 1994). This process of transformation incorporates the everyday family activities, of which family meals form a unique part. Murcott (1997) suggests that there has been no decline in family meals and that, in fact, people have never eaten together as regularly as implied by the concern expressed about its demise. Indeed, the contested nature of the event suggests that avoiding the family meal may well be a means by which recognition of its flaws is avoided. Nevertheless, the
family meal is held up to be a goal, even by those unable to achieve it on a regular basis, as such it becomes both sign and signifier of the family as a cohesive unit.

From religious aestheticism to dietary aestheticism. Regardless of the significance levelled at the family meal or, in contrast, the insignificance with which the work involved in its production is often viewed, food practices act as a strategic component of the norms and values within which people tend to want to live. The symbolism with which food, diet and eating has been identified has also been examined by Bryan Turner (1992) from the perspective of surveillance and social control. He has suggested that the primacy with which 'appropriate' dietary practice is viewed has its source and development in a moral sensibility originally manifested in religion. He believes that it forms an important part of a process of monitoring and restraining social action. Society is said to develop ways by which the 'proper' and 'respectable' behaviour of its members is assured, through the functioning of the social order and the maintenance of hierarchical relationships. Turner, following Foucault (1979), has indicated ways in which the progress of scientific developments and an individualised discipline of the body have interacted to provide new and more successful ways by which social acts can be predicted and managed. He notes that dietary restriction has formed an important component of both medical practice and religious regulation, and that the rise of the former mirrors the wane of the latter (Turner 1982).

Turner suggests that, particularly in areas seen as the domain of the private world of the family, the local general practitioner might be seen as replacing the priest, in terms of the services that role can provide for the prospective patient. The authority of the medical professional is such that stepping outside his (usually male) patronage, by not following medical advice, seeking alternative measures or even asking for further clarification or advice, can damage the doctor-patient relationship (Morgan et al. 1985, Roberts 1985). The scientific knowledge, necessary to be able to demonstrate 'proper' social behaviour mentioned earlier, may be available from other sources, such as books or the media, but is legitimised through its scientific base. The increasing use of dietary advice as a form of prevention or cure for a range of illnesses provides a valuable form of 'medical treatment' (in this context, advice based on scientific knowledge). It places virtually all of the responsibility for and burden of carrying out this 'treatment' upon the individual (or his/her family as will be discussed later), whilst at the same time provides an ideal formula for routine monitoring. The moral imperative which underpins this process means that the individual (or his/her family) can be expected to self-monitor. Thus it is, perhaps, not surprising to find that people undertake following a diet for health reasons from a moral perspective, sacrificing pleasure for the perceived benefits of health (Lupton 1996)
**Surveillance as social control.** Turner (1992) develops Foucault's notion of 'surveillance', as a form of social control which replaced gross punishment and could be extended further and further into many aspects of social life. Foucault describes a 'political anatomy', as a way of viewing the body, which allows it to be surveilled, used, transformed and improved. The development of scientific technology has facilitated this form of social organisation for which surveillance is fundamental. At the same time, assumptions of naturalness and common-sense which underpin this perspective have discouraged any questioning of the acceptability or legitimacy of this ordering of social life (Foucault 1979, Turner 1992). The medicalisation of areas of life not previously seen as the domain of medicine (such as pregnancy, sexual behaviour and diet) provides for a process of rationalisation which, Turner suggests, would have been recognised by Weber, as related processes and actions by which human behaviour is subject to calculation, measurement and control (Turner 1992). As such, preventive medicine, and specifically that related to dietary advice, whether directed at preventing potential disease or managing existing symptoms, as in chronic illness, can be said to offer an ideal opportunity for the regulation of lifestyles. However, Nettleton (1995) suggests that a Foucauldian notion of surveillance in fact provides a greater potential for negotiation than the notion of medicalisation espoused by Turner. The evidence 'on the body' of following or not following the expert's advice may not always be clearly defined, thus allowing an opportunity for resistance, which may explain contradictions in dietary behaviour, as well as negative responses to official dietary advice.

**Civilising the body.** A theme running through this discussion of influences upon current perspectives of food and eating is that of the lived experience of 'the body'. The development of an increasingly individuated social process populated by people who generally lead safer lifestyles (here is meant within Westernised communities subject to the political, economic and legal predictability that those communities imply) is indicated and endorsed through what is seen to be written on the subjective body. For example, most people in the West know where to obtain food and can predict their own access to it. Thus a very obese person or an abnormally thin person may be seen to have individual personal value laden attributes, rather than a general indicator of access to food. The appearance of and behaviour displayed by the individual is seen as evidence of his/her values and beliefs, not, for example, the country's resources. Lupton (1996) distinguishes between the 'civilised' body and the 'grotesque' body, the former being interpreted as self-contained and conformist, the latter as unruly and animalistic.

Mennell (1987, 1989) as mentioned earlier, uses Elias' term 'the civilising process' (which was said to have developed from the 16th century onwards) to examine an ability to manage
emotional expression and an awareness of the value of moderation, particularly in relation to behaviour around food. Mennell suggests that the development of food taste and haute cuisine have been indicators of both a sense of predictability through different forms of social security (such as food security, ie: predictability of the routine access, source and quantity of food) and also a sense of self awareness and self knowledge which has attracted a desire for and an expectation of self control and moderation (Mennell et al. 1992).

This focus on 'the body' has been facilitated by social progress which has improved the lives of many and limited much of the effects of poverty and legal and political inadequacies (admittedly within geographical constraints and class boundaries) and so enhanced the expectations of many, for personal achievement. This has also been aided by technological progress in methods by which individual achievement can be registered or monitored. Individual progress in education, employment and social mobility is routinely the subject of measurement and comparison, as is the quality and form of health, illness, parenting, crime and sexual activity, to mention just some social phenomenon amenable to surveillance. Records are required, kept, reported and monitored, as well as used as a basis for future action, whether through the formal action of government agencies, or through informal everyday comparisons against emerging norms.

Turner, amongst others (for example Hart 1985), suggests that one of the most powerful agents for 'regulating bodies' in this way is the medical profession, through a long historical process of rationalisation and standardisation (1987 p218). He suggests that 'there is a sense that sickness is something that we do rather than simply something that we have' (p213). As such, it is assumed that if we actively construct our state of health, and that this can be observed and measured by ourselves and others, the corollary is that we have a personal responsibility for it. The increasingly close association of food and eating with health and illness, as located in the subjective body, provides the site for both the internal endorsement of the 'proper' social self, through self restraint and self care, and the external ratification of 'proper' social activity, through physical appearance and dietary practices (Lupton 1996). Whilst there is evidence of deviation from these internalised rules and norms, it often takes the form of concealment (Bloor and McIntosh 1990), or may be construed as just not understanding properly, or laziness, rather than as a rational considered choice.
Summary

This chapter has traced the development and the diversity of social science research into food, diet and eating specifically in relation to the place it occupies within the home and family. Following the examination of the literature on the family in chapter one, this chapter has discussed the contribution to social meaning made by activities around different aspects of food and meals within the home. Three linked themes emerge which inform the analysis of data presented later in the thesis.

Process. Firstly, the 'family' literature highlighted the need to address the processual nature of family life to understand the meanings which underlie members' behaviour. Tasks around food, meals and eating have been seen, amongst other things, to embody family identities. Murcott (1982) has suggested that 'the cooked dinner...symbolises the home itself, a man's relation to that home and a woman's place in it' (p693). The act of eating together, commensality, is a culmination of actions and attitudes which represent the aspects of identity to which people aspire or are assigned, such as: status, gender, age, location within the family (Lupton 1996; James 1998, Mennell et al. 1992). A widespread concern about the rise of 'grazing' (eating snackfood at unplanned moments and often alone) as a replacement for the family meal can be understood, not just in terms of possible nutritional inadequacy, but also because the family meal can be said to be constitutive of 'the family'. The regular process of coming together to eat can be seen as a fundamental part of 'doing family' (Bowlby et al. 1997, Gregory 1999).

Gender. Secondly, but very closely linked, is the gendering of the family, which places responsibility, if not control, with women, as acted out through food and other domestic tasks and activities. The caring responsibilities described in chapter one, and closely associated with the gendered nature of the family, prescribe not only who does what within the family, but also how those actions are undertaken. The tasks associated with food in the domestic division of labour include a wide range of responsibilities - 'provisioning, shopping, storage and preserving, preparation and cooking, serving and clearing away, never mind gardening, borrowing and exchange' (Mennell et al 1992 p95). Not only do men undertake different tasks within the home than women, but they do them differently. Men may do more cooking in the home in recent years, but it is often because they enjoy it rather than because it has to be done. Men 'help' with the cooking, are 'understudy' cooks (Gregory 1999, DeVault 1991, Murcott 1983b, Oakley 1974). Again, the process by which food tasks are negotiated and allocated embodies the gendered identities assumed by each member of the family. In the home, not only are people 'doing family', but they are 'doing gender'.
Negotiation. Thirdly, these acts of 'gender' and acts of 'family' locate people within their social milieu. Descriptions of how people construe their family lives are frequently couched in terms of passive compliance. In fact, agreement over how family practices should be acted out is often negotiated in elaborate and convoluted ways. The term 'negotiation', whilst often construed as a face-to-face verbalised method by which all parties come to an agreement and have an equal opportunity to contribute, is often, in reality, an unspoken testing out of relationship, emotion and power. The level to which notions of 'the natural' permeate explanations about the allocation of tasks within the home do not always allow the complex nature of the negotiation that leads to any particular arrangement to remain visible. The social control of the everyday takes place within ordinary events and routine activities which construct social life. The 'natural' comes together with social control in the home to promote the desire for 'normality'.

Within the structural framework of the family, domestic tasks provide the discourse through which these meanings are created and understood. The social understanding of the concept 'family' applies constraints upon the range of action which may legitimately be seen as 'family behaviour' or 'family practices', but is interpreted through everyday interaction. It is the everyday that offers the opportunity to reconstruct or reinterpret the social. Activities around food and eating provide a language for that discourse. Within families the language of food and eating derives its strength through the repetition of routine and the expected but becomes fragile if disrupted by unexpected contingency.

The contingency of ill health is both unexpected and unwelcome and is likely to test the fabric of normal family life to a considerable degree. The next chapter will examine the social understanding of health and illness within the context of the family.
Chapter 3. Health and illness in families

Introduction

The previous two chapters have discussed the nature of the family setting as a location for the everyday activities which are essential for the functional sustaining of human life, and, simultaneously, form the processes by which people constructed the meanings they attach to social life. The literature confirms the centrality of 'the family' for the development and maintenance of roles and tasks which constitute social meaning. Further, 'the family' has been seen to be construed as the 'natural' location for tasks associated with caring, only to be intruded upon when the adequacy of the particular family practices comes into question. The gendered nature of family practices can be seen to be a product of the conflation of the biological basis of gender identity with the social meaning which has been attached to tasks which have been assigned to that location. Thus, an expectation that childcare, for example, should be undertaken by women in the home without economic reward can be construed as appropriate and in no need of problematising, even by many of the women concerned.

The theme of caring, which was introduced in chapter one, was examined further in chapter two, in relation to the tasks and activities involved in the production and consumption of food. Food has been demonstrated to have a special character and meaning within the context of the family. As well as required for daily nutritional needs, and significant for the acting out of gender roles, the offering of a carefully prepared meal to the family as a group demonstrates love and affection in a way that cleaning the toilet or polishing the car does not. This is not to say that ensuring the hygiene of the home and the smooth running of the family process does not provide evidence of the responsibilities felt by family members for each other. It just means that, in addition to the very visible profile attached to the meaning of food as a metaphor for social relationships in contemporary Western culture and beyond, the absence of food events in the home would probably be noticed earlier than the absence of most other family based events, certainly by the family members themselves.

The previous chapter has also drawn attention to the relationship between food and health specifically in relation to nutrition. The ambivalent relationship people have with food when they are expected to pay attention to their health has been seen to have its origins in the changing nature of society, according to Turner (1987, 1992). Turner's conceptualisation of diet as a means of social surveillance - replacing the role of the church - is just part of a broader 'civilising process' (Mennell 1992, Elias 1978) within which medicine and notions of
health and illness play a significant part. If food and meals have been seen as 'naturally' located in the home and as the responsibility of women in the family, then the preservation of health and the caring and curing of illness has also been seen as appropriately handed over to that domain, once the medical and health professions have fulfilled their roles.

This chapter will examine conceptualisations of both health and illness frequently construed as clear-cut through a simplification which has ignored the social setting within which activities around health and illness are acted out. Attention will be paid to ways in which an ongoing baseline caring process is assumed to exist within the family setting and may be recognised and made visible. It will also examine the ways in which the development of 'surveillance medicine' (Armstrong 1995) has implicitly relied upon the family as the site for 'self surveillance', both in terms of ensuring the health and health behaviour of family members, but also for the care and support of people diagnosed with chronic illness. A main goal of this chapter is to show how the role played by family practices in constructing and reconstructing individual and group identities on a day to day basis is brought to bear within the context of chronic illness.

**Conceptualisations of health**

*a complete state of physical, mental and social well-being and not merely the absence of illness*  
( WHO definition of health quoted in Morgan et al. 1985 p21)

Despite the comprehensive, if abstract, nature of the definition above, made in the constitution of the World Health Organisation in 1948, it is more usual for researchers to report health as being difficult to define and often construed only in terms of an absence of illness (Annandale 1999, Nettleton 1995, Stacey 1988). Blaxter (1990), in the Health and Lifestyles Survey noted that a significant minority of respondents found it difficult to define what it felt like to be healthy and many used the word 'ordinary'. Cunningham Burley, in her study of children's illness, found that notions of health and illness were seen contextually rather than in the abstract, thus respondents who could discuss current or memorable problems easily, found it more difficult to articulate ordinary everyday caring routines (1990). Herzlich (1973), in France in the early 1970s identified three dimensions of health from her respondent's accounts of health and illness. The first, 'health in a vacuum, was an absence of illness; the second, health as a reserve, was a form of capital upon which the individual could draw, and the third was a form of equilibrium, which, again, is seen as sense of well-being which comes from
'an absence of awareness of the body' (Morgan et al. 1985 p93) These results, report Morgan et al., were echoed in the work conducted by Rory Williams (1993) in Aberdeen in the early 1980s.

This absence which is health is not, however, absent from social expectations about healthiness and its achievement. It is clear from a number of studies that, despite difficulties in defining it, health is seen as a state of body which is not only desired but required. The patient is now seen as a consumer (implying notions of the sovereign individual) entitled to expect specific rights, embodied in the Patient's Charter, but also guided by obligations as well (Annandale 1999, Nettleton 1995). The notion of the 'healthy body' has become a central feature of contemporary Western culture as an indicator of a moral as well as a physical well-being. Paterson and Lupton (1996) use the vehicle of 'the healthy citizen' to illustrate the gender differences through which the public expression of the virtues said to underlie 'a healthy body' are demonstrated. Woman as 'healthy citizen' is seen as a resource for the reproduction and maintenance of other healthy citizens. Man as 'healthy citizen', whilst only recently singled out as a health focus, tends to be seen within the context of a 'hegemonic masculinity' which is expressed through characteristics such as discipline, authority and control. This is often reflected in the requirement to be able to attain and remain in full-time paid employment. Interestingly, the virtues which are said to be demonstrated by good health: self-control, self-discipline, self-denial and will power according to Paterson and Lupton (1996, see also Crawford 1984, Nettleton 1995, Annandale 1999), and having echoes of Weber's notion of the Protestant work ethic (G.Williams 1993), are those generally associated with the heterosexual masculine body. The notion of 'surveillance', as a means by which bodies are monitored and self-monitored to ensure the prevention of illness and the promotion of health will be pursued further later in this chapter, so, at this point, the disposition of the female body for surveillance will just be noted.

Pollock (1993) found that many of her respondents saw health in functional terms, in an 'ability to carry out normal everyday tasks and activities' (p49), and suggests that '[c]ontrol of health is one direct expression of control of the self' (p50). The focus, within biomedicine, upon illness as a deviance to be predicted and avoided or controlled, has left health 'on the side of social order and norms' (Pierret 1993 p11). Pierret suggests that health is seen as a value, an attribute that people not only want to achieve and maintain, but also are seen to have a duty to do so. Her work in Paris and southern France in the early 1980s identified four ways of talking about health: health in relation to illness; health as a form of wealth; health as an objective; health as a matter of public policy. These categories reflect those of Herzlich outlined above and may well be the basis of work that Herzlich and Pierret (1987) went on to
conduct together. Examining secondary sources of lay and professional historical documents, they show how health has been seen, over time, by the lay person, within a much wider setting than narrow biomedical interpretation and experience (see Stacey 1988). Nevertheless, it would seem that wherever attempts to define health are found, aspects of illness follow.

This means that although not just an absence of illness, health has to be considered in relation to illness and the social meanings which underpin both states of being. Simon Williams (1995) suggests that the act of defining standardised values determines illness rather than health, as does Gadamer, cited in Annandale (1999). The point Annandale makes is that 'health and illness are not polar opposites and it is not uncommon for people to report that they are in good health while [also] referring to a number of often quite severe functional limitations'(p262) (also see Nettleton 1995, G.Williams 1993). This is endorsed by Radley and Billig (1996) who found, in their examination of people's accounts of their experiences of health and illness, that good health was seen in terms of illness and being sick in terms of the demands of the healthy (p222). Nettleton, addressing the experience of chronic illness and disability, says that '[i]llness reminds us that the 'normal' functioning of our minds and bodies is central to social action and interaction' (1995 p69). A pursuit of the everyday, the ordinary, the 'normal' seems to underpin the way people deal with both health and illness on a day to day basis. But further, Radley, introducing his book Worlds of Illness (1993) draws upon Gareth William's concept the 'pursuit of virtue' to illustrate the meanings behind individuals' attempts to be, or at least appear, well. So this is not a neutral, but a moral stance which drives the chronically ill towards wellness and monitors the behaviour of the healthy.

This theme of 'normality' which runs through all of the literature chapters and plays a significant part in the analysis of the data which follows, is, like notions of health, present in the absence of difference. The desire 'not to be different' from other people, or, in the case of recovering from illness, not being different from what went before, manifests itself in notions of the 'normal' or the 'natural'. Chapter one showed the 'normal family' as seen to be 'universal' and 'natural' across cultures, but at the same time individual and unique to each family group. This tension between the general and the particular has further resonance for those seeking health within the home. Radley (1993) sees this normality as a 'social competence' against which those who are ill are judged and judge themselves. This is a term utilised earlier by Anderson and Bury (1988), which they describe as 'the ability to be physically co-ordinated and psychologically well organised in every day life' (p252). They go on to suggest that this involves an 'emphasis on performance, consumption, self-control and the display of interpersonal skills' (p252). The question '[a]m I a normal healthy person?' (Robinson 1988 p142) is wrestled with by the well and the ill alike. However, although the
maintaining of the 'normality' of health involves considerable hard work in terms of time, effort and planning (especially for the ill), it also carries the expectation that it is a universal goal - who would not want to be healthy? This taken for granted quality renders invisible not only the work involved in the maintenance of 'normal health' but also those who are implicitly held responsible for it to be achieved.

In trying to conceptualise lay understandings of health and illness, Stacey surmises that 'individuals feel responsible for their health because, good or bad, they are defined by it' (1988 p143). However, she goes on to assert that 'if women have the primary responsibility for maintaining and promoting the health of their family, it is upon them that the burden of care for the ill and handicapped falls' (Stacey 1988 p207). This was vividly expressed, in Clare Williams' paper, by a mother of a teenage son with diabetes in response to health professionals:

...that's what they've all said to me, it's his diabetes, he's got it, it's his body, he's got to take care of himself, he knows when he feels ill or when he needs more insulin or less insulin', and I think, 'but no - its not just his because it affects us all' (2000 p268)

In fact, what seems clear from Williams' study, was that the person most affected was the mother, as the person bearing the main burden of the 'caring for' and the 'caring about'. The quote represents the lived experience of participants who have demonstrated, in many studies since Oakley's groundbreaking work on housework in the early 1970's, that women, overwhelmingly, remain the main providers of health via the domestic division of labour and are responsible, routinely, for family care through attending to the physical and emotional needs of the family (Oakley 1993, Stacey 1988). Oakley (1993) suggests that, embedded within formal health promotion work is 'an ideology of women's natural commitment to family welfare' (p5), thus feminine altruism becomes unpaid labour. Stacey anticipated this in a quote from a report by the Equal Opportunities Commission on the impact of community care on women's lives which was described as 'care on the cheap' (EOC 1982 p3 cited in Stacey 1988 p208). The close association of health in the family with women is of particular resonance when the responsibilities of motherhood are discussed (for example: Ribbens 1994, Richardson 1993, Backett 1990, Stacey 1988, Ungerson 1987, Graham 1984, 1979), but, in fact, also tends to be the case for all members of the family. A recent study by Cameron and Bernardes (1998) which looked at gender and health from a male perspective, noted that their findings support[ed] common gender roles assumptions about concern and responsibility for people's health being generally and properly the domain of women [with] some men
acknowledging this as being both the norm and how they themselves behave in their families (p678)

It is the implicit assumptions that are made about the 'naturalness' of the health work which is done in the home that underlie Thomas' (1995) challenge of the work of McKeown (1979), which was endorsed by Blane (1987), and which ignores (and in Blane's case specifically denies) the contribution of domestic labour to improvements in population health generally from the late 19th century to the early 20th century. She argues that whilst the increases in real wages were essential to improved living standards, it was the women's work in the home, 'producing and reproducing 'health'' (p347) which ensured that those living standards were, in fact, improved.

What seems clear from these and other similar studies is that health, in terms of meaning, is best understood within the context of the lived experience of the everyday. The emphasis which has been placed on defining and understanding notions of health, in this study of illness within families, is intended to prepare the way for data about illness which are embedded in notions of health and embodied in the experience of everyday family living. Chapter one described the complex processes, identified by Finch and Mason (1993), by which obligations to care and support were negotiated over time. The interplay between structural norms and individual agency was seen to be an ongoing process which works within the rules and roles which frame family life and kinship ties, but recognises the choices available to individual family members. Giddens' term 'ontological security' was used to help explain this relationship, and also provides a useful basis for understanding behaviour and decisions around health and illness. The desire to appear 'normal' generally, but particularly in the face of chronic illness, embodies the need to believe 'in the continuity of self identity over space and time' (Tucker 1998 p83). It is within the everyday and as part of functional activities that families undertake routinely, such as family meals, that individuals can be seen to promote a sense of ongoing self for themselves and for other family members. The close identification that women have with the kind of work which ensures domestic life and 'illness work' and which takes place routinely means that the responsibility for the 'ontological security' of all family members rests with mothers and wives.
Conceptualisations of illness

The chief business of chronically ill persons is not just to stay alive or keep their symptoms under control, but to live as normally as possible despite their symptoms and disease

(Strauss 1984 p79 quoted in Robinson 1988 p44)

Improvements in health status in contemporary Western culture, reflected in lower mortality and morbidity rates, has brought to the fore medical conditions which may not be immediately life threatening, but require a lifelong attention to symptom control. The term chronic illness is a catch-all term used to describe a range of medical conditions identifiable more by their social consequences than by their physical symptoms or medical treatment. In Meg Stacey's words 'nowadays with infectious diseases far less threatening in mass terms, chronic illnesses have assumed a greater importance, and sickness has become a way of life, not a way of dying' (1988 p143 original emphasis).

The sick role. The increase in the prevalence of chronic illness, together with medicalisation of health, has challenged a conventional view of sickness as an event which, once diagnosed, is treated in a way that, hopefully, will effect a cure. The 'sick role', theorised by Talcott Parsons (1951) and critiqued and developed by others (for example Freidson 1970), suggested a series of behaviours which explained and legitimised the act of being ill. These behaviours were said to carry certain rules which both sanction the sufferer's absence from normal, expected social roles and also impose obligations to seek and achieve a cure. It is doubtful, as critiques of the theory have suggested, that this model adequately explained the experience of acute illness, but it proves particularly inappropriate for the process by which chronic illness is received and lived (Nettleton 1995, Morgan et al. 1985, Hart 1985).

The functionalist approach that the sick role demonstrates, as did Parsons' theory of the family discussed in chapter one, provided not only an explanation for social behaviour, but a 'virtuous' means by which social organisation could be channelled into behaviour which supported capitalism and patriarchy. In the same way that the family has assumed a 'natural' and 'universal' role which supports the work ethic, the sick role could be seen to impose expectations upon the individual, when sick, to follow a career path which was to the advantage of the work ethic. That is to say, to be ill and absent from work in a way which could be said to be legitimate, and to follow a process which would lead, whenever possible, to a return to legitimate work (Morgan et al. 1985). Annandale (1999) and Nettleton (1995) amongst others have suggested that the notion of the sick role should be construed as an ideal type which cannot be applied directly to empirical reality, in terms of access or process. This
is particularly the case for chronic illness. Nevertheless, the moral implications with which the sick role is frequently imbued can be found to be reflected in the attitudes of those who live with chronic illness.

*Surveillance medicine.* Armstrong (1995) has described an evolutionary process by which medical knowledge has moved from the classical library, to the bedside, to the hospital and now out into the social world. Employing Foucault's notion of surveillance, he suggests that '[n]ot only is the relationship between symptom, sign and illness redrawn but the very nature of illness is reconstrued' (1995 p395). The medicalisation of aspects of social life, such as marriage (family therapy) (Cheal 1991), reproduction (pregnancy and childbirth) (Nettleton 1995), as well as lifestyle behaviours such as diet and smoking (Graham 1993, Laurier et al. 2000), mean that the medical gaze reaches well beyond the clinic into the home. The distinction between health and illness has been blurred not only for the medical or health professional, but also for the lay person. Pinell (1996), examining modern medicine from an historical perspective, has coined the term 'homo medicus' to describe the individual as '[a]n active collaborator but at the same time an object of medical practices, the patient lives out the contradictory tensions linked to that double position' (p15). The intrusion of this pseudo medical role into the 'normal' private lives of the population has its main impact upon the roles and practices located in the private domain of the home and family. The clinical gaze may *measure* the consequences of the medical advice it offers - the blood pressure of the pregnant woman, the weight of the new born baby, the blood count of the diabetic or the cholesterol level of the angina patient - but the *policing* of the behaviour which leads to that measurement rests with the person concerned, or members of his or her family.

*Biographical disruption.* The sense which is made of the experience of illness by those who suffer from it and those who live with it draws upon the meanings within which it is set. A major contribution to the understanding of how this process of 'meaning-making' (Annandale 1999) takes place has been the concept of 'biographical disruption' theorised by Bury (1982, 1991, Anderson and Bury 1988). The long term nature of the chronic condition and the uncertain quality of life associated with the diagnosis and treatment means that the nature and the identity of the illness must be dealt with in some way by both the sufferer and the family and friends. Bury (1982) describes 'disrupted biographies' in which the illness becomes interwoven into the lives and identities of the sufferers. He suggests that self identity and self worth will be changed as a consequence of the diagnosis of a chronic illness, but the level and direction of change will be influenced by the context within which it takes place. He has also suggested that the ways in which these meanings influence individual decisions and choices may be understood in terms of 'consequence' and in terms of 'significance'. The former is
limited to disruption to the physical consequences of the illness, the level to which the person may be able to continue to function instrumentally, whilst the latter is associated with cultural beliefs and values attached to the disease, and behaviours consequent upon its diagnosis, which can affect ideas of self and identity (Bury 1991).

Distinguishing between these two approaches can be useful for theoretical purposes. It provides a framework for understanding the process by which the cultural norms concerning illness (or health) behaviour inform and constrain the process by which individuals make choices and decisions concerning the illness trajectory. As such it aids in understanding the construction of meanings by both the person with the condition and others who are affected significantly by its presence. Simon Williams' examination of the work of Goffman is helpful for the purposes of this study, in that, despite criticisms that Goffman's work is over-concerned with structure, Williams suggests that his work on stigma 'attempts to bridge "situations" and "structures"' (S. Williams 1987 p135). In contrast to Parsons, whose concern is directed at the compliance with which people may be seen to conform to social expectations (with difference labelled as deviance), Goffman examines the relationship between structure and agency from the opposite direction. He analyses 'the ways in which sustained social interaction can or does break down, the sources and consequences of such interactional tension and the manner in which such malaise is managed' (Williams 1987 p136 my emphasis). Goffman makes a distinction between 'virtual social identity' (the stereotyping which comes from normative expectations of ought) and 'actual social identity' (the reality of the negotiated is) which provides parameters between which both the consequence and the significance of chronic illness are acted out on a day to day basis.

'Meaning-making' strategies. Ongoing everyday identities can be seen to incorporate both the 'virtual' ought and the 'actual' is within the processes which help to 'manage' illness. These processes are often described as strategies which allow the ill person and his/her family to function as normally as possible. The term 'strategy', as discussed in chapter one, has utility in that it suggests a form of rational negotiated plan of action which is, however, capable of a uniqueness according to the setting. It has been critiqued in that, although it has been used effectively to examine, for example, organisation within the household (Pahl 1984, Morris 1990), its implications of 'the presence of conscious and rational decisions involving a long term perspective' (Crow 1989 p19) are not always evident in practice or, conversely, might be applied to any event when examined in hindsight (Morgan 1989). The term has some value within the context of this study when employed to indicate a process, an ongoing activity which is not spontaneous or unconscious, but is, equally, not necessarily debated or agreed by the people concerned, and may be subject to change without anticipation or
permission. In this it is similar to the use of the term 'negotiation', which, when used within the context of the home and family is more likely to be formed out of interpretation and nuance than discussion and agreement.

Bury (1991) distinguishes between 'coping', 'strategy' and 'style' as terms which have been used to try to understand the ways in which people deal with disruption caused by illness in the relationship a person has between self and body. 'Coping', Bury sees as to do with attitude, a process of tolerating the disruption through a normalisation which may take different forms, such as 'bracketing off' the illness to minimise the effect upon self identity, or, alternatively treating the illness as normal, by incorporating it into the sense of self. 'Strategy', Bury (1991) sees in Goffmanesque action terms which 'mobilise resources and maximise outcomes' (p461), and is his preferred term when used as 'strategic management' which, he suggests, expresses the dynamic nature of interaction with the illness and with the setting. 'Style', he sees as the ways in which people can draw upon their cultural repertoires to present themselves within their social milieu. It is the notions of 'coping' and 'strategy' which are of value to this analysis of the literature, in that the process of normalising that many theorists see as the 'meaning making' people undertake around sickness, in fact, incorporates both attitude and action.

The strategies people use to deal with the day to day living with a chronic illness may well be influenced by a range of factors over which they have little or no control. The level to which the effects of the illness or the treatment limit normal social functioning, and the nature of the illness itself and its social acceptability, may affect whether a person would want to or be able to disguise its existence. Following Goffman, Morgan et al. (1985) identify the strategies of: passing (attempting to conceal the condition completely in order to 'pass' as 'normal'); 'covering' (reducing the significance of the condition by containing its noticeability or finding ways of encouraging others to ignore it) and 'withdrawal' (opting out of settings which involves spending time with 'normals'). The employment of these strategies may take a range of forms dependent upon the illness and almost more importantly, the setting. The setting may dictate the level to which the effects of a condition may be disguised or absorbed, and may vary over time and according to circumstances. Passing or covering are unlikely to be one-off decisions set in stone once achieved, but will form part of the tasks and activities which are daily life. Even withdrawal, as a possibility, demands co-operation from others for people who do not live alone. The brunt of the consequences of chronic illness will be borne in the home, whether this means physical and practical changes to the way activities are organised within the home, or whether it means providing the support, sympathy and encouragement needed to help changes to take place. It usually means both of these. This is
the no-cost labour referred to by Thomas (1995) upon which public welfare and health systems, as well as employers, have come to depend.

The energy expended to achieve an image of 'health' has been commented upon already (Paterson and Lupton 1996), and is likely to be considerable in a family (and for the family) where someone has been diagnosed with a medical condition which is likely to be life-long. When biographies are disrupted, it is not just the person with the condition that searches for ways of dealing with the presence of illness:

Spouses have continuously to make accommodations to maintain a sense of balance and give meaning to their lives...individually and collectively as they attempt to carry on their daily lives (Rajaram 1997 p283).

Pinder (1988), in her study of people with Parkinson's Disease, describes 'balancing' which could be said to bring together passing and covering in a trade-off between personal comfort and social functioning:

Balancing is both a personal and, more importantly, a social process. It involves bargaining with others as well as oneself (p69).

Similarly, Drummond and Mason (1990) in their study of the experience of diabetes, stress the significance of context to understanding the process of 'weighing-up' which contributed to their participants' decisions over their medication and other medical and lifestyle practices.

It is through the notion of 'narrative' that many theorists have attempted to come to grips with the ways in which these processes are employed to reconstitute the sense of continuity of self which is disturbed by illness and its consequences. Gareth Williams (1984, 1993), in particular, has shown how respondents, when asked to talk about the experience of ill-health, interweave factual reports of daily life with an expressive contextualising of events in a way that seeks to interpret and understand. Annandale (1999) cites the work of Frank (1993, 1995) who she says 'insists that stories [narratives] do not just describe the experience of illness; rather, stories are repair work' (p256/7 original emphasis), creating a continuity of past, present and future through a sense of self. However, in Bury's words, analytical devices such as 'strategic management', 'narrative reconstruction' or 'trajectories and adaptation' whilst correct, '. . . even here the active and pragmatic nature of such coping mechanisms often seems understated, as if the search for stable meanings ... were, all things considered, relatively straightforward' (1988 p90 original emphasis). It is in the light of this limitation and against the background of 'the pragmatic and even the performative aspects of meaning' (p90) that he developed his ideas of consequence and significance in relation to meaning.
Nevertheless, the use of 'narratives' has demonstrated the attempt within sociological theory to break away from analysis focused upon the dominance of structure, to recognise the complexity and the significance of agency in the organisation of the everyday (Popay et al. 1998). In this respect it provides a starting point for an analysis of the experience of illness (and health) which examines the family setting, not just as a location, and not just as a set of kin influencing and influenced by the experience, but as an ongoing dynamic process which constitutes and reconstitutes meanings on a daily basis.

'Nighting for' and 'caring about' in families

When we look at family life, it is sometimes difficult to see that a large part of what parents do is work for health. We tend to describe family activities in ways which obscure their health-promoting (or health-threatening dimensions). For example, we use the term 'socialisation' in our accounts of childrearing, yet it is a term which fails to convey the fact that parents ensure the survival as well as the socialisation of their children. As a result, we can emphasise the importance of mothers in shaping the minds of children, while remaining blind to their role in building and repairing their bodies. In a similar way, we can describe the nature of housework, but not record how much of the housewife's labours are devoted to maintaining the family's health rather than maintaining the home. It is the shopping, the cooking, the laundry, and the 'being with' activities which consume most in terms of time, money and energy (Graham 1984 p150).

This lengthy quote from Hilary Graham is focused upon health, but could just as easily be used to illustrate the demanding, intuitive and invisible work which takes place in homes, usually by wives and mothers, to provide the practical and the emotional support for family members with chronic illness. Thomas (1995) argues that 'domestic labour is a key social practice which contributes to the creation of the material prerequisites and the immediate tangible and intangible conditions for the daily and generational reproduction of embodied individuals' (p247). This role, of course, must include the management of symptoms and treatment of sickness, whether diagnosed or remaining undiagnosed. Chapters one and two discussed the role played by family practices in constituting a continuous sense of self for individuals and the family as a group. Emphasis was placed upon the juxtaposition of the powerful image of 'the family' as a social institution with its vulnerable nature which requires creation and recreation on a daily basis. This contrast is none more graphic than within the context of illness, unexpected and unwelcome, regardless of how serious it might be.
Nevertheless, it is within the barely visible process of family caring that chronic illness is likely to be eventually located, once the medical profession has exhausted its role. This is not to say that family caring is not recognised - socio-political and lay beliefs about both 'the family' and 'caring' place them firmly together and usually in the hands of women. It is the naturalness with which the two are construed that denies the complexity and the demanding nature, as well as the significance for social functioning.

There are a number of studies on chronic illness within the UK conducted within the final thirty years of the twentieth century which pay attention to the family as location. The analytical devices outlined above, and the use of qualitative depth interviews have allowed the lived experience of illness to be examined in detail. This attention to context and embodiment has begun to reveal the extent to which 'family' as an entity is essential for the normalising of illness behaviour. An important contribution has been the collection edited by Anderson and Bury (1988) *Living with Chronic Illness: The experience of patients and their families*. Within this volume are represented a wide range of conditions in terms of symptoms and treatment, but also in terms of seriousness and stigma. In the introduction the authors acknowledge the place of the family as a key resource for the care and rehabilitation of people with chronic illness, and the disadvantage that responsibility can have upon family members other than the patient. They also comment that 'the future of community care is dependent upon the assumption that women will continue, as the most common carers....., to make the sacrifices demanded' (p5). In their conclusion they go on to acknowledge the 'double disadvantage' for women, noting that 'although .....men can and do perform caring roles it is clear that women are particularly vulnerable to the effects of chronic illness' (p248). It is, therefore, disappointing to find that in the studies reported within this, and other volumes, that the nature of gendered caring within the home and the strategic role played by this work in constituting the normality of family practices, even in the face of the intrusion of illness, is rarely theorised. The impact of illness in the home for family members is carefully chronicled as is the strategy by which the intrusion of illness is received and made meaningful. For example, Pinder, interviewing families dealing with Parkinson's Disease, reports a wife's view:

Well, we're both disabled aren't we....I can't do what I'd like to do. I can't just go swanning off can I? I'm tied up. My first priority is him. (1988 p78).

Bury draws attention to the uncertainties of dealing with illness in the family:

Relationships do not *guarantee* particular responses, indeed, it is the response that shapes the relationship.....Importantly, there is no guarantee that significant others will respond
as a wholly predictable or supportive manner. The contingencies of family life and the expectations that members have of relationships are all put under threat. Thus, the essentially ambiguous nature of chronic illness is constantly confirmed in practice (1988 p92).

However, look beneath the surface of these illness narratives and the negotiations, and the constructive nature of the lived experience can be detected. Robinson (1988), asserting that '[m]aking sense of the disease in a social context is thus a complex and continuing task' (p58), says that 'one of the changes that does appear to occur with the intervention of the disease, is a rethinking of family roles, especially those of husband and wife' (58). However, 'one of the marital strategies in this situation may be to attempt to continue roles as before - to seek to keep the potential social changes which might be wrought by the disease at bay' (p59). In the following two quotes from a man with multiple sclerosis and his wife, Robinson highlights a strategy of 'fighting the disease'. What the quotes also reveal is the constructive nature of, not just the illness, but also the relationship within which it has become embedded:

Andrew says: My wife treats me as a normal person who may just find it difficult to walk. Our relationship could not be improved.....we carry on as we did before we knew it was multiple sclerosis, and we are not going to let that affect us.

Alison, his wife, argues: It is the attitude of the person with MS, and who they live with which makes life what it is..... [Andrew's illness] limits in some ways what we do, but it does not affect the quality of our life or shall I say we are doing our damnedest to make sure it doesn't. (Robinson 1988 p59)

This quote also illustrates the sense of continuity within which people need to address any contingency that life provides, whether welcome or unexpected, and which is not always evident in an emphasis upon the disruption that the onset of illness creates. The concept of 'biographical disruption' has been criticised for its lack of attention to 'what went before'. Emphasis on the disruptive nature of illness has an unintended implication of intrusion into a smooth-running setting with no existing problems, health, illness or otherwise.

Just a few studies remedy this by examining illness within the context of health and from the perspective of process. Interestingly, two studies particularly successful in this respect, address the illness (or not) of children and from the perspective of the mothers. Cunningham-Burley (1990), in a study she conducted in Scotland in the early 1980s, interviewed women that she recruited through a local health centre, also asking them to keep a children's health and illness diary for a week. It has already been noted at the beginning of this chapter that she
found that the women were less likely to be able to identify health outwith the notion of problem. In fact, she noted that '[i]t seemed that the very processes involved in defining and coping with health and illness at a mundane level were carried out routinely, almost without thinking' (p90). By encouraging her participants to be reflective about 'the very routine assumptions which the mothers made with respect to health and illness' she found that 'a focus on behaviour, normality; normal illness; and the use of explanation' (p90), informed her analysis. Nevertheless, she found it was 'easier for them to 'tell stories' about memorable episodes than to comment on the routine and thus taken-for-granted ways in which they recognised that something perhaps was wrong with their child' (p91). The 'naturalness' with which both the family setting and the routine everyday caring that takes place there is seen, conceals processes of 'doing family' and, effectively, 'doing caring'. This is particularly well illustrated by the ways that the mothers construed normality and the notion of 'normal illness':

The mothers' negotiation of their children's behaviour and illness was embedded in common-sense assumptions and individual experiences about what was normal and acceptable in a child. They used a notion for what was normal for their child or children as a method of interpreting that child's action or demeanour, while also recognising that the notion of normality itself derived from that child's behaviour and the mother's own accumulated knowledge. (Cunningham Burley 1990 p100)

The process of dealing with 'normal illness' is not dissimilar to the way 'lived-with' illness was managed, as identified by Clare Williams (2000) in her study of how young people with asthma or diabetes and their main carers deal with and construe the illness. The tension between holding the responsibility for the well-being of children and the task of encouraging their autonomy can be seen to require a finely tuned sensitivity towards the nuances of their individual health status. Williams draws upon the work of Charmaz (1991) to use the concept of the 'alert assistant' to examine the ways in which mothers monitor and aid the health progress of, particularly their sons. She sees the role of the alert assistant, for the mothers in her study, to incorporate a number of potential responsibilities. Firstly they muted the effects of the illness, by helping to reduce perceptions of the effects of the illness. This was mainly for the child's benefit, but also generally. This could involve undertaking tasks that their sons should, in fact, undertake themselves, but might also involve actively overlooking the adverse consequences of such work. By this is meant overlooking the potential future harm which might ensue as a consequence of the child not learning to take responsibility for the treatment of his illness himself. Secondly they absorbed emotions, by recognising the social pressure boys in particular have to not express feelings, and so acting as a buffer for the absence or presence of those feelings. Thirdly she found that '[t]he mothers of sons were much more
likely to feel the need to act as mediators than the mothers of daughters' (p263), making it possible, if the boys wished, for them to 'pass' within the public domain as someone without the condition.

Williams' study draws attention to the complicated, reflective, acute process that caring in families demands, usually of mothers. The salience of this process is thrown into relief within the context of illness and in relation to children and young adults, but the evidence of Cunningham Burley's (1990) work indicates that it is a family process rather than an illness process. The invisibility of 'caring about', discussed in previous chapters, which is borne out of notions of the 'naturalness' that caring generally has for women, particularly in the family setting, is also largely absent from studies of the experience of chronic illness. The pursuit of ordinariness may well be borne out of a desire to reduce the impact of the knowledge that a family member has a disease, with all of the connotations of stigma or deviance that illness can bring. It is, however, also part of a much larger pressure to preserve the 'ontological security' of the individual and the family as a group. The emphasis upon being 'normal' is echoed again and again through studies of chronic illness:

and he doesn't like the fact that he is diabetic in that respect, he wants to be normal (Williams 2000 p261).

They've never had anything to really worry about other than normal childhood illnesses (Cunningham Burley 1990 p102).

We are a normal family [mother of a severely disabled 13 year old] (Chamberlayne and King 1997 p613).

I intend to carry on and live as normally as possible...I did not want people to treat me any differently than they had done before [man with MS] (Robinson 1988 p56).

'Being normal' might be said to be not so much what you are, but what you do and how you do it. People tend to link health and illness in a causal or interactive chain which has been described as a form of biography and which contributes to the shaping of self identity (Williams 1993, Radley 1993, Blaxter 1990). 'Normality' seems to be the framework (rather than the yardstick) which guides and moulds (rather than measures) this process. Within families, it is through ordinary everyday tasks and activities which allow day to day functioning that normality is acted out. These activities, which both represent and constitute 'caring for' and 'caring about', are not just, in Frank's terms, the 'repair work' (Annandale 1999), made to disrupted lives, but are the building blocks for the identities which form those lives.
Summary

The literature presented in this chapter has drawn together ideas about how both health and illness has been construed by people living with chronic illness, but also generally. The changing nature of illness, particularly the increased prevalence of chronic, as opposed to acute, illnesses, together with the medicalisation of health, via what has been described as surveillance medicine, has been shown to place the home and family in the central role of responsibility for care. The powerful message of the medicalisation of many aspects of everyday life, has, through surveillance medicine, placed a major responsibility for the maintenance of health and caring for illness in the hands of wives and mothers. The gendered nature of family practices, discussed in the previous two chapters, has been seen to be a key to understanding why, despite recognition of how crucial maintaining health and caring and support has been seen for people suffering from a chronic medical condition in the home, the process by which such work is conducted remains barely visible and under theorised. The notions of 'naturalness' which form the basis of the link which joins women to caring, especially in the family setting, are the foundations upon which assumptions, both lay and political, that the family setting is the proper place for this have been built. The family' as location has been addressed in terms of its unique and appropriate characteristics for the long term monitoring of medical treatment and lifestyle behaviours that chronic illness demands. Family members' experiences have been examined in terms of the interactions that influence both recognition of and reaction to symptoms, diagnosis and treatment. The burden carried by wives and mothers is usually acknowledged in studies which look beyond the experience of the person with the condition. What seems to remain elusive is an examination of the processes by which caring (both for and about) becomes fundamental to what family practices mean to the people engaged in them.

By reviewing a number of analytical devices which have brought the examination of the lived experience of chronic illness for both patient and family to a deeper understanding, attention has been drawn to the value of examining process over time. Bury's work on 'biographical disruption' (1982, 1991) and Gareth Williams work on 'narrative reconstruction' (1984, 1993) have been seen to provide valuable signposts for the direction that research into the illness (and health) experience should take. However, a focus upon illness as an event in time has meant that there has been a lack of attention to the extant processes of monitoring and noticing which anticipate and create the needs of the family over time. It is this assumption of a natural caring family culture which allows illness to be placed there with a confidence which does not attract questioning. However, it is not an examination of the adequacy of the caring
or support any one family might bring which is being questioned here, it is the *meaning* with which family caring is imbued which is of interest.

The main aim of this chapter has been to draw attention to those aspects of the sociology of health and illness literature which will inform and frame an examination of the sophisticated, intuitive and skilful qualities which underpin the organisation of care and provision of emotional support for family members generally, but especially within the context of chronic illness. Attention has been drawn to the significance of the family setting as crucial to the understanding of how people deal with illness experience. More importantly, the significance of understanding the meanings underpinning family practices for the understanding of behaviour around illness has been stressed. What has not been directly addressed in this chapter, but is implied within the term 'family practices', is the role of food and meals in the caring process for both health and illness. Chapter two has shown the special meaning associated with activities around food both individually and culturally. The use made of notions of nutrition as a vehicle for surveillance through expectations about lifestyles has been mentioned. The role of food as a strategic feature of caring around illness is rarely mentioned in the sociology of health and illness literature. When mentioned in association with those conditions for which attention to diet is recommended, the part it plays is seen as instrumental rather than constitutive (for example Kelleher 1988). Activities around food frequently form the basis of the 'being with' activities Graham mentions in the quote earlier, and embody the 'caring about' meanings which are family life. Thus, whilst food activities may not be mentioned specifically in studies about the experience of health and illness, they may well be at the heart of caring in families.
Part two
Methodology
Chapter 4. Methodology

Introduction

The study takes a qualitative approach to the examination of the processes by which families manage and accommodate chronic illness from the perspective of diet, food and meals. The literature has confirmed that the family setting has been construed as the 'natural' location for caring in relation to ordinary everyday activities such as tasks around food and eating and also in relation to the unexpected and potentially disruptive intrusion of illness. Caring, especially within the home, has been seen to remain strongly gendered, despite changes in the world of paid employment.

The initial research design for this study aimed to interview the person within the home who took primary responsibility for the running of the household and who ensured that all of the activities associated with domestic arrangements took place. I chose to define this person as 'the home manager', in order not to presume that the person would be either female or male, and also to draw attention to the organisational nature that this role could take. It was planned that interviews would centre around tasks related to diet, food and meals, such as food purchase and preparation, as well as organising meals and mealtimes. This might involve actually undertaking the tasks, but could also include enabling others to undertake tasks, as well as thinking about what needs to be done (Ekstrom's notion of 'the cupboard in her head' (1991)). Sharing tasks and role reversal will also be shown to be of significance for a few of the participants.

At the outset the main aims of the study centred around how family members perceived and understood family practices when having to deal with the intrusion of a diet related illness. By focusing upon diet and meals, the study has been grounded in everyday activities which are likely to take place in most families, but are likely to be affected by the experience of illness as well. The close association which continues to be made between 'caring' (whether in terms of illness or in terms of domestic labour) and women's lives as indicated by much of the literature, has made this a fruitful area of enquiry. Equally, 'family life' can be seen to be a dynamic process with activities often allocated and shared through negotiation, but also strongly influenced by gendered assumptions. Locating this enquiry within the family setting brings together three sociological areas conceptually: the family and its ideological basis; the symbolic meanings which underpin food, diet and eating; and the social meanings influenced by and influencing the experience of chronic illness. These three areas have been studied widely, and the latter two have been located within the family setting in many reported studies.
However, it seems clear from the literature that there has been an absence of attention paid to the conceptual role played by the family and family practices, particularly in studies of the experience of chronic illness.

**Conceptual goals**

When this study was first designed the conceptual goals pivoted around two main areas. Firstly, and in the light of the literature on the sociology of food and eating, to examine diet, food and meals as a means by which relationships within the family are both acted out and construed. Secondly, and in the light of the literature on the sociology of health and illness, to examine the effect of chronic illness upon those relationships as a disruption to established and ongoing understandings of family processes and identities. It was assumed that chronic illness had the potential to introduce unexpected and unwelcome changes to lifestyles and self images which might challenge existing self identities (Anderson and Bury 1988). Women, in particular, might be called upon, in the role of 'home manager', to develop new expertises about health and about illness (and, for the purposes of this study, in diet and food related tasks). The level to which women, whether suffering from the condition themselves or as spouse of the sufferer, would be willing or able to adapt to these changes may not always be considered by medical/health practitioners, or by other family members. The effects of having these changes thrust upon them may be complex and may change over time. These effects are likely to be manifested in what she does or does not do, as a consequence of the diagnosis of the condition, but also in how she construes the illness, her spouse, other family members and herself.

The nature and function of qualitative methods is discussed in more detail below in the rationale for using such an approach for this study. The essence of a qualitative approach rests in the reflective character of both collection and analysis of the data. It was, therefore, not surprising that the process of data collection and preliminary analysis revealed a relationship between these three areas of interest which shifted the emphasis of the conceptual goals to bring the role of 'the family' into centre stage. Whilst providing the backdrop evident in many studies on chronic illness, the family and family practices were also found to play a strategic part in the construction and reconstruction of individual and group identities. A focus upon family practices also drew attention to the processual nature of understandings about personal and group meanings. The notion of 'process' when applied to 'the family' can be understood to mean the process by which everyday activities embody the meaning of family as an ongoing practice as well as a social institution. Further, it can be seen as the process by which chronic
illness can be reduced to the everyday, for practical reasons: the diet has to be followed, and for affective reasons: to lead a normal life.

**Research design**

The study takes a qualitative approach employing in-depth interviews. The two medical conditions chosen to represent chronic illness in the study were coeliac disease and coronary heart disease. The study was conducted in two phases. The first phase involved brief interviews with medical and health professionals and the second main phase involved in-depth interviews with members of families in which one of the two conditions had been diagnosed. The phase two participants were recruited with the help of the phase one medical/health practitioners associated with aspects of the two conditions, and the regional secretary of a coeliac support group. The participants were interviewed on two occasions three to four weeks apart. The interviews were taped and fully transcribed for analysis. The rationale for the decisions made in the design of this research are set out below, followed by a description of how the research was conducted.

**Rationale for using qualitative research methods:** As the data collection method, the choice of interviews which were conducted in an open, relatively unstructured way was made for a number of linked reasons. The nature of the family setting as the main focus of scrutiny is one of multi-layered relationships which, whilst widely theorised per se, is largely absent from research into health and illness or into food, diet and eating. It is felt that the symbolic meaning of food in society and the socially mediated understanding of health and illness may be better understood when examined within the context of the family setting. Conversely the complex role played by 'the family', as a means by which identities, both individual and group, are constructed, may well be better understood through activities associated with health, illness and food. Gaining access to the meanings which underpin these social processes is most effectively achieved through a medium which allows a good level of self-expression in the participants.

A qualitative approach to research has as its focus not structure or demography, but social processes which create and sustain individual and shared meanings, resonant of Weber's notion of verstehen. As such these activities are dynamic, interactive and contextual. The family setting is an exemplar of the kind of social entity best suited to a qualitative perspective to data collection and analysis, evidenced by the wealth of studies which have employed the approach in terms of method and philosophy (Handel 1992). Gilgun has described qualitative
family research as 'processes used to make sense of data represented in words or pictures, not numbers,...[and] include ways of conceptualising, collecting, analysing and interpreting data' (1992 p24). The data in question are rarely in a form that is simple and systematic when collected, and requires an examination and analysis which will identify significant patterns and relationships between people, their beliefs, values and behaviours without losing the context within which they are found. As such, the qualitative principle recognises the value of the notion of diversity which, whilst benefiting from making significant comparisons, also has value in identifying the unique. The concept of 'thick description' which is often associated with qualitative data is often made up of considerable and sometimes minute detail but is better described as a 'process of elucidating a matrix of meanings' (Gilgun 1992 p31).

However, it is probably the case that there is no complete agreement about what constitutes qualitative research in terms of a unified set of techniques and philosophies. It is often defined in relation to a quantitative approach to research which relies upon randomly controlled sampling, pre-determined questions, often multiple choice, to which numerical values are attached, asked of large and representative groups within specified populations, and analysis through statistical significance, or at least most of these criteria. In contrast, qualitative research is usually conducted on a small-scale basis, frequently using observation of specific behaviour and/or detailed interviewing of small numbers of people. Jennifer Mason suggests that 'qualitative research is perhaps most commonly associated with....what is known as the interpretative sociological tradition...' (1996 p3). The analysis of data collected within this tradition would have as its aim the construction of an explanation of the meanings which underpin what is said and how it is expressed. This approach assumes that, whilst there may be a fundamental reality which forms individuals' lives, it is mediated through understandings and belief systems which are constructed and developed within and contingent upon the social milieu. This research design has, therefore, been constructed in a manner which would allow both data generation and subsequent analysis to fulfil that aim. The detailed and complex material necessary for such an analysis requires the creation of a good rapport between researcher and participant, and, often, considerable time for the interview to generate these kinds of data.

Recruitment of such participants within this approach, although systematic, is not randomly controlled and often relies upon personal contacts. It is often the case, as with this study, that the area of enquiry is not made up of people easily identified within or accessible from the general population. Thus access is necessarily gained through specific pathways, in this case, initially through medical and health professionals. Equally, the numbers of potential participants may be limited for a range of reasons, not the least, self-selection. The use of the
term 'snowball' as a technique for recruiting participants implies a non-statistical randomness which can be misleading. In fact, when relying upon specific sources and in the knowledge that numbers of potential participants are limited, it is likely that those people invited to take part in such a study would be chosen purposively.

This study used in-depth interviews conducted using a framework which anticipated the essential aims of the enquiry, but did not presuppose the likely range or detail of the responses (Mason 1996). Participants were interviewed twice with a three to four week time period in between. The advantage of interviewing a participant more than once has been outlined by Milburn (1995) by drawing attention to how the narrative may develop and amend what the participants have to say in subsequent visits. The use of this kind of interview allows the opportunity for knowledge, beliefs and values to emerge as a product of the researcher/participant exchange. On a practical level this offers the chance for clarification and amendment by both parties, particularly the participant. It also provides an interactive and discursive basis for the emergence of views which, for the participants, may not have been conceptualised by them in the same way before. It elicits the participants' interpretation of the events and processes under enquiry. This approach, for the purposes of this study, was intended to offer the participant the centre stage for her/his views and ideas. Although the interview process has been described as being interactive and discursive, I have been, necessarily, mindful of the aims of the study, to elicit and understand the ways that the participants understood their lives, that is, 'conversations with a purpose' (Burgess 1988 p102).

Rationale for including the two medical conditions: The aim of this study has been to examine the process of and meaning behind family management of an apparently practical aspect (diet) of chronic illness, particularly in relation to the gendered nature of caring. It was felt important not to focus upon just one medical condition which might generate data strongly contingent upon the characteristics of the condition itself. Nevertheless it was important not to introduce too many potential variabilities, so two conditions were chosen which, diagnostically, were very different:

Coeliac Disease: according to the Manual of Dietetic Practice: 'is a condition in which the lining of the small intestine is damaged by gluten, a protein found in wheat and rye.....[which] impairs the absorption of nutrients.....causing wasting and ultimately severe illness resembling malnutrition' (Thomas 1994 p378)

Coronary Heart Disease: according to the Manual of Dietetic Practice: is a term which 'represents a group of clinical disorders including angina pectoris, acute myocardial infarction
and sudden ischaemic death. The pathological basis of CHD is atherosclerosis, a proliferative process which ultimately results in the narrowing of the blood vessels, subsequent impairment of blood flow and thrombosis. It is the concurrence of atherosclerosis and thrombosis which results in infarction (Thomas 1994 p475).

Thus the coeliac group had experienced a little known condition, with a purely dietary treatment, whilst the coronary heart disease group had experienced a well known and widespread condition of which dietary advice was just a part of the treatment, which could also include surgery and/or medication.

A background for the two conditions, by symptoms, diagnosis and treatment: The information which follows has been derived from interviews with specialists in gastroenterology and cardiology, as well as from the references cited.

The similarities between coeliac disease (CD) and coronary heart disease (CHD) are that both result in the recommendation that a dietary regime be followed as part, or all, of the treatment. It is usually suggested that this advice forms the basis of dietary behaviour for life. Equally, these two conditions, once stabilised, are ones which can be considered to be 'chronic' as opposed to 'acute'. This means that the potential dangers from the diagnosis are present for the life time of the patient, but, with successful management, the likelihood of succumbing to the original symptoms, or a range of potential consequences, are reduced considerably. These are two chronic illnesses which patients are encouraged to believe will, if 'properly' managed, allow them to lead a 'normal' life (for example see British Digestive Foundation, no date).

There are a number of characteristics associated with each of these two conditions which, on first examination, seem quite distinct, some of which are, indeed, so. There are, however, a number of strategic characteristics which, on further examination, are far less clearly distinguished, either in fact, or in terms of how they are construed by those who work to diagnose and treat them. A major difference between the two conditions is related to the diet itself. Coeliac disease requires the exclusion of gluten from the diet completely. Gluten is found in food which forms a major part of the contemporary Western diet, including bread, pasta, biscuits and all foods which routinely include wheat and rye. Included are a number of unexpected products, such as those which use modified starch as a bulking agent. This not only means that the recommended diet is very different from that of the general population, but, as a consequence, creates a number of major dilemmas for the creation and production of meals, despite the availability of specially made gluten-free foods, some of which are available on prescription.
In contrast, the dietary requirements associated with coronary heart disease are, in many ways, similar to those recommended to the general population as 'a healthy diet'. Diets related to CHD are centred around the lowering of cholesterol specifically, and controlling weight generally, with high cholesterol levels and obesity being seen as two major 'risk' factors. Thus lowering fat intake, and increasing dietary fibre intake are specifically aimed at lowering cholesterol, but are also two of the recommendations for a 'healthy diet' generally, as found in the government's Health of the Nation document (1992). The other recommendations include reducing the intake of red meat, sugar and salt, and increasing that of fruit and vegetables, which will also tend to be included in a weight loss diet.

It is likely, therefore, that diets not dissimilar to those recommended for CHD will be both familiar to the newly diagnosed, but also not too different from what other people might be eating. The coeliac diet, in contrast, is unlikely to be familiar to the new coeliac patient, and involves tastes and sources (prescribed food from the chemist) that are very new and different from those experienced by friends and family. These have the potential for both difficulties and advantages for both diets. The unique nature of CD means a lot of new food to become accustomed to; food products which are much more expensive and not as easily available (often only from chemists); food that can mean a great deal of extra work in meal preparation. In contrast, the CHD diet, being close to a 'normal' health diet, has the potential to slot easily into the family meal, with little or no extra work in food purchasing or preparation, and not marking one person out as different. Thus the CHD diet could be eaten by all of the family, whilst this would not be the case for the CD diet. Nevertheless, the very uniqueness of the coeliac diet, as well as, in some cases, the immediacy of the negative consequences of not following it (vomiting and diarrhoea) could have the effect of a constant reminder of the existence of the problem and the need to follow the diet. The absence of difference in the CHD diet could provide conditions within which the temptation to ignore the diet was more likely.

The incidence of coeliac disease is low (Cooke and Holmes 1984) and considerably lower than coronary heart disease. This means that the likelihood of a person newly diagnosed with CD being aware of the existence of the condition is much smaller than that of the person diagnosed with CHD. There is some indication of a genetic predisposition for CD, resulting in an increased incidence within families. Nevertheless, the overall number in the population is small, and it is likely that a GP list will have no more that one or two patients with CD at any one time. The diagnosis of coeliac disease, once identified, is more clear cut in comparison with CHD. However, because of the low incidence of the condition, it is possible that it may take some time for a GP to link the symptoms to the condition. In fact, the patient
may be referred to the gastroenterologist with a general group of symptoms for which the GP has no clear diagnosis. Sometimes diagnosis has been made opportunistically, as a consequence of less severe symptoms than the classic ones defined above, for example with problems of anaemia, rather than malabsorption. However, once the specialist has an idea of what the condition might be, there is a straightforward test - a biopsy - which will confirm the diagnosis. Treatment, again, in principle, is quite straightforward, in that it is restricted to the exclusion of gluten from the diet, even if the practice is less simple. In the early stages and if the symptoms have been severe, it may be necessary for the patient to be given specific dietary supplements, but there is no other drug or surgical treatment required.

In comparison, the range of clinical disorders which fall within the term CHD and their potential treatments would seem to be far more varied. The dietary advice intended as a method of preventing the symptoms and the consequences of CHD is offered to those people who have experienced some kind of medical event, such as a heart attack, or chest pains leading to the diagnosis of angina, or who have undergone heart surgery, such as heart bypass or angioplasty. It is also offered to people who have demonstrated that they may be 'at risk' of CHD, but have not yet experienced a physiological event. These risk factors include raised cholesterol, high blood pressure, obesity, smoking, high alcohol consumption, heredity, genetic factors and stress. These may be identified through a range of triggers, such as routine checks offered by GPs or employers, or during routine hospital checks in unrelated areas. The 'at risk' group may be offered advice, usually by the GP, or a member of the practice staff, of which diet may be just one recommendation for preventive measures. Others are regular exercise, giving up smoking, and different kinds of stress reducing activities. The former groups will either have had to spend time in hospital as a consequence of a heart attack (such as surgery), or will have been required to attend hospital for examinations and tests to determine the identification of the symptoms presented. In addition to the same advice (dietary and other lifestyle change), the patient may be given a drug treatment which may have to be followed for life.

These differences in diagnosis and treatment suggest that CD is far more clear cut, straightforward and immediate compared to that of CHD. In fact, mainly as a consequence of the developments in the technology of diagnosis, it would seem that these differences are far less clear cut than seems at first sight. Until fairly recently, CD had been seen as a condition of children, emerging once the baby moved to solid food and identified through indications of failure to thrive. Even those who were not diagnosed until later life tended to be seen as people who were undernourished and frail, changing quite markedly once the diagnosis had been made (Cook and Holmes 1984). The exclusion of gluten from the diet had an
immediately beneficial effect upon the person, and any deviation from that restriction results in a fairly immediate resumption of the adverse symptoms originally displayed. More recently, certainly during the last decade, there has been a marked increase in the diagnosis of adults with the condition, coupled with a decrease in diagnosis in childhood. It has been suggested that an increase in breast feeding for a more prolonged period of time, as well as a reduction of the use of wheat in weaning foods, may explain the decrease in childhood diagnosis (Cooke and Holmes 1984). The increase in adult diagnosis is informally speculated, by the specialists interviewed, as possibly the consequence of: an increase in general health checks at which some indicators may be picked up; a greater expectation of good health resulting in consultation with GPs over less serious symptoms (such as fatigue and breathlessness due to anaemia); as well as, in the case of women, a reduced expectation that women will be slim, frail and look anaemic! These, together with the development of the biopsy test in the 1950's (Mee et al 1985), and a more recently developed blood test, mean that it is not unusual today for the person newly diagnosed with CD to have no severe symptoms to be alleviated via dietary changes. A situation not dissimilar to that of the CHD patient identified as displaying a number of risk factors but no immediate adverse symptoms.

The patient diagnosed with CD, whether with severe symptoms or no symptoms, is said to be at risk, in the long term, of lymphoma in the small intestine and also osteoporosis (Cooke and Holmes 1984, Walters et al 1995). Evidence of this is not clear and has only been recently available. The level of risk is also not clear, and so the consequence for not following the dietary advice in this respect is related only to the lowering of risk rather than guaranteed prevention. Thus the symptom-free coeliac seems to be in a similar position to the 'at risk' CHD patient, where following dietary advice is more to do with health investment for the future rather than symptom prevention in the present.

Sample criteria and selection

Phase one: Participants, methods and access: This phase was intended as brief interviews with a small number of medical and health professionals who would have had experience of the diagnosis and treatment of the two medical conditions. For the patient, it is likely that the practitioner will be the first direct and formal source of information about the condition, particularly for those with coeliac disease. These interviews were primarily intended as a means by which phase two participants could be recruited. It was, however, also hoped that they would provide valuable information for the researcher about the procedures by which practitioners diagnosed conditions and offered treatment, as well as an insight into their
attitudes towards the ways treatment might be followed. This was not, therefore, intended as a comprehensive observation of practitioners' attitudes towards their patients, nor was it intended to be a representative sample of medical and health professionals. Nevertheless, an attempt was made to speak to practitioners from the different levels of medical encounter, that is, those involved with the actual diagnosis, ie: general practitioners, specialists, and also those health specialists likely to be involved in offering dietary advice, ie: dietitians, nurses (practice and cardiac) and health visitors (Table 4.1).

<table>
<thead>
<tr>
<th>Dietitian</th>
<th>GP Nurse</th>
<th>Cardiac Nurse</th>
<th>Health Visitor</th>
<th>General Practitioner</th>
<th>Hospital Consultant</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>19</td>
</tr>
</tbody>
</table>

*Table 4.1 Medical and health professionals interviewed*

The practitioners were approached through letters followed by telephone calls, or via contact through colleagues. Some of the practitioners who took part also recommended colleagues to take part. The most successful means of attracting the interest of these practitioners was direct contact. General practitioners were the most difficult to recruit. Letters were sent to 75 GP practices in the Reading area to which only six responded, and these were in order to refuse to take part. Of the two GPs who agreed to take part, one was recommended by a colleague and the second was planning to set up a study on CHD in conjunction with a government funded promotion, and so had a special interest.

The geographical locations of the practitioners was originally West Berkshire and Hammersmith Hospital. These two locations provided a contrast in terms of demographic background, by including inner city hospital and urban town hospital settings, as well as GPs and other health practitioners based in a range of urban settings, which include working class, middle class and different ethnic groups.

In total nineteen practitioners were interviewed. The interviews were intended to take no longer than half an hour and included questions about (a) diagnosis and advice procedures and (b) perceptions of the patients experience of the dietary advice. The interview guide shown in Appendix 1 was a requirement of the ethical approval procedure. It also provided a useful vehicle for framing the questions to be asked. At the end of each interview the practitioner
was asked for help with recruitment of participants for the main phase of the study and all but two expressed willingness to do so.

Phase two: Participants, methods and access

Gender: The gendered nature of caring is a fundamental theme identified in the literature as significant to the understanding of family practices, and so a basic requirement for the design and analysis of this study. It was surmised that there might be differences in both attitudes and actions concerning diet related illnesses dependent upon the sex of the person with the condition. Although no other socio-economic factors were seen to be essential characteristics to be represented within the sample, an attempt at a gender balance was considered crucial. Difficulties encountered in achieving this aim will be discussed in the phase two access section.

Marital status and children: The varied forms of communal living which have members who construe themselves as 'family' have been discussed in the literature review. It reveals that there is evidence to suggest that the conventional notion of a married couple with children as the 'normal' family is no longer the dominant form (Bernardes 1987, 1999). Nevertheless, it was felt important, in such a small study, to limit the range of 'family' types, in order to allow some level of similarity of the 'family experience' to be compared. It was not felt essential for participants to have children living within the home, not least because the CHD group were likely to be in an older age range (see Table 4.6 on page 20), and so any children were more likely to have left home. Nevertheless, it was also felt that, although children have been seen an essential component of 'family' (Ribbens 1994), it is also the case that childless couples construe themselves as 'family' (Henson et al 1998). Childless couples were not, therefore, excluded from the study. Just five sets of participants did not, in fact, have children (see Table 4.7 on page 20), but, as the data analysis chapters will reveal, were not all free of regular and active interaction with children of the extended family. It was felt important to attract participants who had experienced a form of communal living which involved a long term commitment which tends to be seen as a central characteristic of 'the family'. The use of the term 'family' in the recruitment process was intended to ensure this. In fact, five participants were not in current marriage relationships at the time of recruitment and a further participant separated from his wife in between the two interviews. However, all of these had had children and all but one had been living with partners at the time of the diagnosis of their illnesses. Thus they were able to describe the experience of accommodating the consequences of the illness within the family setting.
Medical and health professionals: The study was conducted in two phases. Phase one involved a series of brief interviews with medical and health professionals (Table 4.1) in order to enlist help with the recruitment of people with the medical conditions. These practitioners were located using a range of strategies, from recommendations by colleagues to contact via a standard letter sent to GP surgeries.

Identifying and attracting research participants from particular illness groups is rarely simple or predictable and, for the sociologist, often relies upon the individual interest or benevolence of a contact person. For a study of this nature, the support of medical and health professionals who have direct access to people who have been diagnosed would ensure an accurate diagnosis and also a direct route for recruitment. Equally, the weight of the practitioners' support might encourage people to volunteer. An alternative route for recruitment was to approach specific support groups, a strategy used in an earlier study (Henson et al 1996). This strategy was rejected originally as having the possibility of attracting people from a particular and unique group, but was used eventually when recruitment of the coeliac group proved inadequate. It was felt that meeting the potential 'gatekeepers' and engaging in a dialogue about the topic area would provide an incentive for co-operating in the recruitment. These interviews also provided the researcher with a better understanding of how people are diagnosed and provided with dietary and other information.

The characteristics of the phase two participants. The person originally to be recruited to take part in this study was the 'home manager' in 40 households where there was a married or co-habiting couple. Half of these households were to have one spouse diagnosed with coeliac disease, and half were to have one spouse diagnosed with coronary heart disease. Within each medical condition equal numbers of men and women would have the condition. (Table 4.2)

<table>
<thead>
<tr>
<th>Sex of person with condition</th>
<th>Coeliac Disease</th>
<th>Coronary Heart Disease</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>20</td>
<td>40</td>
</tr>
</tbody>
</table>

Table 4.2 Original numbers of families to be recruited by sex and condition
Thus the forty participants' households would be made up of ten females with coeliac disease, ten males with coeliac disease, ten females with coronary heart disease, ten males with coronary heart disease. In fact, the success with which participants were successfully recruited for each group was variable. The problems encountered will be presented in the access section below, but Table 4.3 sets out the final numbers recruited.

<table>
<thead>
<tr>
<th>Sex of participant</th>
<th>CD group</th>
<th>CHD group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
<td>13</td>
<td>23</td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
<td><strong>19</strong></td>
<td><strong>41</strong></td>
</tr>
</tbody>
</table>

*Table 4.3 Numbers of families participating by sex and condition*

If all of the households had operated a traditional gendered domestic division of labour, in half of the households the person being interviewed would have been both home manager and the person with the medical condition, and in the other half of the households the person being interviewed would have been just the home manager. In fact, as the data analysis chapters will discuss, the ways in which the tasks and activities were allocated was complex and variable. A number of couples took responsibility for different aspects of the meals production process, but this could often be seen to be variable at different points in the 'marriage' relationship, and also at different times of the week or for specific events. Even those who practised a traditionally gendered view of how those tasks and activities should be divided revealed exceptions to these 'rules', which tended to be explained in pragmatic terms. What became clear was that it was the ways in which these arrangements were construed and how this informed the family relationship that was of significance, rather than trying to identify significant differences *per se*.

These participants formed the main part of the study and most were recruited through the phase one practitioners. The original research design focused upon the role of the 'home manager', that is the person mainly responsible for the organisation of food and meals in the family. As indicated by the literature (DeVault 1991, Charles and Kerr 1988), the 'private' domain of the home and family still tends to be seen as the responsibility of wives and
mothers, and family tasks, especially those related to food and meals, as most appropriately conducted by women. It was felt that, in the light of this, the impact of any alterations to family food and meal routines would be felt most by the female 'home manager'. It was assumed, therefore that this was the most appropriate person to be interviewed, regardless of who in the family had the medical condition. Thus the recruitment was oriented towards the 'home manager'.

Recruitment of participants was, however, made through the person with the medical condition, who was not always going to be the home manager. During the course of the interviews it became clear that many of the people who volunteered to take part felt they had a contribution to make to the study, whether they contributed to the food and meal organisation or not. (This may have been an artefact of nature of the recruitment, that is, the fact that the recruitment was taking place through a medical practitioner and the person with the condition, rather than the person responsible for food). This was the case in many of the homes visited, even those where the domestic tasks were allocated on traditional gender lines. That is to say, even those family members who had no involvement in food and meal tasks and activities in the home had opinions and views about those roles and responsibilities. In addition, the participants construed domestic arrangements in complex and variable ways.

In the early stages of the interviews attempts were made to interview just the home manager, and alone. This was not always possible, for the reasons given above, and also, in some cases, because in some households it was not possible to ask one person not to be present, because there was nowhere in the house for them to go. As the interviews progressed, it became clear that, in a number of cases, the interview interaction was, in fact, enhanced by the presence of the spouse/partner of the home manager. The final decision over who should be interviewed became pragmatic. Some volunteers were quite clear that they expected to be interviewed alone, whilst others were equally clear that they should be interviewed as a couple.
Table 4.4 shows the number of sets of interviews conducted with just one or with both members of the couples, by the condition and the sex of the person with the condition. (However, within the couple interview groups, on a few occasions both members of the couple only attended one of the interviews).

<table>
<thead>
<tr>
<th>Gender of person with condition</th>
<th>Coeliac Disease</th>
<th>Coronary Heart disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single interview</td>
<td>Couple interview</td>
</tr>
<tr>
<td>Male</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Female</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>41</td>
<td></td>
</tr>
</tbody>
</table>

*Table 4.4  Single - v - couple interview participation by sex and condition*
A total of sixty two people took part in the interviews. Table 4.5 below shows the breakdown of people who took part in the interviews by condition, sex and spouse.

### Coeliac Disease

<table>
<thead>
<tr>
<th></th>
<th>Total participants</th>
<th>Total interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male with condition</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Female spouse</td>
<td>11</td>
<td>10</td>
</tr>
<tr>
<td>Female with condition</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Male spouse</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>18</td>
<td>30</td>
</tr>
</tbody>
</table>

### Coronary Heart Disease

<table>
<thead>
<tr>
<th></th>
<th>Total participants</th>
<th>Total interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male with condition</td>
<td>11</td>
<td>24</td>
</tr>
<tr>
<td>Female spouse</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Female with condition</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Male spouse</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17</td>
<td>32</td>
</tr>
</tbody>
</table>

*Table 4.5 People interviewed by condition, sex and spouse*

*Phase two access:* As mentioned earlier, access was achieved mainly through medical and health practitioners. The method of recruitment varied according to the preferences of the practitioner. One hospital consultant offered the opportunity to attend his out patient clinic to approach people whilst waiting to see him. Several offered to send letters to potential participants, which they identified, on my behalf. Others said that they would be willing to approach potential participants personally (in their clinics). The level of cooperation received from these 'gatekeepers' varied considerably. Some were very helpful and remained so for the duration of the recruitment period. Others assured me of help, but did not quite ever get around to doing what they had agreed to do. Others had changed circumstances which meant that they became less helpful at particular points.
When just over half of the participants had been recruited, but the planned numbers in the coeliac group (both male and female) had not been achieved, strategic decisions had to be made to undertake two alternative recruitment paths. Information became available about a database held by the East Berkshire Health Authority, of information on CD patients in the region. Permission was obtained to recruit through this source. At the same time, the organiser of a regional coeliac support group was approached for help via their newsletter. As was seen in Table 4.3 on page 12, these strategies allowed the coeliac group target to be reached. However, I failed to achieve the target numbers for the female CHD group. This is, in fact, a difficult group to identify as most coronary care clinics are attended by men. Small scale studies on this subject have suggested that it is more difficult to diagnose coronary heart disease in women (Blues 1997). Certainly, the practitioners who helped me with this study were more likely to expect men to attend their clinics and found it more difficult to identify women to take part in this study.

Consent and confidentiality

The recruitment of participants via medical and health professionals had the consequence that ethical approval was required from the overall authority for the particular institution concerned. It was anticipated that the number of participants needed for this study would be found within the West Berkshire Health Authority and within the two appropriate departments in Hammersmith hospital (cardiology and gastroenterology). Ethical approval was obtained from both of these organisations in the very early stages of the study (in 1996). The later strategy, to use the East Berkshire database of CD patients, required additional approval which was a little time consuming, but did not delay the interviewing a great deal.

A fundamental part of achieving ethical approval was fulfilling the requirement of ensuring that all participants were offered the opportunity to make an informed consent to taking part in the study. To this end a series of documents were designed. The first was a letter to the potential participant by the practitioner inviting the person to take part and offering an outline of the study (Appendix 4f). Further information was made available at the first point of contact with the researcher, which was on the telephone. Once the person had given verbal agreement to take part, a consent form was sent by post (with a letter confirming the time and date of the interview) which was collected, signed by the participant, at the first interview (Appendix 4e).
Over and above the ethical requirements mentioned above, it is within the spirit of a qualitative approach to research to be aware of the sensitivity of an enquiry which frequently takes place in the home of the participant, and is conducted on a face to face basis between participant(s) and researcher. It is also the case that the kind of enquiry conducted in this way has the potential to go beyond the predictable boundaries of the topic in question, but also that even predictable issues can be of a personal and sensitive nature. Awareness of the possibility for unanticipated self exposure which might be regretted is central to the presumption of confidentiality, and was a significant part of the reflexive process which guided all stages of this research. During the course of the interviews I strove to ensure that I was sensitive to the status and position of the participant, making sure that I did not intrude into unacceptable areas. None of the participants expressed any overt concern about confidentiality over identity, and a number expressed the desire to help others in similar situations, as reasons for taking part. Nevertheless, the identity of all participants has been protected by the use of pseudonyms throughout the thesis. Any publication of data will pay attention to the requirement of confidentiality by ensuring that participants cannot be identified by name or description.

The interviews

The phase two interviews took place on two occasions separated by three or four weeks, and lasted on average one hour. The data collected related to all relevant aspects of the experience of health and illness and of organising and managing food and meals in the family. Appendices 4a to 4d show the interview guides designed to fulfil the ethical approval process (Appendices 4a and 4b) and the guide eventually developed for the actual interviews (Appendices 4c and 4d). The ethical approval guides were designed with the requirements of the first ethical board (West Berkshire Health Authority), who required the use of the term 'housewife' to be used. The members assumed that the person responsible for food and meals would be female and would describe themselves as 'housewife'. The board found the term 'home manager' problematic. As this was intended as a guide which would not be shown to the participants, it was not felt to be a major compromise to conform to this specification. Subsequent ethical boards did not require such detailed submissions. The guide itself will be discussed in the next section.

The phase two methods: The interviews were aimed at revealing the processes by which family practices were organised, specifically in relation to activities around food and meals, with particular reference to the experience of a chronic illness which was diet related. The
interview guides (Appendices 4a to 4d) were designed in anticipation of the range of issues likely to be seen to be of relevance by the participants. The topics itemised in the guide specifically for ethical approval (Appendices 4a to 4b) were devised some time before even preliminary interviews had been conducted and covered the full range of potential issues thought likely to emerge. It was also assumed, in the spirit of inductive reasoning, that the direction and flow of the interview process would vary within and across interviews, according to the nature of the emerging data and the way it was emerging. In other words, if one line of enquiry proved particularly effective, it might be pursued at the risk of missing other opportunities, and that if specific areas were not productive, they might be relegated to a lower priority.

These interview guides incorporated the following areas of enquiry: the interviewees were to be asked to talk about the background to the condition and to the diet; specifically how they acquired the information they needed and the sources; what, if any, support systems (formal or informal) were available and how useful they were; and any other factors that had been significant for them, in the early days of diagnosis. This would also include the practicalities of making the change to the new diet, specifically to food choice and shopping, food preparation and cooking, as well as the actual meal arrangements. Of particular interest would be the way in which the diet and dietary arrangements fitted into the family practices and expectations. The gender implications of these practices were key to the enquiry, requiring the examination of how responsibility and control was distributed, and seen to be distributed; how food and meals activities were negotiated and undertaken; as well as how individual family members' views and attitudes were perceived and acknowledged. It was assumed that this process would be one which was likely to have changed and developed over time, reflecting the functioning of the family as a dynamic process. Changes would be of interest, whether related to or independent of the onset of the condition. Interviewees were to be invited to talk about what was helpful, what was problematic, compromises, barriers, plans and expectations.

The second interviews, as already mentioned, were expected to be useful to ensure clarity, to allow for follow up enquiries, and to allow interviewees to develop and enlarge upon what they had already said. In this particular study, such an opportunity was felt to be of value because the topic area was wide ranging and likely to touch on a number of issues. The participants would be able to consider and talk about issues that might come up for them in between the two interviews. The researcher intended to bring to the second interview ideas and enquiries drawn from scrutiny of the transcripts of the first interviews, but also, the
Interviewee would be encouraged to think about the issues that came up in the first interview and bring comments to the second interview.

The actual process of interviewing the people who were eventually recruited varied in a number of ways. The nature of the condition and the severity of the experience had a considerable impact on a number of the sufferers and their families. This resulted in a number of participants describing this in detail, and so taking up a large proportion of time in the first interview. Also, the level to which the participants found it easy to contribute to the discussion influenced the level to which I, as interviewer, took part actively influencing the direction of the conversation. Some interviewees seemed to assume that the encounter should follow a specific question and answer format and had to be encouraged to express themselves freely. Some participants seemed naturally reticent and others were unsure about the relevance of 'ordinary everyday' activities to the topic area. Nevertheless, a useful device was developed after just a few interviews which enabled most participants to discuss their family practices in a comfortably concrete way. The first interviews began with questions about the nature of the illness and how it was first manifested and then diagnosed. Perhaps because the recruitment process took place within a medical context, and most through medical and health professionals, most participants seemed to assume a need to spend at least some time placing this experience within their life experience. All questions and prompts that followed in the first interview were couched in terms of life experiences, major or minor, in relation to the onset and path of the condition. The second interview began by recapping on what had been said during the previous interview, and inviting comments that the participant might like to make (these were rare). The interviewees were then asked to look back to childhood and family arrangements around food and meals over the lifecourse. This varied, often according to the person's memory, but had the value of taking people's thoughts away from the illness itself and moving it away from centre stage. It also created a longer term perspective upon current experience by locating it in a lifecourse context.

**Characteristics of participants**

This was a small scale study aimed at examining the meanings (particularly in relation to gender) that underpin the way people organise and understand their family lives within the context of chronic illness. The rationale for choosing two medical conditions and for balancing gender has been explained earlier. Within such a small sample demographic differences cannot be said to play a significant part in explaining the results. Nevertheless, the following information provides a background for locating the data analysis. Appendix 2, which participants were invited to complete at the beginning of the first interview, provided most of this information. Table 4.6 on the next page shows the age range of the participants:
<table>
<thead>
<tr>
<th></th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coeliac Disease</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>12</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>9</td>
<td>19</td>
<td>32</td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>6</td>
<td>11</td>
<td>21</td>
<td>23</td>
<td>62</td>
</tr>
</tbody>
</table>

Table 4.6 Age range of participants by condition

It will be noted that, not surprisingly, the age range for the coeliac disease group was broader than that of the coronary heart disease, in that the latter group tend to be an older age group in the population generally. However the overall majority of participants fell within groups above 45 years.

Table 4.7 below indicates the distribution of participant families with and without children. Those with children still in the family home are indicated in brackets.

<table>
<thead>
<tr>
<th></th>
<th>Coeliac Disease</th>
<th>Coronary Heart Disease</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No children</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Children (still at home)</td>
<td>20 (7)</td>
<td>16 (2)</td>
<td>36 (9)</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>19</td>
<td>41</td>
</tr>
</tbody>
</table>

Table 4.7 Families with and without children

It will be noted that only five participant families were without children, and also only nine families still had children in the family home, although there was a higher proportion of these
in the CD group. Thus, the majority of participants, when speaking of the present, were
discussing the management of a new diet in circumstances in which only adults had to be
considered. The presence of young children was likely to be an added factor about which, in
this study, there are limited data. Nevertheless, because the topic areas that the participants
were asked to talk about ranged from childhood to the present day, issues related to children
arose regularly if not frequently. It should be noted that the 'no children' group includes
two couples who have children from one spouse's previous marriage but who have not lived
with the couple. The 'children' group includes two couples who have children from one
spouse's previous marriage who have lived with the couple.

Another factor which may have had an impact upon how people construe the intrusion of a
medical condition was whether one or both partners were in paid employment. In fact this
issue, as with many of the aspects of dealing with illness, or construing the family generally,
was not simple or clear. The analysis chapters revealed that employment, for most of the
women participants (whether the person with the condition or not) was contingent upon the
presence of children, but also on the ways in which traditional gender roles in the family were
construed. Thus whilst accommodating a new diet might be seen as perhaps easier for those
not subject to the different kinds of demands made by paid employment, this was likely to be
only one of a number of factors to be considered. Table 4.8 (on this and the next page)
shows the break down between employment and retirement/unemployment by condition, the
person with the condition and sex.

<table>
<thead>
<tr>
<th></th>
<th>Coeliac Disease</th>
<th>Coronary Heart Disease</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male with condition</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Female with condition</td>
<td>9</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>\textit{Sub-total}</td>
<td>16</td>
<td>4</td>
<td>20</td>
</tr>
<tr>
<td>Male Spouse</td>
<td>8</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Female Spouse</td>
<td>8</td>
<td>5</td>
<td>13</td>
</tr>
<tr>
<td>\textit{Sub-total}</td>
<td>16</td>
<td>7</td>
<td>28</td>
</tr>
</tbody>
</table>
Retired/ Employed

<table>
<thead>
<tr>
<th></th>
<th>Coeliac Disease</th>
<th>Coronary Heart Disease</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male with condition</td>
<td>3</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>Female with condition</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>6</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>Male Spouse</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Female Spouse</td>
<td>2</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td><strong>Sub-total</strong></td>
<td>3</td>
<td>12</td>
<td>15</td>
</tr>
</tbody>
</table>

Table 4.8 Employment v retired/unemployed by condition, person with condition, spouse and sex

It is not surprising that more people with coeliac disease were employed (32) than not-employed (9) compared to the coronary heart disease group with 11 employed and 27 unemployed. The former group had a greater age range, but also were involved with a condition which might be seen as resulting in an easier route back to employment. Notwithstanding this, the complexity with which the families organised their lives and negotiated their food and meals within the context of illness drew upon a range of beliefs and attitudes of which the presence or absence of employment was just one.

A linked factor was the occupations of the participants. As an indicator of class this can, in large scale studies, offer an important contribution to explanations of behaviour and choices. In a study such as this, occupation as a clear cut explanation has less power. It is also important to note that the place of occupation as a contributor to understanding the social experience of women is particularly problematic for reasons already touched upon. Most of the women who took part in this study had given up paid work at some point of their marriage relationship, usually at the arrival of children. Most of them returned to work (but often part time) and also in jobs which tended to match the school terms and the holidays of their children. However, it was useful to know the range of occupations experienced by these participants in order to be able to make comparisons between the results of this study and those of others. Appendix 3 lists the occupations of all participants in this study, with the
occupation of those retired indicated in brackets. These participants seem to reflect the full range of class differences found in most formal classifications. Most notable, in fact, was not a specific occupation but the high level of part-time work among the female participant groups.

A factor which will be seen, in the analysis chapters, as of some significance was the presence of medical conditions other than the ones upon which this study has been focused. As has been highlighted in the literature review chapters, the notion that a medical condition 'disrupts' a life previously untouched by illness can imply a simplicity of trajectory which is not always the case. In this study some of the people with the condition were found to have to contend with more than one condition, and some spouses also had their own conditions with which to deal. Table 4.9 sets out the range of multiple conditions experienced by the people who took part in the study.

### Coeliac Disease

<table>
<thead>
<tr>
<th>Sex</th>
<th>Single conditions</th>
<th>Multiple conditions (1)</th>
<th>Multiple condition (2)</th>
<th>Multiple condition (3)</th>
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<td>Female</td>
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<td>7</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>10</td>
<td>1</td>
<td>3</td>
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### Coronary Heart Disease

<table>
<thead>
<tr>
<th>Sex</th>
<th>Single conditions</th>
<th>Multiple conditions (1)</th>
<th>Multiple condition (2)</th>
<th>Multiple condition (3)</th>
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<tr>
<td>Female</td>
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<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>1</td>
<td>6</td>
<td>1</td>
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<tr>
<td>Total</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

(1) One person with more than one condition

(2) Both partner with condition

(3) One person with multiple conditions and spouse with one condition

*Table 4.9 Multiple medical conditions*
**Data analysis**

The process of analysing qualitative data, whilst systematic is not always precise. The research design began with an area of enquiry and a series of ideas, fuelled by the literature review and previous research findings, which were intended to guide the process of gathering the views and experiences of the participants. The interviews were conducted with this in mind. The tapes and transcripts of the interviews were scrutinised for themes and significant issues, as well as continuities and absences. This process ensured an integration between the two interviews, but also formed the basis of the very early stages of the data analysis. It was also part of a process of constant comparison which continued throughout the analysis in different forms and at different stages (Mason 1996, Lofland and Lofland 1995). At the interview stage the comparisons were largely factual rather than abstract, instrumental rather than conceptual. By this is meant identifying activities and actions which were similar or different across participants (such as eating together as a family meal or the practical organisation of the special diet), or noting items that stood out in some way.

As has already been noted, the interview process was conducted in an open but guided manner with a number of broad areas that it was felt would be fruitful to pursue:

- the nature of the illness, diagnosis and treatment (diet), and feelings about/attitudes towards these
- the meanings/importance of 'health' to family members
- issues of gender within tasks and activities in the home
- beliefs and attitudes about the above over time: generation; marriage relationship

Thus these were the guiding ideas which informed the interview process and the early stages of analysis, and it was in these early stages that the pivotal role played by notions of 'the family' emerged. Once the formal data analysis process commenced it became increasingly important to place family practices at the centre of understanding how the participants organised daily life (such as food and meals) and dealt with the consequences of illness. The literature had drawn attention to the multiple roles that family practices provide and which incorporated both the practical and the meaningful. The emerging data supported these views.

Equally significant was the relationship between the general and the specific, structure and agency. Understanding family processes would be achieved by locating the specific in the general, and by identifying the general in the context of the specific. Whilst identifying the conceptual framework within which the family processes under scrutiny could be understood,
it was going to be important to retain the identity and the uniqueness of the participant's lives. This desire has shaped the form within which the analysis proceeded and the way in which it has been presented.

The analytical process, whilst incorporating movement between the specificity of the transcripts and the conceptual nature of the themes which were identified, nevertheless followed a route which moved from the descriptive to the thematic.

Thus the first stage was to attach descriptive codes to all of the text in the transcripts. This took the form of a number which indicated the location in the transcripts of the text which was being described. In effect this has meant that all of the dialogue in each interview has been described apart from social exchanges (such as offers of cups of tea). It has been a map of the content, form, direction and flow of the interview. The description was kept in a separate file but still within the context of the particular participants transcript. Appendix 5 offers an example of a coded page together with a page of descriptive codes. It should be noted that, although primarily a descriptive exercise, where appropriate, particularly significant quotes were coded, as were potential concepts. As the descriptive coding of each set of transcripts was completed, a summary was made of the background details and an overview of the salient features of the two interviews. This last formed the basis of the vignettes of each interview couple found in Appendix 6.

An emerging theme at this stage was seen to be that of 'normality'. A definitive explanation of the meaning this term seemed to represent for the participants of this study will be discussed in chapter nine. At this stage of the analysis it was noted that most, if not all, of the participants, either explicitly or implicitly, conveyed the view that they would like to be able to 'lead a normal life' despite the intrusion of the medical condition. Through talking about the preparation and consumption of food within the family setting they revealed, to a greater or lesser extent, what they assumed to be 'normal' for them on a day to day basis. By talking about food and meals over the lifecourse - in childhood, in early marriage relationship, with young children, before diagnosis and since - the participants indicated how those assumptions were influenced over time.

Using the coded descriptions, overviews, and returning to the transcripts and tapes to check detail, a list of what might be described as 'normalities' were identified. These 'normalities' were constructed via two stages. The first stage identified normalities of significance to each of the participants. These were then collated into twelve overall working themes. Thus whilst constructing conceptual themes, nevertheless the specific data remained to the fore as far as possible. The twelve working themes (in no specific order) were as follows:
• Lifetime symptoms/multiple conditions - expected/unexpected symptoms/events
• (Not) drawing attention to the condition/diet - being a person not a condition
• Gendered divisions of domestic (food) tasks (incl. changes over time)
• Acting as an advocate for spouse/family - v - personal responsibilities
• Making light of the demands of the condition/diet
• (Not) eating the same food/eating together
• Food/the diet/the condition as a joint project ('we')
• What makes a family
• Consistency and change over generations
• Not wanting to be different/wanting to be normal
• Flexibility and strictness over the diet
• Feelings (about the diet/the condition/food/relationship)

The next stage involved a concurrent movement back to the raw data to identify examples, in the form of quotations, which illustrated the working themes, whilst at the same time distilling the working themes, into overarching concepts. This dual analytical strategy had the advantage of containing the search for illustrative or exemplary quotations within the constraints of the emerging concepts, whilst allowing the identification of an abstract conceptual framework which was grounded in the data. Four overarching concepts were identified: relationship; caring; negotiation and selfhood, and which formed the basis of the final stage of the analysis. Working definitions of these concepts guided the final search for the evidence in the text which would form the basis of the analysis chapters. Final versions of these definitions introduce the discussion chapter. These concepts represent the shape, form and content within which the participants can be seen to understand their lives within families when dealing with illness. They also provide an effective way of showing the processual nature of the family practices with which both the every day and the disruptive can be construed and accommodated.
Presentation of analysis

This study has taken a qualitative approach to the data collection and analysis to allow the issues of significance to the management of a diet related to illness to emerge from the participant-researcher dialogue. The nature of the family setting was felt likely to make an important contribution to how people construed and managed the illness experience. It was assumed that, whilst that experience had many characteristics which participants might have in common, understanding the feelings and attitudes of different family members required an open, barely structured format. The data have, indeed, revealed subtle differences in the ways that the participants achieved a common goal, that is, the assimilation of the condition and the diet into family life. To understand the processes by which this took place, the descriptions of ordinary, every day family activities have been examined for the complex meanings which underpin them. Participants were invited to talk about family practices around food, past and present, as well as the management of symptoms and treatment of the illnesses. They were encouraged to talk about feelings and attitudes as well as describe events and activities. The narrative that emerged found participants making connections and drawing parallels themselves, as well as revealing beliefs and values which reflected cultural norms.

To convey the detail and complexity of the narrative it was felt important to retain the uniqueness of the participants' lives as far as possible, whilst at the same time drawing together common features and significant differences. Thus the presentation of the analysis has been undertaken using a series of devices which would help facilitate this. Firstly, as noted in the Data analysis section, a series of vignettes has been formulated (Appendix 6) for each of the participant families. These include their background details and a thumbnail impression, drawn from fieldnotes, of salient aspects of the interviewees and the interview setting. Secondly, the data provided as the basis for analysis have been presented in considerable detail. At times lengthy extracts of the interview dialogue have been provided in order to preserve the context within which it was expressed, and also to encompass the multilayeredness of meaning that the interview exchanges facilitated. Thirdly, whilst it is necessary to draw together interview extracts which demonstrate common themes, attempts have also been made to link together extracts from the same family's interviews across chapters.
Explanations of conventions within interview extracts:

{......} data excluded for conciseness

[****] data missing - not audible on transcript

... pause in dialogue/ interviewer/ee interruption

[the doctor] information for clarification
Part three
Analysis section
Introduction to the analysis section

The aim of this study has been to examine the effect upon the family relationship of a member developing a chronic illness which requires a special diet. It examines the nature and meaning of 'the family' to its members and the implications these have for the assimilation of the new diet into existing family practices. The literature review has highlighted the processes by which caring is acted out through family practices on a day to day basis, and is based upon fundamental assumptions about gender. It is assumed that focusing upon tasks and activities around food and meals would provide an insight into the everyday experience of chronic illness. It is also assumed that examining chronic illness in the home would reveal the contribution made by family practices to that experience.

The analysis section comprises five sections. The first four chapters present data drawn from forty one sets of interviews with family members whose common experience has been dealing with the symptoms, diagnosis and treatment of one of two diet related illnesses. The people who volunteered to take part in the study varied considerably, as discussed in the methodology section. The two medical conditions also had distinctly different characteristics, and participants were chosen in order that both men and women with the conditions were represented. Nevertheless, the significant themes which emerge from this analysis are those which identify similarities across most or all participants, rather than distinct differences between clearly identifiable sub-groups. Thus, in the following analysis, attention will be paid to the ways that participants use a range of meanings and understandings to achieve recognisably common goals which allow the family relationship to run smoothly on a day to day basis.

Chapter 5. Families, food and notions of caring

This chapter introduces the family relationship as a setting for informal caring through activities around food and meals. It begins by using the family meal as a focus for the examination of the means by which this relationship was construed and acted out on a day to day basis. It goes on to show how gestures of care and concern offered and received disclosed gendered assumptions about roles and responsibilities. The terms 'caring for' and 'caring about' are examined within the context of gendered caring.

Chapter 6. Doing family - learning family

This chapter continues to examine the nature and characteristics of the family relationship through gendered roles and responsibilities. The notion of location within the home as 'territory' which is also strongly gendered is discussed. This is followed by an examination
of the ambivalent role of children in the home with respect to domestic responsibilities, and concludes by considering attitudes towards food and meals over generations. The processual nature of 'doing family' is revealed through ordinary every day family tasks and activities.

Chapter 7. The 'special diet' - learned and lived

This chapter analysis focuses specifically upon the participants responses to the 'special diet', starting from the point of consulting the dietitian. It goes on to look at the ways family members (usually spouses) adjusted the new diet into existing family practices, and also created ways of construing the diet which would allow it to be accommodated. Most notable is the way that the diet could come to be seen as a joint task, rather than an individual responsibility, and the level to which the 'home manager' took responsibility for it's successful integration into family practices.

Chapter 8. Negotiating symptoms, conditions and family life

This final analysis chapter focuses specifically upon the process leading up to diagnosis of the medical condition and then dealing with the consequences. It begins by showing how symptoms were construed and dealt with until diagnosed and then how the recommended diet was managed. It goes on to examine multiple illnesses within the home and the implications these might have for the management of chronic illness. The chapter discusses the notion of 'normality' as a way of reconciling the effects of chronic illness with assumptions of the family relationship.

Chapter 9. Living a normal family life - discussion and conclusions

The final chapter will draw together the themes examined in the four analysis chapters, within the framework of the four concepts which informed the direction and content of the analysis: (family) relationship; caring (for and about); negotiation (family practices); selfhood (gendered and family identities). The discussion will incorporate:

- the ways 'caring about' and 'caring for' are acted out through every day activities associated with food and eating specifically related to health and illness
- the process by which food tasks and eating activities prescribe and demonstrate gender
- ways of dealing with symptoms, illness and treatment within the family
- the process by which the normalities of the family relationship are learned, negotiated and transmitted through the life of the family relationship and across generations
The notion of 'normality' will be used as a way of explaining and understanding how the participants dealt with contingency, especially the unexpected or unwelcome. Reactions to the development of symptoms and the consequences of the diagnosis of illness will be explained in the light of the desire to maintain existing life patterns. Participants presented these consequences largely by underplaying the impact or seeing them in a positive light. The domestic tasks tended to be undertaken by women (the gendered nature of home) and the often major impact of the work involved in introducing a new diet was not overtly acknowledged. Thus the minimising of these responsibilities became part of the process of normalising the event. Within the home, tasks and activities generally will be seen to be strongly gendered, creating a gendered template over which new responsibilities are laid. These assumptions, combined with a desire to promote the notion of normality through the minimisation of difference, will be seen to render invisible the burden generated by the new diet.
Chapter 5. The family relationship and notions of caring

It [her children accompanying her when she first started going out to work as a children's entertainer] was good and I am sure as a family that is a critical time, 12 [years] and 14 [years] and if you actually are needed, somebody needs you to do something, I think it is a real - and I did need them and they knew I needed them and I feel that makes a family much more cohesive.

(Mrs Smythe CDF)

The production and consumption of food within the setting of the family meal provides a means by which the nature of the family relationship can be conveyed and understood on a daily basis (Charles and Kerr 1988). The everyday experience of contributing to and taking part in the family meal is imbued with meanings associated with gender and role identity, as well as love, affection and duty (DeVault 1991). Most of the participants in this study operated within a traditional perspective of what men and women usually undertake in terms of tasks and roles both within and outside the home. All of the participants conveyed an understanding of what a conventionally gendered division of domestic tasks and activities should look like, even in cases where these divisions had been transgressed in some way. None of the participants offered a view that these gendered domestic conventions should be transgressed for ideological reasons. Those couples who shared domestic tasks and activities or had reversed roles gave explanations which were pragmatic, subject to contingency and were often time-limited (such as when children were first born).

The family meal was described by many participants in terms which suggested a vehicle through which the nature of the family relationship was expressed. Family meals were usually described in similar terms to those of the 'proper meal' identified by Murcott (1983) and Charles and Kerr (1988) That is, as cooked meals, usually prepared by wife and mother, eaten by all family members at the same time around a table, and seemed to carry an almost universal recognition as an activity to aspire to even when not regularly achieved.

Whilst not all participants adhered to a conventional meal table around which the family gathered each day, many saw this activity as admirable and to be achieved where possible. A number were unable to do so because of employment demands, such as shift work, long working hours or work in the evening. Just a few described children's after school activities which limited the opportunity for family meals during the week, whilst others identified an age at which children need no longer be expected to join the family meal if they did not wish to do so. However, many of those restricted by competing activities pointed to the weekend, especially the Sunday lunch, as a chance to make up this deficit, and a number offered
disapproval of the trend of 'grazing' (that is, eating snacks, often alone) and also the use of 'convenience' or 'junk' food.

In talking about managing the diet recommended for the medical condition, as well as food and meals arrangements generally, participants revealed beliefs about what they expected, from themselves individually and each other collectively, as family members. Each family varied in interesting ways over what they did themselves and expected of others, but there was a common theme which combined caring, responsibility and role identity, which, if not always adhered to, acted as a norm around which the family relationships ranged. At the heart of these expectations were notions of gender roles and relationships, and of the caring of children. These roles and responsibilities were expressed through regular and routine daily activities in the home.

This chapter is made up of three sections which, using family meals as a focus, examine the nature of the family relationship as revealed through views about attitudes towards these daily routines, particularly related to concepts of caring. The chapter sets the scene for the study, in that views about the family setting generally, as reflected in descriptions of family meals, are highlighted here. As the chapter progresses ways of caring are presented, generally and then specifically to the illnesses in question.

The first section: Family meals - being together, examines the ways in which the family meal can be seen to be used as a symbol of family togetherness in which family members could gather in an enjoyable, shared activity. The family meal, for many participants, provided a pivot for family members to meet, communicate and monitor each other. The ideals which people attached to this activity will be compared to the difficulties which can arise in trying to achieve it.

The second section: Family meals - monitoring the family, will focus specifically upon the portrayal of the family meal as a means for the socialisation and monitoring of family members. The gendered nature of family practices will be seen to be evident in the ways that family meals were organised by the participants of this study. This will also be shown in the ways that the responsibility for managing the special diet was perceived and adopted. The final section of this chapter: Sympathy, empathy, concern and support - caring for and caring about, considers the gendered nature of caring as expressed through food and diet particularly in relation to the special diet associated with the medical condition. This is examined in the light of the 'naturalness' with which caring has been associated and which can lead to an invisibility, particularly of 'caring about'. Notions of gendered caring will be pursued further in chapter six.
The notion of normality, (an underlying theme which will arise throughout this analysis) underpins the nature of the decisions and negotiations which allowed participants to accommodate lifecourse events. Thus, in any one description, a valued ideal, such as the daily family meal, can be found to be expressed as desirable, but may not always be adopted regularly or routinely. The ideal of 'the family meal' was almost a backdrop against which the reality of life was played out. Equally, gendered roles provide a framework within which family relationships could be negotiated, monitored and maintained.

• Family meals - being together

You are a family if you have a meal on the table

(Mrs Howard: CHD M)

Eating together as a family was, for many of the participants in this study, an activity intended to be as much an enjoyable family event as it was a convenience. However, the routine with which the organisation of daily meals was conducted can be seen to embody a specialness of the everyday which does not, usually, require comment. The flexibility with which many had to organise such events, around employment demands and other competing activities, meant that it was unusual to find participants whose family meals were never disrupted. Nevertheless, the following two quotes represent many of the participants' experiences:

Mr and Mrs Scruton (CHD M), both retired, described their expectations of their two sons when young:

Mrs Scruton: Then when they got older we moved in about 1970 over to this area and I was a part time secretary at [firm] but I was always home no matter how old they were I was always home for them coming home from school. And that was not only I thought a good idea, because even into teens I think particularly boys can get into trouble if you are not there and sometimes they need someone to talk to immediately when they get in from school, but also of course it gave me time to cook properly, so that is how we did it.

Int: So you waited until your husband came home from work?

Mrs Scruton: We always had our meal together and it was always at the table

Mr Scruton: We have always eaten together as a family, none of this grab and run. Oh no

Mrs Howson (CD F), widowed, indicated her preferences when her two sons were young:
Mrs Howson: ...I always made those decisions [what to eat] and they would come in and have their meals, we would have them altogether in the evening time.

Int: You always ate together?

Mrs Howson: Yes we did

Int: You preferred that?

Mrs Howson: Yes it was nice really

Int: Or was it just convenience?

Mrs Howson: Well I suppose it is convenience up to one point, but then we were all in about the same time, so it was enjoyable just to sit down and eat together really. My younger son did prove to be a bit more difficult after a while with the sort of job he had, he would come in late sometimes, so I would cook for him.

Both of these couples were looking back to a time before their children had left to set up homes of their own. Their memories convey a notion of family meals which incorporated enjoyment and cohesion, but also implied a rule or code of how these meals should be conducted. These 'rules' were often carried on from childhood experiences, as in the following from Mr and Mrs Royle (CD M) who spoke enthusiastically about their enjoyment of both cooking and eating and stressed the importance of eating together as a family. In particular they both described Mr Royle's background in India where it was servants who prepared meals, but where both his father and his mother indulged themselves by preparing specific items occasionally, and insisted upon large, long family meals, which all of the children wanted to attend.

Int: I am just trying to get a picture of what meal times were like? What was the cooking like? Did your Mum do the cooking?

Mrs Royle: Yes, so did the servants.

Mr Royle: My mother always loved cooking. She dabbled. But the main cooking was done by... we had a cook and people who were servants. That wasn't a problem. We always ate.. my father always wanted to get all the family together at the table.

Int: And this was your father's preference?

Mr Royle: Yes. We had a very happy childhood, so we wanted to be with them.

Nevertheless, later in the interview, it was revealed that within their own family, Mr and Mrs Royle found it less easy to insist on uninterrupted family meals. These were, in fact, disrupted by the children's (competitive) tennis practice which, for many years, took a higher priority. The following quote incorporates an indication of the perceived social nature of the family meal. It also shows how the meal was seen as providing opportunities to socialise
children's behaviour, whilst acknowledging the need to be flexible over legitimate (that is, approved of) interruptions:

_int: So as far as family life is concerned the idea of having a meal...

_mr royle: As a family unit, it is a very important fact.

_int: Yes, and having the meal is an important part of that?

_mr royle: Oh yes. We sacrificed in our early age... when we came back [to Britain], at a time when we were young, we were very hard up, but we still went for a meal out in the evening, once in a while we would go, four of us would go to Berni Inn; Steak House, and go all four, sacrificing our..

_int.: So if you wanted to go out for a meal it had to be with the children?

_mr royle: Yes, and where they were accepted. Otherwise.. we have gone out ourselves, but I always.. in the back of my mind think about the children missing out they love their food. We thought it was the best thing for them, to know table manners and all that sort of thing, so that they can grow up with that idea.

_int: And how easy was that, when your children were young, were there any sort of.. as I say, children quite often have extra curricula activities and I find a lot of people nowadays say it can be quite hard to organised meals around children?

_mr royle: Oh it is now. But the microwave is God's gift now. With our children it was tennis.

_int: Oh I remember you saying. Was that from quite an early age?

_mr royle: Yes. We tried to promote it that way. As soon as they showed any interest we pushed it and our holidays were geared to their playing tennis. So actually yes it was a reason, obviously, if we can't wait [to eat] they would have it on their own, but it was very rare.

However, the reality of the kind of difficulties which can be encountered when attempting to follow such a rule with a less than co-operative family was vividly illustrated by Mrs Hufton (CD F). Mrs Hufton described the double dilemma of someone who had been diagnosed with coeliac disease as a young mother, and then discovered that her young son (5 years) also had the condition. She explained that her husband was sympathetic to her medical condition, but was having difficulties in truly understanding because he himself was never ill. Caring for their children, dealing with her own symptoms and then the new diet, combined with structural changes to the new house they had moved into at about the same time had made life very difficult. The following quote shows her trying to create the meals times she learned from her own family that she felt important to introduce to her husband and children:

Mrs Hufton: Yes.. Steve has never really .. if we are talking about now, Steve has never been a breakfast person, so he is just not that bothered, which I think is a
shame, because it doesn't give a good message to the children, but equally, I love breakfast, but it is always a little bit rushed, and it is cereal, but at least then I feel they have had some, and by the time Matthew goes to school... well, he always has breakfast. so I think that side of things has rubbed off. But for me, I think I have said before, since we have moved into that house, it has really affected mealtimes a lot, because we have had so much work going on, with the kitchen all taken apart and it really did affect things. I think, badly, from the point of view of Matthew and getting him... I wish now, if I could go back and do it again, I would have spent more time doing family meals, getting it right, getting him to sit down, because that is one of the things he is...

Int: How old is he now?

Mrs Huston: He is five.

Int: And how long has he been diagnosed?

Mrs Huston: Three. He was eighteen months when we moved. And I will work harder with Matthew and Rachel now, I think family meals are important. And the way he eats, I hope he will settle down as well. He is such a fidget, to try to get him to sit still to eat a meal is so difficult. And Steve does not like us going out as a family to eat because he is embarrassed because Matthew is such a fidget, he will, like, fall off the chair, he is under the table.

Int: And it makes it far less relaxing

Mrs Huston: It becomes a stressful time. And Steve doesn't like sitting down as a family because it is stressful. Matthew will be messing around at the table. He is an attention seeker. I am convinced. He is a bright child and quite manipulative.

For Mrs Huston her role in the family was very clear - ensuring her own and her family's nutritional health, socialising the children - but all within the context of the family setting, here embodied in the family meal. Her difficulty had been the day to day reality of those responsibilities where fulfilling those goals were constantly subverted by the attitudes and behaviour of different family members.

Change over time in attitude and action was evident as strategic to most families' methods by which contingency was accommodated, but within the context of a constant notion of family relationship. Thus, Mrs Howson (CD F), mentioned earlier, although an example of what might seem to be a traditional and unchanging family tradition, could contemplate change in family meal arrangements as her family changed. She described a childhood in which family meals were ground into us, becoming an accepted form of life which she and her husband were happy to continue, as indicated by the earlier quote. She gave up paid work soon after getting married and never returned, seeing her role as at home caring for her husband and two children. Neither husband nor her two sons were ever expected to be involved with food preparation, and this continued for the duration of her marriage. Nevertheless, now that she
was widowed and just had one adult son living with her, she commented that meal arrangements were far less strict.

Mrs Howson: I think they were just quite happy really, I mean I never heard anything. Obviously I would say 'do you fancy so and so today?' But no I don't think either of them said 'Don't do anything Mum, I'll do it for you.'

Int: I think you would remember that wouldn't you?

Mrs Howson: Yes, I definitely would. No, I suppose we felt that within the family it was just the way of life really.

Int: Yes and a lot of families do. You have your particular roles and that's fine. And they are obviously quite happy with it.

Mrs Howson: Yes and I suppose looking back perhaps that was the way that we were brought up, you know, my Mum always did the cooking and it was a role I sort of carried on.

Int: Yes, it is certainly a thing where it is usually women that do it, although it may be changing a bit.

Mrs Howson: Oh yes. Mind you, lots of things I did years ago I don't do today. I have cut down a lot of things because I find it a lot busier and I haven't got the time, and as you get older you can't always do it anyway. As long as you have a good three meals a day.

Mrs Kelner (CD F) described learning about eating together as a family, especially Sunday lunch, as a child and continuing to live this experience as an adult. She had grown up in a large family where regular family meals were seen as the norm, even though her father could not always be there:

Int: And your Dad joined in as well?

Mrs Kelner: Sunday he always cooked the breakfast

Int: So you had a cooked breakfast on Sundays?

Mrs Kelner: Yes, I think it was his thing just to get us all up actually. And of course once you started smelling bacon and things like that

Int: Yes of course, it must be quite hard to stay asleep

Mrs Kelner: Yes. Or else he would come up singing to us

Int: Did you have a family Sunday lunch?

Mrs Kelner: Yes
Int: So did you always eat together?

Mrs Kelner: Yes always

Int: So you got home from school or work or whatever and waited for each other?

Mrs Kelner: Yes. My Dad wouldn’t always be there because he worked shifts, but other than that sitting round the table all together was a pretty normal thing.

Int: It never crossed your mind not to?

Mrs Kelner: No. It was just the way it was and that was it. That was why - there was an article recently about how the amount of people that just don’t sit around the table anymore. You know, they come in, select what they want, stick it in the microwave and watch the TV. And I think that is a shame

This continued to be the case when Mrs Kelner became an adult, but was acted out in a modified way. She did not have any children, and she and her partner were both in full time employment. During the week it was whoever arrived home first that prepared the evening meal. However, every Sunday three generations of her family who lived nearby gathered in the large Kelner kitchen for Sunday lunch.

Mrs Kelner: I mean we can sit around here on a Sunday afternoon, we can sit down at three and get up at seven, just sit there chatting and if there is a crowd of us I bring in the other table from out there because we have the room.

Int: You have, it is a lovely big kitchen isn’t it. It is ideal for that kind of thing.

Mrs Kelner: Yes. I mean, a couple of years ago my uncle came over from Ireland and he had brought some fresh salmon, but he had frozen them to bring them over, so of course they were thawing out coming over and I mean they looked like guns coming through customs, I don’t know how he ever got through. He brought four of them and I am not talking about tiddlers here and I thought ‘Oh God, what am I going to do’, because you had to cook them. So that was it, I just invited everybody round and it was in the summer and on a Friday night, and we all sat in the garden and had a party. It was good. So that is why me being a coeliac, it never really changed the eating habits.

and also

Int: But tell me a bit about the actual organising of the meals. Do you usually eat together?

Mrs Kelner: Oh yes, he will eat the same as me

Int: So you come home from work at night...?

Mrs Kelner: Whoever is in first will prepare the dinner

Int: And when that happens... I want to get a picture of what having meals together is like, just generally as a social event...?
Mrs Kelner: Well let's put it this way, my family come over every Sunday. The whole family.

Int: What do you mean by all the family?

Mrs Kelner: My parents, my sister, the kids. So there might be nine or ten of us for dinner.

Int: So you or your partner will cook?

Mrs Kelner: The two of us will cook the meal and if I fancy something special [...] so they have it

Int: A gluten free cake?

Mrs Kelner: I have got the flour and I say 'come on what will we make today'

Int: How old are the kids?

Mrs Kelner: Well they are growing up now, they are 13, 12 and 14

Int: These are nieces and nephew?

Mrs Kelner: Yes

Int: So you get them involved?

Mrs Kelner: Oh yes. I get them doing the baking. The cake tastes exactly the same. I am not that good, I wouldn't call myself cordon bleu or anything, but chocolate cake or pineapple upside down cake, I will get them to do it, so they enjoy it and it tastes the same.

Int: So this family Sunday lunch is every Sunday?

Mrs Kelner: Yes. If they don't come here we go to them.

The ideal of the happy family meal as an expected norm emerged even from adverse settings. More than one participant, when asked to talk about their childhood, offered stories of difficulty and uncertainty in dysfunctional families. Mrs Garside (CD F) had, when looking back, experienced severe symptoms from what was probably undiagnosed coeliac disease as a child. She received no sympathy from a 'brutal' father who made her sit at the table until she finished her meal. This led her and her siblings to try to avoid family meals as often as they could, in the absence of 'a nice meal in a nice family':

Mrs Garside: Yes, Mum had an allotment

Int: Four children and a job and an allotment, that's a lot?

Mrs Garside: Yes. She was only very tiny, but yes. It was a very traumatic family, it wasn't a happy family at all. My father knocked the boys around very badly and my nearest brother, although he was older than me, he would drag him around by his ear
and my father was not a very nice man. So there was trauma in the family right from that stage. My mother would sit with me with this dinner and one of my elder brothers would come in and try and eat some of the dinner for me so that I didn't have to sit there any longer. But I wasn't going to eat it and there was no way they could force me to eat.

and later

Int: So mealtimes wouldn't have ever been something you ever looked forward to?

Mrs Garside: No you ate because something was put in front of you. Well, whether you ate it or not was another kind of thing.

Int: And then if you did eat it you felt ill?

Mrs Garside: Not so much then, that was worse, you just didn't eat as a child because I didn't have any interest in eating, there was no reason. You know, you weren't sitting down to a nice meal with a nice family or anything like this. Everybody was just desperately trying to survive.

Mrs Garside, as a child, describes family life as very different from the 'happy family' which is implied in the term 'a normal life'. Her experience contradicts notions of 'normality' but can be a reality for many. Despite this, as an adult in her first marriage, Mrs Garside discovered the sociability of eating together and became actively involved in meal preparation, to the extent of regular entertaining in the early years of that marriage:

Mrs Garside: Well, yes, food was very bland, cabbage, boiled potatoes and what meat you could get hold of... As a matter of fact I didn't really start eating properly until I got married and I could go out and I could buy it, then I did start eating meat. A bit.

Int: When you got married, bearing in mind that you hadn't had much to do with food, you hadn't been interested in food, and you had been ill an awful lot around food and meal times, were...well, if you had to eat to attend them were pretty traumatic and you would try and avoid them - how did you see mealtimes when you did get married?

Mrs Garside: Better. Because we used to entertain quite a bit.

Int: So you weren't put off?

Mrs Garside: I kind of went into a different lifestyle then.

Int: You are obviously quite an optimist?

Mrs Garside: Yes, I hadn't seen it in that light! I became more positive and I could buy things that I fancied

This section has presented examples which reflect different family backgrounds in terms of age range and experience of children. It draws upon the participants' memories of far and recent past experiences as children themselves, and with their own children, to reveal the
expectations people have of what family meals should be. They represent the differing experiences of many of the participants and convey ideas of 'family meals' as the lived experience of the family relationship. This can be seen through the interplay between the need for rules and the need for flexibility, manifested in the ways that the people attached significance to the notion of the family meal through changes over time and over generation. A constant can be seen as the sense that routine happy family meals are a norm for and an indicator of a normal family relationship.

- **Family meals - monitoring the family**

As can be noted from a number of the quotes so far, eating together as a family was seen as particularly relevant to the care and parenting of children. A number of participants spoke of the value of what children could learn from the act of eating a meal with the rest of the family, but also what parents could learn about their children. The socialisation of children within the family setting has been said to introduce young people to the behaviour and attitudes necessary for them to make their way successfully into the world outside home and family (Bernardes 1999). The value of family meals for the socialising and monitoring children, and, in some cases spouses, was mentioned or implied by a number of participants. The meal time was seen as a location within which children learn 'proper' social behaviour as well as where children's experiences and attitudes might be, discretely, monitored.

This view is reflected in a number of the following quotes, even that of Mrs Hufton (CD F) who was used as an example in the previous section to illustrate the kind of difficulties parents, and particularly mothers, can encounter when trying to fulfil the range of expectations seen to be attached to the act of eating a meals:

**Int:** So what happens with the meals? *Presumably you are home first?*

**Mrs Hufton:** Yes, at the moment the way it usually works is... If we are around during the day I will do a lunch for them and it had been very much a changing pattern in that Matthew was doing afternoon nursery, which meant for three days he took a packed lunch and it was always a rush. Even [***] when he was here it would mean lunch would be a rush, it would either be a packed lunch and he would eat it there, which is nice for the social skills and being with friends, but it is very much they eat everything with their hands, so ... Or I try and do it here but it would be stressful because as well as trying to get their lunch I am rushing because I need to get them in the car to get them there and he would have his shoes off and then he would want to go to the toilet and it would mean it was rushed. Then I find he would come in from nursery and ravenously hungry and I wasn't organised enough to have something for him straight away so he would sort of pick at things and then I would try and, either if I knew Steve was coming home early enough we would all eat together, or if he was
doing long hours and he wouldn't come in until about half seven some days...
[interruption for tape to turn over]

Mrs Hufton, in this quote, draws attention to her awareness of how she sees eating together as
a setting for children to learn social skills, and so, for her, a preferred setting. This was clearly
important to her, despite the overwhelming problems she had to overcome of managing a very
active young son and the special diet for both herself and her son. This tension between the
desire for a 'normal' family meal and the difficulties in enabling this to take place, did not
reduce her efforts to create family meals.

In contrast, Mrs Smythe (CD F) did not recall the same kind of difficulties when organising
family meals at mid day for her husband and children. Her emphasis, as was a number of
participants, was upon the informality of the setting which encouraged children to reveal their
thoughts and activities:

Int: ...How did you organise meals when your children were at home?

Mrs Smythe: Well, then the big meal was nearly always in the middle of the day.

Int: Right. So you were all able to get home?

Mrs Smythe: Well, he was usually home in the middle of the day, rather than,...In
those days he [husband] was covering more adult work [***] so he does more
children's work now. So he was nearly always home at lunch time and they went to
the local school then so they could come home at lunch time, which was lovely and
then we all had lunch together because we often used to go out in the evenings.

Int: And I don't know how important eating together is?

Mrs Smythe: Oh I think it is terribly important

Int: Really. Something you...?

Mrs Smythe: It is when you hear what [***] with the children. When you hear what
is going on.

Int: I think you are right {....}

Mrs Smythe: I feel sad when I hear of families who have to put something in the
microwave when they are ready to eat and [***] I feel sad really

And in the second interview:

Int: How did the sort of meals work out then [when a child with her own parents]?

Mrs Smythe: Oh well, much the same. I mean, meals were a definite time you were
expected to turn up and sit round the table and chat to each other

Int: It wasn't something where people popped in?
Mrs Smythe: Oh definitely not, no, you had to be there on time. And I must say I do... I suppose it has stuck with me, but I expect it of my children, unless they have said beforehand, I expected them to be there for meal times.

Int: It is interesting because it does seem to be something that people do even if they don't necessarily do it all the time, it is something that they seem to aspire to, that the meal time is seen as a sort of family event?

Mrs Smythe: Well, I think honestly they relax more when they are eating, the children and you hear things you would never hear in the ordinary way. I don't mean dark secrets or anything, just chatter, how things are going and I think that is very important.

Int: Yes, I hadn't thought of it in that way but that's right, if you are getting together to eat then that is the reason you are getting together and it may well be that particularly children who sometimes don't necessarily, don't want to talk about things, would sometimes chatter, because it is sort of by the by, rather than...

Mrs Smythe: Yes, you are not having a heart to heart about it. I think heart to hearts are terrible, they don't work, because everybody immediately brings this up.

Int: But is it [eating together] something that you have always done?

Mrs Flow: Yes we have always done

Int: Is it something you wanted or just convenience?

Mrs Flow: Well, I just used to think it was nice, to sit down and have our meals together.

Mr Flow: Yes.

Int: I think you are right actually, it is sort of a point in the day when you get together

This quite lengthy extract encompasses beliefs in the enjoyment that eating together could bring, but also seems to stress the value of the 'ordinariness' of a process within which important things like 'good parenting' (mothering?) could be fostered. This is a good example of how the 'alert assistant' (C.Williams 2000) becomes just a part of everyday family interaction.

Mr and Mrs Flow (CD M) also noted the way in which mealtimes provided the chance to enjoy the company of the family and check on children's activities:

Int: Yes. But is it [eating together] something that you have always done?

Mrs Flow: Yes we have always done

Int: Is it something you wanted or just convenience?

Mrs Flow: Well, I just used to think it was nice, to sit down and have our meals together.

Mr Flow: Yes.

Int: I think you are right actually, it is sort of a point in the day when you get together
Many of those who saw the family meal as a parenting aid pointed to, as did Mrs Smythe, the influence of their own childhood and parents. The following is also a lengthy quote in which Mrs Conley (CD M) remembered a childhood with large social family meals to which family and friends were regularly invited. It demonstrates the sense of togetherness discussed in the previous section, but which had the simultaneous role of monitoring family members:

Int: What were meals like? For example, was your Mum one of the traditional ones who stayed at home to look after the children and home?

Mrs Conley: Yes to start with, yes, during the war years. But then as I was a teenager she started working, but she was always there at mealtimes. I never had to come in and cook anything. She was a traditional cook too and food was important in our family.

Int: In what ways?

Mrs Conley: Sunday dinner or Sunday lunch, everybody had to be there for Sunday lunch. My Dad was very strict about that.

Int: Really. Yes. It was important?

Mrs Conley: Yes

Int: ....well, if you are going to the trouble of making a big meal, then you really want everyone to eat together because it is convenient. But a lot of people sort of go beyond that I think and see it as something more than just that?

Mrs Conley: Yes, I think Dad did. Well, we all did and we used to do it with our children as well. Until they got to teenagers and they were never there. We carried that on.

Int: You say your Mum was a traditional cook, what do you mean by traditional?

Mrs Conley: Well, lots of meat. Lots of gravy and pies and pastry and you know, large helpings!

Int: So she did a lot of baking?

Mrs Conley: Yes, lots of baking.

Int: Do you think she enjoyed it?

Mrs Conley: Yes, I think she did. It used to be her way of treating us I think.

Int: So although she was traditional she liked doing different kinds of things?
Mrs Conley: Oh yes. I think she made up, also when, because Dad was a prisoner of war and he was away for three years and when he came back I think it was a case of feeding him up and I think that is where it all really started.

{......}

Mrs Conley: ...I remember her cooking too for her younger sister, her family weren't very well off and they always used to be there for Sunday lunch.

{......}

Int: So the meal on Sunday was quite a big affair, it wasn't just the immediate family?

Mrs Conley: No. Not all of the time, they didn't come, but then it was my friends and Roy [her husband]

Int: Were sort of drawn into meal times?

Mrs Conley: Yes.

Int: I remember somebody saying it was sort of a way of finding out what people were up to, what they were doing?

Mrs Conley: Oh I am sure it was. A way of my Dad keeping an eye on me, I know!

Int: And you had a younger brother?

Mrs Conley: Yes, seven years younger.

Int: Oh right.

Mrs Conley: Which was quite a gap really, because I mean he got away with everything!

Mrs Conley's description of family meals with her parents shows how her parents monitored their children, but also the different and gendered roles played by her mother and father. Her mother is praised as always there for the children even when she took paid work, and her father noted as the person who enforced the rules of family meal attendance. Nevertheless, it also hints of the flexibility that time brings. The onset of teenage in her own children saw a relaxation of these 'rules'.

Whilst most of the comments about monitoring behaviour tended to be related to the care of children, it was clear that the family meal was also an opportunity for monitoring the eating behaviour of adults, especially in relation to the special diet. Mrs Calman (CHD M) was one of the few participants who explicitly described her strategy for ensuring her husband followed his diet. When talking about her children's views about cooking and meals and
how it had been conveyed across the generation, she also mentioned how family meals allowed her to monitor her husbands health:

Mrs Calman: Well my son has never had any problem because he enjoys it so he does a lot of the cooking at home anyway My daughter I think she has just found her way as time goes on. But again she is very much.... It is a family meal, it is that time for discussion, it is the time we can be together and she won't let them get off and leave the table and go off to play.

Int: And she got that from you?

Mrs Calman: Yes. I think so.

{.....}

Mrs Calman: Yes. I think it is just something that has been passed on from generation to generation. Even with my daughter, although they went through the stage as teenagers when we didn't have the family meals so much, it has come back to her in the end and she has got a very young family

Int: And now with your present husband, you have been together 12 years so do you see eating... I mean he works long shifts so you can only eat together now and again, so how do you feel about those meals together, when you do manage to get together?

Mrs Calman: It is a time when I can decide what he is eating and I know what he is eating so I know he is eating properly. Although as I said to you before, he is very good now since his heart attack.

Int: Yes you said he has improved a lot

Mrs Calman: Yes he has, but still not how I would like it, but again I can control it, I know what is happening.

{.....}

Mrs Calman: The week that he is here it is important in that it is only every other week, so I want us to be together

{.....}

Mrs Calman: No that week is... I mean I won't go out that week. This is my week when I do all my visiting or people come around. Obviously if it is friends of both of us they can come round when he is here, but if it is things that I want to do then I do it all in this week. I don't go out in the other week.

Int: So the week that he is at home at night you set aside in a different way?

Mrs Calman: Yes. We are together, everything we do is together. If one of the girls at work said 'we are going out for a meal', if it is the week he is home, no, I don't go.

Int: No I can understand that. I think when you do have work patterns that don't synchronise all that well, then you do have to think quite carefully about it don't you?
Mrs Caiman: Yes.

Int: I am assuming he feels the same way about it as well?

Mrs Caiman: Yes and we have always been like that. I mean the heart attack hasn't made us like that, we have always been like that, but I do appreciate it more now.

Mrs Caiman's desire to make sure her husband followed the diet recommended for CHD can be seen to fall within her remit of caring for the family generally. Her concern about her husband's diet had the added difficulty of his shift work which meant that she was unable to monitor all of his meals. She describes a strategy which she felt best ensure that these aims could be achieved. By making sure that she was always at home, whenever possible, in the evenings that her husband was, she could monitor and supervise his meals, within the context of the ordinary evening meal. This was part of a strategy, which might also include ensuring the appropriate food was in the house (and inappropriate food was not) and eating the same food at the same time as a couple. It also had a particular value in being seen to disrupt family practices as little as possible, but does not acknowledge the (willing) restrictions Mrs Caiman placed on her own social life.

Thus, the family meal can be seen to provide a dual role. Firstly, in the practical aspects of 'caring for', embodied in the monitoring of family member's health generally and specifically. Secondly in the sense of 'caring about', embodied in the togetherness that eating together represents, actually and symbolically. In some families this might mean making changes to promote further the sense of togetherness in the light of the imposition of the special diet. For example, Mrs Greig (CHD M) described her strategy for helping her husband with his diet and also preserving their relationship:

Mrs Greig: No I still... I adapted my eating to Tony's, if he had to cut out something I would try and do the same, you know, it was togetherness. I didn't want him to feel he was missing out on anything. We cut down drastically on everything that we could and should have done.

When family members, and in this study this was mainly women, undertook specific behaviour which would enhance the health of the person with the condition, it could also be seen as intended to avoid perceptions difference.

An almost idealised notion of togetherness seems to run through all of the examples presented in this section. Nevertheless, this theme was always part of an everyday lived context which reflected gendered role expectations of the family members. Monitoring children or spouses at meals combined the everyday with the ideal. Being good parents and being close families can be seen to be demonstrated through the everyday and necessary activity of eating a meal. The
one event could embody values of health and nutrition, parenting, family relations, gender roles and normality, concurrently. Some of these examples show how these ideas and beliefs travel and evolve across generations. They show how the desire to create a family setting, however idealised, is mediated by competing demands and the needs of family members over the passage of time.

• Sympathy, empathy concern and support - 'caring for' and 'caring about'.

The notion of gendered caring has already been introduced in the previous section, and attention drawn to the different forms that it can take. The literature has shown how 'caring for' tends to take a practical form, whilst 'caring about' is seen as affective behaviour (Arber and Ginn 1999, Morgan 1996). This section will develop this further by examining the form and function of the concern expressed or implied by family members specifically in relation to the special diet.

Most of the couples who took part revealed evidence of an expectation that the female partner would take the main responsibility for food and cooking. It followed that there was an expectation that the same person should know about the diet and make sure it was followed. The following four examples are taken from each of the gender/condition groups:

Mr Appsen (CD M) had retired within the previous year and his wife was still in part-time work. Although both were present at the interview, Mrs Appsen took the lead in describing the diagnosis of his condition and the management of the diet. Mr Appsen had not yet taken up cooking despite saying that he quite liked it:

*Int*: have you ever been involved in cooking?

*Mr Appsen*: Oh yes, I quite like cooking, but I have never had the time. I used to work in London and most of my time I spent up and down to London, left early, came home late, so there was no time for anything and the weekends it was just doing the jobs around the house. So there was never an opportunity was there [to wife]?

*Mrs Appsen*: I am interested to hear you say that you are interested though

*Mr Appsen*: Well, you have been away on holiday on your own sometimes and I have looked after myself.

*Mrs Appsen*: Yes but because I have usually left you casseroles

Mr Watten (CHD M) and his wife were both retired but maintained a very clear division of meal preparation tasks:
Mr Watten: Yes, they said there was room for improvement but it [cholesterol] was OK. Do you want me to go on to measures we took to correct this?

Int: Well, yes.

Mr Watten: Well, not so many eggs for a start! My wife looks after that and she often tells me 'You have had your quota for the week'

Mrs Watten: Three eggs he is allowed a week.

Mrs Rose (CD F) was in her second long term relationship (of 12 years). She was a very keen confident cook (with a plate of gluten free scones for the interviewer to try on arrival) who had no expectations of sharing her kitchen:

Int: Do you think that was useful having him there [when she went to see the dietitian] when they were talking to you?

Mrs Rose: Not really (Laughter) He is very good, very supportive towards me but as long as I am coping with the things he feels OK. He doesn't interfere, He feels I know better than him. If I say 'What do you think?' [he says] 'Well I suppose...' sort of thing. 'But you are the best one'. And of course the fact that I have such a good relationship with my own doctor he [her husband] says 'Have a word with Felicity [the doctor] and see what she thinks' He hasn't been excluded from anything and if I need an injection and I can't do it or anything like that he is very good and he gets a bit uptight if we are going out to eat that I get the right foods. He would almost say 'Well it is better that you eat at home and then we will go out' and I say 'No I am not going to be brought to that point'.......

Mrs Colman (CHD F) had retired due to ill health - this will be discussed further later in this chapter - and routinely cooked for the family, including a grand-daughter who had come to stay for an indeterminate time. Her husband's involvement in meal preparation cannot be said to reflect a sense of responsibility for domestic tasks or for his wife's special diet:

Int: ....But you say your husband is still at work?

Mrs Colman: Yes he has still got another....well, he is a year younger that me. Oh no, he doesn't take over the kitchen

Int: Do you think he might when he retires?

Mrs Colman: No.

Int: He is not that interested?

Mrs Colman: No, he is not. It is only just if he feels like it or, as I say, if I don't happen to be here and he is in first or something like that, or my sister has come down and we have been out shopping and we will come home and he got it all ready for us.

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These four quotes were made by people from both conditions and represent two women and two men each with the condition. All were over fifty in age and all who had the condition were retired from employment, but in only one couple were both retired. One couple had children still living at home and one couple had a grandchild living in the home. Mrs Colman was the only one of these four who mentioned instances of her husband undertaking cooking and these suggested contingency or preference rather than routine duty. They did not seem to be the consequence of the introduction of her recommended diet, although a further quote later in this section shows the complex way in which couples can be seen to understand each other's roles and attitudes in the home.

The theme common to all (and reflecting the views of most couples who took part) is that the wives in these examples did not display (in these quotes, or elsewhere in the interviews) any expectations that changes might be made to well established clear cut gendered divisions to domestic tasks. In these four examples, the two women with the conditions managed their own dietary demands with the sympathy and concern of their spouses, but with little or no active input. In contrast the two men with the conditions relied upon the extensive intervention of their wives to ensure that they followed their diets. The few mild comments made by wives expressing a desire for change seemed to be made without real conviction of the potential for that change.

This is not to say that there were any male spouses in this study who did not show levels of sympathy and concern for their wives. Many of the men conformed to dietary changes introduced by their wives without complaint and also became knowledgeable about the content of the diet. (This knowledge often came into its own in the supermarket when checking labels and locating appropriate foodstuffs). This was, however, by no means all of the participants and rarely extended into regular, active and routine contributions to food tasks and meal preparation.

This somewhat passive form of support and concern could, in a few cases, be seen to develop into an almost free floating anxiety. This might be described as a form of 'caring about' which, when not actively linked to the more active form of 'caring for' has no avenue for resolution. In this study this was only found to be mentioned by women of their male partners, and not by men of their women partners. Mrs Rose has already been mentioned above as someone who took care of her own dietary needs. Her quote also shows a woman who was managing her husband's anxiety about her illness and dietary needs. The following two cases also show male partners of women with the condition, expressing this kind of concern about the potential health (or, more aptly, illness) of their wives.
Mrs Howson (CD F) has been quoted earlier in this chapter as someone who learned a traditional gender division in domestic tasks from her parents and carried these on in her own family. Now a widow, she was diagnosed with coeliac disease almost ten years earlier, and some considerable time before her husband developed heart disease. Their traditional division of domestic roles meant that he had never expected to become knowledgeable about diet, and, in fact, relied upon his wife to reassure him about her wellbeing:

Mrs Howson: {...} No I do keep absolutely strictly to the diet.

Int: And you say your husband was very keen on checking on things as well?

Mrs Howson: Oh yes, he was... Well he made me a bit embarrassed at times over his concerns

Int: Was this when you were out somewhere?

Mrs Howson: Yes. Sort of 'are you sure that was alright?' and I'd say 'Well yes, they say it is done with this and done with that so I can't sort of go through somebody's kitchen and see what they are doing so if they say it is alright then yes'. He was very much that wayy perhaps a little bit over the top sometimes, but that is just the way he is

And in the second interview

Mrs Howson:....Because if they are just ordinary people eating ordinary meals that is all they want to know. They don't want to know the fact that you have a special diet, and then they ask you why it costs so much. No but I mean the friends I go to are very good, I mean there is a lady whose husband... well, her husband and my husband knew one another at work and we have been friends for goodness knows how many years. Her husband died and mine died and we still meet up. I go and stay with her and she comes and stays with me and she has just accepted the diet as well. She knows it is Bovril cubes and not [***] so she will keep those there for you and she knows it is cornflour, as I told you before, if I didn't have cornflour in my kitchen I would be lost. She says 'I always keep my cornflour in that [***]' so she just copes normally with it and I don't have to worry.

Int: I can see from your expression that it obviously makes you feel... I mean apart from the fact that it is very convenient, it also makes you feel as though....

Mrs Howson: Yes, I am just normal. Exactly. I mean my husband was more sort of, well, just over the top a little bit.

Int: I remember you saying that he used to worry an awful lot. Why do you think that was?

Mrs Howson: He was protective of me, I don't know. And the fact that he thought, well now, I have got this and someone has got to take care of you and look after you.

Mrs Howson's desire to feel 'normal' created a tension with her husband's concern over her wellbeing, a concern which he seems to have felt was her responsibility to allay. The
interviews with Mrs Howson suggested that neither she nor her husband expected that any relaxation to their very clearly gendered divisions of tasks would take place. Her explanation that his concern was born out of a desire to protect points further towards the dilemma for a man whose desire to care was circumscribed by gendered location. (The notion of the kitchen as gendered territory will be examined in chapter six).

Mrs Colman (CHD F) has already been quoted earlier in this chapter in terms of her husband's lack of involvement in the day to day management of the consequences of the condition, including the diet. Mrs Colman had attempted to return to work after her heart attack but admitted that she had not felt fully fit since that event. Nevertheless, her decision to give up work completely also seems to have been strongly influenced by her husband's anxiety about her health:

_Int_: And I am assuming you were quite happy with that? [giving up paid work]

_Mrs Colman_: And especially after I had that first attack, well he nearly drove me up the wall to be quite honest, he was a bit like a mother hen, worrying about me.

_Int_: And did that involve wanting to take over things, do things for you?

_Mrs Colman_: Yes, Oh he would say 'sit down and I will do it'.

_Int_: So he was trying to do the cooking for you?

_Mrs Colman_: Yes, I suppose he was a bit worried that it would happen again

_Int_: So did you have to stop him?

_Mrs Colman_: Well first off it was lovely of course, I thought, Oh I like this, he can get on with it. But then after a while it gets on your nerves.

_Int_: Yes. If you are used to organising things it can be. You feel as though there is something missing.

_Mrs Colman_: Yes. But as I say, I haven't got the energy now that I used to have.....

{.....}

_Mrs Colman_: No. After that first attack he said 'that's it, no more'.

_Int_: Who, your husband?

_Mrs Colman_: Yes. He wouldn't let me go back to work.

_Int_: Did you mind that?

_Mrs Colman_: Well, at first I did, then afterwards I thought, well I suppose I am getting on a bit and it is hard to get a job and I did, I thought I know what I will do I will try cleaning, I have never done any before, apart from my own.
**Int:** Which is probably extremely well done

**Mrs Colman:** So I went out and started to... It was just hoovering, early morning cleaning, but then a couple of times I got this terrible pain and I think it was rushing around, the doctor said it was probably rushing around, so again, my husband said 'well that's it, pack it in, don't bother to go in anymore'. So I don't.

What is clear from this quote is the complex negotiation that goes on between gender role expectations and responses to the onset of unexpected and potentially terminal illness.

Unlike Mrs Howson, Mrs Colman had a husband who was prepared to make an attempt to 'care for' her. Being looked after in this way after her heart attack was, to begin with, attractive to Mrs Colman, but eventually came to be frustrating. This may well have been because her husband's activities in the kitchen came into conflict with her expectation that she should take charge of food tasks and so challenged the 'normality' of that family's life. At the same time Mrs Colman's own desire to continue in paid employment was overwhelmed by her concern about her own health, but finally decided by her husband's concern over her health status. These two examples, Mrs Howson and Mrs Colman, illustrate further the way that the women with the medical conditions were more likely to have to manage their male partners' anxiety about their wives health status.

In only one couple interviewed could there be detected major input from the male spouse over the introduction of the specific diet because of his wife's illness. This was a couple who were both in second marriages and had been together for just three years. Mrs Garside (CD F) described her husband's reaction to her illness and the diet with a sense of both acceptance and relief, and offers a vivid description of his active 'caring for', together with sensitive 'caring about':

**Int:** Was that something [preparing special food] that you did when you were first diagnosed or something that you are doing now

**Mrs Garside:** No. It is mainly Ian, he kind of takes over, he does the bread for me. Organises me.

{....}

**Int:** Yes. So then you met Ian and he is a keen cook.

**Mrs Garside:** Yes.

**Int:** So when you set up home with him did he start doing all cooking?

**Mrs Garside:** Yes, he took over

**Int:** And that was OK with you?
Mrs Garside: Yes. We have got a pattern, he does breakfast in the morning which is two small pieces of toast of this coeliac bread and scrambled egg, so I have got something substantial and with nutrients and without anything that would kind of over aggravate.

Int: And at the time you hadn't been diagnosed with colitis?

Mrs Garside: No.

Int: Although presumably you were [***]

Mrs Garside: Well it was mainly that he started doing this, I mean I would always perhaps... Well I would knock up a couple of pancakes for my breakfast so again I would take the easy option but when I got so ill at Christmas then he took over the breakfasts so that has been the pattern for the last six or seven months.

Int: But you have been married for about three years?

Mrs Garside: Yes.

Int: So you were doing your own breakfast before?

Mrs Garside: Yes, but he has taken over because he feels that he can keep... What he wants to do is to make sure that I am eating some kind of protein and he will stop me if he sees me going to the fridge and perhaps pigging out on something!

Int: So when you were first married was he still doing quite a lot of the cooking?

Mrs Garside: Oh he has always done the main cooking for the main meals. Probably I will do two or three meals a week and he will do the rest. He always cooks our Sunday meal.

{....}

Int: So you have never really felt interested in cooking?

Mrs Garside: No because I would like the men's side of things....

Mrs Garside had a history of undiagnosed symptoms since childhood which had an unsympathetic response from her father, as indicated by the quote earlier in this chapter. Her present husband had responded practically to her ill health in a number of ways, to the extent, two years earlier, of bypassing an unresponsive GP to ensure treatment for what turned out to be meningitis. However, it is clear from this quote and a number of other comments made in the interviews that this response was in keeping with the relationship the couple had developed from the outset. Mr Garside enjoyed cooking and had had training and considerable experience of catering earlier in his life when he was in the army. Mrs Garside, whilst recognising the notion of gendered territory, provides a justification for it's transgression. (This issue will be pursued further in chapter six) Thus, even in this unusual case, the pattern of responsibility remains true to two emerging themes - conventional assumptions about the
gendered nature of home and family (even when transgressed) and the desire to deal with change within the context of continuity and normality.

However, whilst it was rare to find spouses who did not sympathise in some way with their partners' dietary demands, the responsibility for making sure it was followed tended to rest with the female partner. This was regardless of the sex of the person with the condition. This was also despite noticeable differences in the way that many of the men and women who took part in the study reacted to the introduction of a special diet into the family practices. Awareness of what constituted the content of the diet was variable, whether the person with the condition was male or female, and was not dependent upon the sex of the person responsible for food and meals.

Mr Garside was not the only husband to undertake cooking tasks in families, most noticeable amongst those who where retired. Mr and Mrs Rice (CHD F), when they married 12 years earlier, agreed to reverse roles as a consequence of his retirement and her continued employment. She had since retired but her husband remained the person in charge of shopping and cooking. Her heart attack had highlighted her desire to make changes to her eating patterns but had not attracted the response she would have liked from her husband:

Int: .....So you are having to negotiate [with her husband] these changes in your diet {.....} the kind if diet you should follow, you had already taken a lot of that on board, like the dairy, like the fruit and vegetables, like the bran and stuff, and it is really the meat you are having to negotiate?

Mrs Rice: Yes. But it is OK because we can vary it a bit. But you know, that is John's realm I think and that is his role and I have to get over his feeling slightly hurt if I don't eat what he eats. But since I know that it would be good for him, if he didn't eat so much and because I certainly know it would be for me I am sticking to my guns a bit. But you see we do eat a lot of fruit and vegetables, we eat far too much almost, because we both eat too much and I suppose they say five helpings actually and we have far more than five.

Int: I don't suppose it does any harm, not when it comes to fruit and vegetables.

Mrs Rice: No. It is quite interesting the power struggles that go on......

Later

Mrs Rice: Yes well we always ate...Well of course it was easy because when my father finished work we finished, my father was a school teacher and school teaching was OK so we always had our meals together. But the Scots have this high tea so generally speaking we ate at lunch time and then we had a high tea rather than an evening meal. Now John has always eaten in the evening he says. So I found that difficult when we married because I had always eaten at lunch time.

Int: And as a school teacher it is not that difficult to do.
Mrs Rice: Well that's right, it was much easier and I didn't bother in the evening. I had work to do in the evening, so it didn't cut into the evening. But we eat at a quarter to six and neither of us likes eating late and we get desperate if we go to people's houses and they make us eat late.

Here and in other parts of the interviews Mrs Rice expressed her frustration over her desire to follow particular eating patterns, preferences to which her husband was less than sensitive. Nevertheless her reluctance to express this forcefully to her husband, or even state it clearly in the interview is very evident. It seemed that the need to maintain recognised patterns of responsibility and control within the relationship vied for priority with her desire to attend to her own dietary needs.

Summary

Mr and Mrs Garside and Mr and Mrs Rice were two of the more unusual examples of couples negotiating a path between relationship and health needs, in that both husbands had taken over responsibilities for food at the beginning of their marriage relationships. Despite this they have in common with other participants that, nevertheless, they illustrate beliefs about the gendered nature of care which can be seen to underpin the planning, preparation and monitoring of food and meals in the family setting. Most of the participants in this study tended to follow a conventionally gendered view of how domestic tasks should be allocated. Although there is evidence in this chapter, and those that follow, of circumstances where that convention has been overturned, usually temporarily, but sometimes permanently, this has tended to be on pragmatic grounds. Only Mr Garside has proved the exception by taking over the meal planning and preparation whilst he was in full time employment.

The chapter has shown the ways that relationships and roles are acted out through the everyday experiences, such as the family meal, providing the material context for social meanings. The participants represented in this chapter did not seem to question the way their family practices were organised in principle, other than to indicate dissatisfaction with specific difficulties, such as Mrs Hufton and her overactive son. The final section introduced the two aspects of caring which can be seen to be of particular significance to the family relationship. 'Caring for' and 'caring about' are shown to be manifested in ways in which gender is particularly significant. The family setting can be seen as one which was preserved through beliefs about it as an ongoing relationship with socially recognised characteristics to which all of the participants of this study, largely, conform, in spirit if not always in practice. A desire
to appear 'normal, stated explicitly by Mrs Howson, but implied by many of the other participants quoted in this chapter, seems to rely upon those beliefs.

The next chapter will continue to examine the processes by which the family is constituted and reconstituted through day to day activities. It will explore the gendered relationship that the women and men and their children had with food tasks and activities, paying attention to the active nature of this process, of not just 'being family' but 'doing family'.

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Chapter 6. Doing family - learning family

The previous chapter, using the family meal as a focus, showed how the caring that takes place within the family is constituted through necessary activities. The gendered nature of that caring becomes the main focus of this chapter, which demonstrates the processual nature of being in a family. The processes of organising and consuming food and meals act as the vehicle for issues as varied as responsibility, duty, personal identity, affection and togetherness. Much of the narrative through which the data were conveyed took the form of on-going lived experience, of doing those tasks and activities that constitute 'family'.

Gender identity can be seen to be acted out through family practices, in specific locations and across generations. In this study, women were, in most cases, assumed to be willing (by both the women and the men) to take on organising domestic tasks, and, usually, to undertake them as well. The close association made between women and caring responsibilities seems to underpin the decisions women make at strategic points of their lives. Certainly most of the women who took part in this study made decisions about their paid employment in the light of their relationships and parenting status.

None of the women who took part had remained in full time paid employment after the arrival of children (five had not had children). Some continued with or returned to part time employment after they had children. A few took up full time employment once their children became adults and two did so when they became single parents. None of the men in the study altered their full time employment when their children arrived. Many of the female participants confessed that their ambitions in life had been to be wives and mothers. Others spoke of employment that they enjoyed and were committed to, but which had to come second to the family, especially at the birth of children. Those who spoke of returning to work when the children were young described work which fitted round the needs of the children. Thus most of the female participants were disposed to adopting a conventional female role in the home. Of the five women who had not had children only one had adopted a complete role reversal arrangement with her husband. Of the other four two shared and two had taken full responsibility for the organisation of home and domestic tasks.

Thus section one: Women's work - being a wife, being a mother, provides rich evidence of the responsibilities undertaken by the women in this study, whilst section two: Men, food and cooking, describes choices that men were seen to be able to make. Both of these sections contribute examples of feelings about gender roles as well as examples of the ways they were
conducted. They convey a sense of being as well as the act of doing. The third and fourth sections: *The kitchen as territory* and *Transgressing territory*, examine the ways that location can demonstrate gender expectations about family practices through the notion of territory. The kitchen has already been referred to both explicitly and implicitly as a place within the home which can be construed as owned and as transgressed. This section draws attention specifically to the ways in which participants construed the kitchen as gendered territory. The final two sections: *Children and food* and *Food and families across generations*, look backwards at the attitudes and behaviour of participants' parents in childhood, and forward to expectations about and practices of participants' children as adults. This allows the process of continuity and change over generations to be highlighted.

This chapter continues an emphasis upon family practices, not just in terms of which tasks men and women tend to do, but also how this organising of the home was explained and understood by participants. The processes by which they understood their lives was embodied in the acting out of ordinary everyday tasks and pastimes. The data presented here continues to illustrate how the family relationship is maintained and evolved through the themes of 'gender' and 'normality', which thread through the course of this thesis. A complex interplay between past experience, current contingency and lifecourse change is revealed within an ongoing and stable idea of family relationship, whilst, at the same time, incorporating new and differing demands and beliefs over time.

*Women’s work - being a wife, being a mother*

Although a few participants purported to share meal preparation, and two participants had formally undertaken to reverse roles, all conveyed the view, directly or indirectly, that tasks within the home, including those related to food, were primarily 'women's work'. This was evident in comments about care responsibilities for spouses and for children. For example, Mrs Greig believed strongly that men should not have to prepare meals. She and her husband were both retired, but she had given up full time work when she had had their children, apart from periods of part time work. Mrs Greig, since her own and her husbands retirement, had continued to prepare their meals, attracting strong praise from her husband about her ability. Mr Greig had cooked when his wife was incapacitated and, now retired, contributes to the general housework, such as cleaning. However, his wife was very clear about her responsibility for food:

*Int: So do you still do the cooking Mary?*
Mrs Greig: Oh definitely yes. That is a woman's job.

Int: So that is your job?

Mrs Greig: It always has been Susan, he has never had to cook himself unless I have been laid up or in hospital. I look after him, don't I?

Mr Greig: Oh yes.

Int: And you have obviously never fancied cooking?

Mr Greig: I can cook. When Mary has been to hospital either having a baby or whatever, and there has been me here with the other kids, or when you went in for two weeks with the prolapse and whatnot, I have cooked.

Mrs Greig: Yes, and when I have had the 'flu and been in bed you have.

Mr Greig: Yes, I can cook. Simple food.

Mrs Greig: And the housework. We share the housework. I do the dusting and he does the hoovering.

Int: Well, I suppose that is exercise as well isn't it?

Mrs Greig: That day I let him off because you know he does all the hoovering, so I figure that is enough exercise. He is sweating by the time he has done that.

Mr Greig: Like the whole house!

Because food and meals are imbued with significant meanings, from love, affection, to femininity (Furst 1991, DeVault 1991, Mennell et al 1992), it is, perhaps, not surprising that Mrs Greig had maintained her sole responsibility for these. Of less significance in terms of role seemed to be the housework, which they both seemed happy for Mr Greig to start doing. Nevertheless it is clear from the quote, that the domain of the home was seen, by both of them, as Mrs Greig's responsibility to organise. In this family, beliefs about gender roles within the home have been understood on very clear traditional lines. The motives behind these actions could be construed as love, affection or concern for Mr Greig by his wife. Mrs Greig might be said to be 'caring about' through her 'caring for' activities. However, this arrangement might also be interpreted as a way of creating and maintaining an environment recognisable as a family relationship within which gendered roles were clearly identifiable.

Mrs Jamson (CD F) expressed beliefs about the roles that she and her husband took within her family in terms of not just what they should do, but also why within the context of their relationship as a family:

Int: So he had learned how to cook from his Mum?

Mrs Jamson: Yes.
Int: So he knew how to boil an egg and all that?

Mrs Jamson: Oh yes. If ever I was ill, which was many times, he often used to cook a meal for himself and the boys and Charlotte.

Int: So when you were first married you learned how to cook from him. And were you working full time at the time as well?

Mrs Jamson: Yes.

Int: But did you feel that you needed to do the cooking? Even though he knew how to cook and you didn't?

Mrs Jamson: Oh yes. I loved my home. I am always.. I am a homemaker you see and I like to be in charge.

Int: You like to be in charge of the home?

Mrs Jamson: Yes I do.

Int: So he showed you how to cook things?

Mrs Jamson: Yes, but for his tastes really, and as I say, he was a meat and vegs man.

Int: So when you came into the marriage were there things that you would have cooked had he liked them but they were different?

Mrs Jamson: Yes. Oh yes. I wanted to please him and I have always done that, all through my married life I wanted to please him. So whatever he would have, if I could cook it or not I would just try it until I got it right.

Mrs Jamson, now a widow, had been very happily married and regretted not being able to have many children. (She had experienced a number of miscarriages and one very difficult live birth and eventually they had adopted two children). What is interesting, in this and in other comments made in interviews with Mrs Jamson, is not just that she felt she should do all of the cooking unless she was too ill to do so, but also the way in which she explains this preference. She saw herself as 'a homemaker' who wanted to please her husband, in this specific example, through food. She saw her identity as 'homemaker' within the context of an ongoing family relationship which draws upon conventional gendered role assumptions.

Mrs Greig, mentioned earlier as someone who clearly identified cooking as 'women's work', was described by her husband as deciding upon an evening meal routine which was right for her husband, even when she worked in the evening:

Mr Greig: The other thing is, if I knocked off at 6 o'clock, I would always phone Mary if I was working on late without knowing. I would phone her from work and tell her. If not, I knocked off at 6 o'clock every night, I would come home and wash my hands and sit down at my meal, every night without fail. That was Mary's idea. I
never had to wait, she was always here for my dinner. When you weren't working that was. What did we do when you were working?

Mrs Greig: Good God, I can't remember. I should think it must have been ready and all you had to do was heat it up or something like that. I don't believe in men having to cook for themselves, not when there is...

Mr Greig: Didn't I knock off at five thirty, which is the right hour to knock off?

Mrs Greig: Actually I think that was it. Tony did finish early so I could get him a meal before I went out in the evening

In this one quote is encapsulated a gendered relationship which sets out the responsibilities expected by and of both wife and husband - providing a meal at a specific time, being home from paid work at a predictable time - as well as the shared relationship demonstrated by the activity of eating together.

In fact many participants tended to demonstrate rather than state their relationships. Their understandings of the appropriateness of gendered behaviour emerged through how they explained or accepted both exceptions from or conforming to gendered conventions. For example, Mrs March, in describing her husband's (in her view unusual) active involvement in the caring of their son when a baby: 'He used to bath Graham, well, men didn't used to do that, but Len did. He enjoyed bathing Graham. He used to say, "I don't know how you cope". Despite his involvement in childcare this did not move it out of the category of 'women's work', which she went on to describe as 'a continuous thing'. Mrs Smythe (CD F) commented: 'I think women are much better at thinking about several different things at once. It seems to me that if he does occasionally cook a meal the whole house has got to be cleared of every other distraction. Much more hard work than just going out and doing it'.

Many participants brought in a sense of continuity and inheritance when explaining their choices over domestic tasks. Mrs Brigson, had clear views on how domestic tasks should be divided and went on to say: 'Oh yes, I would say it was my job, the same as Mum always said it was her job...' Whilst Mrs Howson commented: 'Well I suppose the way we were brought up we always felt it was the women's job'.

The examples offered so far in this section have been positive and would probably be seen as appropriate by the participants themselves. However, even within the families which revealed, to a greater or lesser extent, conflict and dissatisfaction, the pressure to conform to gender expectations also seemed to be strong. Mr and Mrs Morton (CHD M) seemed to have lived a
very traditional life together. Mr Morton described his expectation that his wife should stay at home with the children:

*Int:* So when you first got married the assumption was that your wife would do the cooking.

*Morten:* Yes.

*Int:* Was she working?

*Morten:* She was working obviously before we got married and she was working.. I mean she got pregnant straight away really. We got married in the May and we had the first boy in the following May, the girl in the following May and then a three year gap, then a boy and a three year gap and a girl. But she basically did not work. It was my wish that she didn't work until I think the youngest one went to [name] school, the school round the corner and she was the headmaster's secretary, so that worked out quite well. So she had her on school holidays and she came and she went with her. So that was... I am pretty certain that was her first job after the children. So she was probably out of work for probably 15 years.

*Int:* But was that 15 years before she got part-time work?

*Morten:* Yes, that was a part-time job actually. I didn't want my children to be latch key children you see. So they all had someone here when they came home.

Listening to his description of his own childhood revealed a similar way of life to the kind that he expected for his own family:

*Morten:* Yes, I have got two brothers, both younger that me and we had a ... I mean my father was a doctor, he was a GP, and we basically had quite a normal happy family life. My mother did all the cooking. I don't think my mother ever worked in her life. She married at 16 and had me when she was 17.

*Int:* Oh quite young then, and her career was looking after the family?

*Morten:* Basically yes. And you know in those days you didn't have those GP clinics, it was just the sole practice and she was the sort of receptionist I suppose.

*Int:* Oh right, so she did work in as much that she helped in the family business, so to speak?

*Morten:* Yes.

*Int:* And she managed looking after the children and cooking meals and things around that?

*Morten:* Yes.

Mr Morton's strong view that women's work of caring for their children allowed him to avoid recognition of his mother's role as his father's receptionist, and to see the 'normal happy family life' of his childhood as having a non 'working' mother.
Mrs Morton's contribution to the first interview was very limited. She seemed very reserved, apart from a rather strong comment about her family's expectation that she do all the cooking which came across as angry and frustrated. In the light of what followed, it seemed that these two people were finding it increasingly difficult to accommodate differing notions of family relationships. When Mr Morton telephoned, in between interviews, to say that his wife had left him, it was shocking, but it was tempting to see this as the product of a context in which an agreed 'normality' had not be achieved.

A similar example is Mr and Mrs Jolson (CD M), who remain married, but under conditions of long standing difficulties. These Mrs Jolson strongly identified with the illness with which her husband was eventually diagnosed. Despite the disintegration of their relationship described by Mrs Jolson, she took upon herself major responsibility for ensuring her husband conformed to the new diet. When asked to talk about her own and her husband's parents she described the latter as follows: [husband's father] *Didn't know how to boil an egg and didn't expect to know how to boil an egg and mother wouldn't have expected him to know how to boil an egg*. In contrast, she saw her own family as being *'lovey, touchy feely people'*, and compared this with her husband's family which she described as follows:

*Mrs Jolson:* ...*But his parents really weren't*

*Int:* *They weren't communicators?*

*Mrs Jolson:* No. Not at all. His father was also domineering, but bossy and aggressive and domineering. He was always right. A woman's place was in the home. My mother in law has never worked.

*Int:* *Ever?*

*Mrs Jolson:* No. Never. She adored my husband, he was spoiled rotten, he didn't have to do anything either, he didn't have to look for anything, certainly didn't have to wash up or do anything else around the house...

Whilst the anger felt by Mrs Jolson over her relationship with her husband may well have coloured her perspective, what is also evident is the legacy of gendered expectations in the home which both she and her husband had inherited.

The responsibility for the care of children, as indicated in the Morton quote above, was also frequently expressed within the context of traditional gendered expectations. A sense of appropriate role responsibility in the family relationship could be detected in the following case of role reversal. When Mr Cotton (CHD M) had been pressured by his employer to retire after his heart surgery, he and his wife decided to make radical changes to their lifestyle. Mrs Cotton developed the part-time employment that she had begun when their children reached
their teens into full-time work, whilst Mr Cotton experimented with baking as well as providing regular meals. His descriptions of how he and his wife came to this arrangement showed a background with a very traditional division of family responsibilities until following them was challenged and so became impossible.

Int: So you would still come and collect her [from work], so the two of you would arrive home at the same time most of the time, and so, before you retired, has much changed in terms of who did what in the kitchen?

Mr Cotton: Yes, she used to cook most of the time. We had a method of... When we had children we thought that Sandra's place was at home with the children. And, in effect, the job she has now, my youngest daughter - she is 26 - she had the job first, and after I retired, we decided that she should take over. She manages [the shop] now and loves every minute. So for a long time for a period in her life she was at home.

and in the second interview:

Int: So your children ate at school?

Mr Cotton: Yes

Mrs Cotton: No they didn't - Do you know I can't remember!

Mr Cotton: Yes, but you were at home with the children?

Mrs Cotton: Yes, when we had the children I didn't go to work at all then. No, not till Jo was 13 or 14. Because I remember asking her and she said 'Oh no, you do it!'. Because she had done her GCSEs.

Mr Cotton: I think it was a conscious decision that someone ought to be there

This decision to reverse roles took place despite a long relationship which had operated on a traditional assumption about who should care for the children. Earlier in their marriage Mrs Cotton had given up a job in a bank (in which she had risen to supervisor) in order to care for their children.

Mrs Batley spoke of what she tried to do when her husband worked very long shifts and was rarely able to join the family for meals: 'You just worked round it. I mean as far as possible I suppose when the children were at home I tried to keep their days as normal as possible because I suppose my husband and I...it was our job to bring up the children and they were the ones who should be the least inconvenienced'. Mrs Garside described bringing up her son on her own after her first marriage ended: '...I got a job where I worked from home, so I didn't neglect him. I could pick him up and take him to school. I didn't get the best wages but...!'
Mrs Batley and Mrs Garside had tried to organise their lives for the convenience of the family, in order to promote a sense of continuity and normality. This reflects a theme which continues to run through the examples presented so far in this chapter and resonates throughout this study. The power of traditional gendered assumptions about 'women's work', when examined within the context of family practices, rests with the very ordinariness of the pragmatic and the everyday.

• **Men, food and cooking**

Throughout this study the close association between women and work in the home will be repeated again and again. This was most frequently reflected in the responsibilities the women in the family saw as theirs, as indicated in the last section. It was also evident where location - specifically the kitchen - was seen as territory, examined in detail in the next two sections, but foreshadowed here, where men's involvement in cooking is discussed. A few couples described sharing the cooking, particularly when the man no longer worked full time due to illness or retirement. However, many of the participants described men who actively set themselves outside tasks related to cooking, or those to whom cooking was never considered. Mr Watten (CHDM), for example, when directly asked whether he had ever thought of cooking responded: 'Well no. I suppose I didn't fancy it. Pat never complained when she was doing it'.

The men who were routinely involved with cooking - in contrast to those who took over in times of crisis - were more likely to give the reason of 'enjoyment'. For example, Mr and Mrs Flow (CDM) described their arrangements since his retirement:

**Int:** So you started when you came back off holiday and from what I can gather there isn't a traditional division of labour in the house that you have?

**Mr Flow:** No. It is reversed. My wife does the gardening and I do the cooking.

**Int:** Has that always been the case?

**Mr Flow:** No.

**Mrs Flow:** Oh no I always did the cooking and the gardening! It is just since Norman has retired. He loves cooking and I am not a great lover of cooking.

**Mr Flow:** Well if it is cakes or anything I bake, I do that. But I prepare the meal and normally Lorna cooks it.

**Mrs Flow:** Norman prepares it and I actually cook the meal.
Int: That is a pretty good arrangement isn’t it. Is cooking something you have always liked doing or is it something you have just learned as a consequence of retirement.

Mr Flow: No I have always like cooking but of course I never had the time before and I used to come in and the meal was there and already done. I might of helped out on a Sunday and do the vegetables sort of thing, prepare it on a Sunday when I was at home. But the last job I had at ASDA I was sometimes working on a Sunday.

It should, however, be noted that Mrs Flow had not completely given up her part in meal preparation, even though they both present the cooking as a task that Mr Flow has taken over.

When asked about the way their parents organised domestic tasks, many reported a very rigid division of labour, but a few reflected that the opportunities for their fathers to become involved in cooking were limited for reasons other than choice. Mrs Royle (CHD M) looking back on her childhood concluded that her father did not have an opportunity to cook in a house full of women, but also described his rather self indulgent contribution to the weekend meals:

And at weekends he always scraped the potatoes if they were new ones, or peeled them, he used to go and sit in the garden and do it. And he would cut up the beans as though they had been sliced with an open razor, they were so finely done, and slowly I might tell you! I mean, the average woman would have had the meal prepared, cooked and everything while he was slicing the beans. But they were beautifully done.

Nevertheless, she and her husband (both officially retired but Mrs Royle had continued with a part time job), recalled their own family life as one in which cooking was enjoyed by both and entertaining meals were central. In contrast to Mr and Mrs Flow, they both saw their married life as one of equality of action and endeavour:

Int: You say you both enjoy cooking, have you always... I mean, I am assuming you share the cooking?

Mrs Royle: Yes, he does more than I do because I am still working you see, but before that I probably did more, but very often at weekends he would cook.

Int: Has this always been the case from the word go?

Mr Royle: Yes always.

Mrs Royle: Yes, I am just trying to think back, because when we lived in India you didn’t do so much.

Mr Royle: No, because you were not working.

Mrs Royle: No, I was not working and I had the children and also there was domestic help as well.

Mr Royle: You had help as well.
Mrs Royle: But certainly in the last... how many years have you cooked for?..I mean your cooking has increased even more since you have retired, obviously, but before that he did cook quite a lot.

Mr Royle: We share everything in the house, ironing, putting clothes on the line.

Int: Really. I am impressed!

Mrs Royle: Yes, he is very good. Excellent.

Mr Royle: Dusting and hoovering.

Int: Yes.

Mr Royle: Mopping the kitchen floor.

This exchange shows attention to the notion of equity but reflects the sense of fluidity - as remembered and as lived - in terms of how domestic tasks were construed as shared over time. The interplay between lifecourse events and gender conventions is particularly resonant in this quote. This seemingly egalitarian couple reveal gendered assumptions about childcare as non-work, as well as differing constructions of the value of male and female input to domestic tasks. By this I mean the considerable praise offered by Mrs Royle about how good her husband was to undertake household tasks, both in this quote and in other parts of the interview. Thus, whilst the notion of equal sharing was clearly seen as relevant, it can also be seen that it tended to be the woman in the home who was the default to whom responsibility would revert.

Nevertheless a few participants, whilst not questioning traditional gendered domestic tasks per se, commented on (often with surprise) instances that contradicted these views. For example the two following quotes show two participants commenting on relatives who did not conform to conventional gendered traditions:

Mrs Appsen (CD M), mentioned in the previous chapter as a wife who took responsibility for the cooking, even though her husband was retired and she was still in paid work, commented: Yes certainly Vicky, our eldest daughter has got a boyfriend and they share a house and Neil does as much cooking as Vicky, if not more.

Mrs Conley, when describing being taught to cook for her husband by her mother in law (this will be described in more detail later in this chapter) compared herself to her sister in law:

Int: So she was very keen to make sure her daughters in law knew?

Mrs Conley: That's right. Yes. One of us does, that's me, and one of us wasn't interested! Well you are either interested in cooking or you are not and that is it.
And my sister in law has never been interested, but they are still married and they are still happy, so...

*Int*: It isn't necessary is it? It is just that it can become something that symbolises...

*Mrs Conley*: Well it has because that is all I wanted to do, was to get married and have children and look after my husband. I mean that was my role in life at the time. I have changed a bit since then.

The examples so far have illustrated the belief that work in the home was 'women's work' which these participants endorsed through their beliefs and behaviour. Men's experiences of cooking and meal preparation can be seen to be contingent rather than routine, such as upon retirement. Even when domestic tasks were said to be shared throughout the marriage, such as Mr and Mrs Royle, the sharing had been subject to Mr Royle's work outside the home and defaulted to become Mrs Royle's responsibility whilst caring for their children. The gendering of roles in the home can be seen to be constituted out of what women and men do, and what they do not do as members of the family (West and Zimmerman 1991, Gregory 1997).

The kitchen as territory

The previous sections have shown how the participants in this study tended to see tasks in the home, especially those to do with food and meals, as most appropriately allocated on gender lines. This division could, of course, be seen as a very practical allocation, particularly at the point in the family lifecourse when the women chose, or were expected, to work in the home caring for their children. Nevertheless this understanding seems to have gone beyond the identification of tasks as male or female. The notion of gendered territory conjures up, not just activities which were 'women's work' or 'men's work', but locations within the home which were female or male 'domains'. Whether conforming to or infringing these territorial boundaries, the participants conveyed their beliefs about the gendered nature of their family relationships within the concrete setting of the home. The quotes that follow are intended to illustrate the range of ways that participants, both male and female, construed specifically the kitchen as 'female territory'. In most cases these gendered boundaries were adhered to, especially by men. However, in a number of homes, the kitchen was carefully guarded by the women. For example Mrs Brigson's husband had tried some cooking in the early days of their marriage, but Mrs Brigson (CD F) had reasons for discouraging him from doing so:

*Int*: .... I have got the impression your husband didn't do any cooking?
Mrs Brigson: No Bert didn't. He did used to cook fish some nights, when we first got married and I went to work, on the Friday nights he would cook fish. Oh he used to make a terrible mess though and I think that got to me so much that I thought 'Oh forget it'.

Int: So he sort of tried?

Mrs Brigson: Oh yes he did try, yes. On one occasion I had 'flu really bad, I was just in bed and that was it. And I can remember he said 'I will cook some pork chops', and I am trying to call out to him how to do it, you know. He wasn't all that clever at cooking, he was quite a nice gardener, a very good gardener, he grew vegetables.

However there were many layered reasons for this arrangement, as is evident from a comment made later by Mrs Brigson which suggests an additional social sanction to tidiness:

Mrs Brigson: No. No. Bert never did anything. Oh no. We often now, my sister, because she is a widow as well, and we often say what the husbands do now to what ours did then, of course it was lowering you see, in those days, for the man to cook.

This is the most explicit quote from a female participant to suggest that the status of 'maleness' for men can be seen to be as important to preserve for wives as for the men themselves.

An indicator of territorial boundaries could be detected through the use of the term 'not interfering' by a number of participants illustrated by the following two quotes. The first is from Mrs Abel (CHD M) who can be seen here to be taking responsibility for failing to encourage her husband to become involved with cooking when they first married:

Mrs Abel: We weren't married until I was 46 and I did two years [of full time employment] I think and then there was a bit of a sort out at the university and I was put on half-time, but for the first two years, yes, we had an evening meal, we took our sandwiches with us for mid-day and that was it.

Int: And was it you that did the cooking?

Mrs Abel: Yes. But mind you if I said will you stir the gravy he would stir it.

Int: He could take instructions?

Mrs Abel: Yes, but looking back I think it was partly my fault, he said he didn't want to interfere. He had... well, when he was 15 he went into the navy and stayed there for 18 years, so he didn't really have any...

Int: Didn't have much experience?

Mrs Abel: No, they did cooking and laundry work in the Navy, but the sort of day to day things, no he hadn't much experience of it....

Unlike Mrs Abel, Mrs Rose (CD F) found taking responsibility for her own condition unproblematic, as was made clear in the quote from her in chapter five. The following repeats
part of that quote, and draws attention to the way that 'not interfering' as an explanation for her husband's non-involvement again illustrates the notion of territory within which she and her husband operated:

*Mrs Rose:* ...But when he arrived [at the hospital] and said he had come to pick me up she said 'Can you hang on because the dietician is coming'. .....  
*Int:* Do you think that was useful having him there when they were talking to you?  
*Mrs Rose:* Not really (laughter) He is very good, very supportive towards me, but as long as I am coping with things he feels OK. He doesn't interfere, he feels I know much better than him. If I say 'What do you think?' [he says] 'Well I suppose...' sort of thing. 'But you are the best one'....

Both Mrs Abel and Mrs Rose had husbands who saw food and meals surrounded by a boundary that they preferred not to cross. As women they had both taken on the role of being responsible for food and meals with no attempts at alternative arrangements. The onset of illness can be seen to have caused some disruption to both their lives. However the ways they each expressed themselves indicated considerable differences in how they felt about the arrangements. Mrs Rose relished carrying the total responsibility of her home and her medical conditions, whilst Mrs Abel found it a heavy weight to shoulder. Mrs Rose was managing her own illnesses, had had a lifetime of medical conditions to deal with, and had a very supportive husband. Mrs Abel was trying to manage her husband's medical condition, and did not have a great deal of co-operation from him.

Like Mrs Rose and her husband, two other couples were very clear about the notion of territory as a domain over which they expected total control. Mrs Calman (CHD M) will be mentioned in chapter eight as a wife who had taken responsibility for making sure her husband's symptoms were diagnosed, as well as monitoring his health. Here she describes how, during the course of her first marriage, her concern over orderliness in the home had reached almost obsessive levels, which her children, once they became adults, could tease her about. Her current marriage, she suggested was very different. Nevertheless territory remained an issue, and fortunately her new partner agreed:

*Mrs Calman:* Yes. And then I met John about two or three years later and I moved in with him and John was totally different. Totally, totally different. The kitchen cupboard wasn't for food or saucepans, it was for his tools!  
*Int:* And how did you deal with that?  
*Mrs Calman:* Well, obviously, we said we have got to accept that the kitchen is a woman's place...  
*Int:* Had he lived on his own before that?
Mrs Calman: Yes, for a couple of years so he was very good in that respect. Because my children warned him what I was like and he said 'I want help with it' and I think we both changed. Give and take on both sides.

Mr and Mrs Unwin (CD M) were in their seventies and had been retired for some years. Mr Unwin had been diagnosed with coeliac disease only four years earlier, but had concluded that he had probably had the condition for most of his life in a mild form. What is particularly interesting about this couple is that they were both professional caterers running restaurants when they were in paid employment, travelling across the world together in that capacity, even when they had young children:

Int: You have obviously worked together in terms of your employment, your cooking, has this been the same at home, have you shared?

Mrs Unwin: Oh yes.

Mr U: Yes, although I wouldn't dare go in the kitchen now. She is the boss there.

Int: Really. You are the boss in the kitchen are you?

Mr Unwin: She will ask me to do something and I will do it, but I would never interfere.

Int: That is your wife's domain is it?

Mr Unwin: She is in charge.

Int: Has that always been the case?

Mrs Unwin. Yes.

It would seem that, despite Mr Unwin's expertise in meal preparation and their professional life working together, within the home responsibility for cooking took on a different meaning. This arrangement makes an important statement about the home setting as socially significant in terms of their understanding of gendered identity. Not only did Mrs Unwin expect to be in charge of the kitchen in their home, but Mr Unwin saw this as quite normal.

Perhaps because of the nature of this enquiry, there has been an emphasis upon the identification of women with the kitchen as a location, and food and meal preparation as a task. The notion of 'male territory' arose to a lesser degree, but in a form and context which, although flexible, conditional and multilayered, also endorsed the idea that gendered tasks represent territory, whether conformed to or transgressed. For example Mrs Garside (CD F) was quoted in chapter five as someone who has always preferred 'the men's side of things', whilst the following quote from Mrs Clarke (CD M) shows how she and her husband had come to a satisfactory agreement on the domestic tasks they should undertake:
Mrs Clarke: Steve can, yes, but he doesn't. He says 'No you do that bit, I will do the decorating and the gardening and the cleaning of the cars, you stick to the cooking and ironing and the washing'. Which is fine by me.

In fact, there were just a few cases where the actual food task itself was identified as a 'male' task, in comparison to others which were seen as 'female' food tasks. A favourite 'male' food task was the care of the barbeque and other outdoor activities which involved food preparation. Mrs Clarke (CD M) shows here how, notwithstanding her responsibility for food and meals inside the home, cooking outdoors was seen by both of them as a legitimate task for her husband:

Mrs Clarke: He can cook but he can only do one thing at a time and the children despair of him. Yes, he can cook. Very basic things. He will heat the beans and then he'd put the toast on half an hour later. No that is being unkind, he would hit me! He takes them camping and he is pretty good when they are camping.

and in the second interview

Mrs Clarke: ...I mean Steve is not into preparing the food at all.

Int: He hasn't expressed an interest in it?

Mrs Clarke: No. If he goes camping and takes the children, which they have done over the years, him and his brothers, then he will be chief cook, chief organiser if needs be. He would rather not be but he will do it if I am not there, so invariably it tends to be men only and the children, so it's wonderful, we get let off the hook. But he is capable of cooking. When we camped when we were young, when we were first married we would go camping, Steve would invariably cook then. But put him in the kitchen and...

Int: There is something about outdoors, men and outdoors, like barbecues, a male thing somehow.

Mrs Clarke: Yes, he will cook the barbecues, I don't want to get involved, it is not my scene.

Int: Why is that?

Mrs Clarke: I leave it to him.

Int: Is it because you are not keen on barbecues?

Mrs Clarke: No. I think it is for him, it is his domain. I will do all the jacket potatoes and preparation of the salads and lay it out, but no, that's it.

Where women saw themselves, or were seen by the rest of the family, as primarily responsible for food, this seems to have been taken as a given, rather than requiring an explanation, unlike cases where the male family members undertook meal preparation. The
latter tended to attract a clear practical reason, such as role reversal or wives' incapacity. In a few cases the explanation was because they enjoyed it, not because they felt they ought to undertake this role routinely. For example Mr Flow (CD M) was mentioned earlier as having taken over most of the meal preparation after he retired, because he had always wanted to do so.

The next example, although rather lengthy, provides an interesting exemplar for the perspectives mentioned so far in this section. Mr and Mrs Watten (CHD M) were both in their sixties and retired. Mr Watten had had minor heart 'events' for a number of years before a full blown heart attack followed by heart surgery 18 months before the interview. Mr Watten's attitude followed a traditional gendered view which his wife also followed with only mild comment about the potential for him to start cooking. Within the two quotes that follow Mr Watten evokes the notion of 'non-interference' in gendered territory, the idea that certain food tasks might require 'male' elbow grease, but also undertakes specific food tasks that he particularly enjoys:

*Int:* So do you do any cooking at all?

*Mr Watten:* Basically no. I can scramble eggs and things like that

*Int:* I mean if you had to cater for yourself?

*Mr Watten:* If I had to cater for myself it would probably be all microwaved stuff.

*Int:* Well I suppose nowadays there is an awful lot of choice isn't there. You can just go across to the supermarket and collect....

*Mr Watten:* Probably you could buy it about as cheap as it would be if you make it up from scratch.

*Int:* I am not entirely sure about that but I guess...

*Mr Watten:* No...looks good in the package, it's true and we can all be conned by the pretty picture in the front. If Pat is choosing something we look at the picture and I think it looks awful, but we will try it. You can never tell until you actually try it.

*Int:* That's true. Very true. But it is very convenient especially with microwaves. It takes no time at all.

*Mr Watten:* Yes. Speed and how easy it is. [to wife arriving with tray of tea] I have been asked how I would get on if I was cooking for myself.

*Mrs Watten:* Oh dear!

*Mr Watten:* I said I think I would be a microwave merchant

*Int:* It isn't something you have felt inclined to much, cooking?
Mr Watten: No. It was something I was quite happy to leave for Pat to do.

[discussion about tea]

Int: So you are usually in charge of the cooking?

Mrs Watten: Yes.

Int: Is it something you like doing?

Mrs Watten: No.

Mr Watten: She wouldn't like me interfering.

Mrs Watten: Well, if you want to cook we will see what we can do.

Mr Watten: Would you?

Int: I think it is quite interesting because....

Mr Watten: I put the icing on the cake.

Int: Do you really?

Mr Watten: Yes and the marzipan an all that. And decorate, I love going round with the old squeezy bag.

Int: It is not easy that.

Mr Watten: I like that. I have got a turntable for it. A Nut Brown turntable so I can turn it round.

and in the second interview

Int: So tell me, I know traditionally that if women are at home looking after the family and generally doing stuff at home the opportunities for men to get involved in sort of cooking are less, but they vary in terms of the level to which they want to, is that something that you got involved in at all?

Mr Watten: Not really. Not on a regular basis. There isn't much I can do. I can boil a very good egg [to wife] can't I?

Mrs Watten: I wouldn't know!

Mr Watten: Well I can tell you I can. But it is not much better than that. Alright I can scramble eggs, when I used to get up early when I was younger to go out fishing and I used to come down and cereal, so I can pour a mean bowl of cornflakes.

{......}

Mr Watten: That's the time to catch them really [talking about night fishing] Many is the time I used to pack up at 9am in the morning. But yes, I used to get up on those occasions to grill a rasher or scramble an egg, but I think if I was left to my own devices I would probably be using that microwave.
Int: Yes, it is very useful. But back in the old days when they didn't have microwaves, did you do much then?

Mr Watten: No.

Int: It wasn't something you fancied?

Mr Watten: Well no. I suppose I didn't fancy it. Pat never complained when she was doing it.

Mrs Watten: He only ever cooked a dinner once and that was when we were in a caravan and I had Asian 'flu.

Mr Watten: It was so bad you thought that was the last thing I would ever cook. She has been healthy ever since!

Mrs Watten: I can't remember what it was but that was the only time he has ever cooked dinner.

Mr Watten: Do you know I can't even remember doing that.

Mrs Watten: I think it was mashed potato and something.

Mr Watten: I mean where there is a need I think that is what people do. No, I don't have a great involvement out there. I will go out there and wash up. Or give Pat a break and she will dry when I am out there. And you know some of these stubborn things you can't move, I am better at putting a bit more elbow grease on it, put my weight on it a bit more and I can get that off and between us it seems to work out alright.

Int: I find some men start taking an interest in the kitchen when they retire.

Mr Watten: Yes well I love helping with beating up the Christmas cake and dressing the Christmas cake, icing it and marzipanning it and doing the decorative stuff.

Int: Yes I remember you saying. Is that your artistic talent coming out.

Mr Watten: Yes it probably is, yes. Writing Merry Christmas on it. It is like a giant hypodermic needle that we have got out there, it is not one of those bags that we use, it is probably easier with those bags, but there is this thing like you see in the comics when they say 'this one will hurt a bit' and boom, a great big thing. And if you knock the stuff up too thick it can be a job to squeeze out because it is almost solid and you are trying to get a solid mass out of the end. But it is fun. I enjoy that.

Int: So when birthdays come along do you do it then?

Mr Watten: I have done one or two cakes.

Mrs Watten: Sometimes he will mash the potatoes up. He loves mashed potatoes like water.

Mr Watten: Oh yes, I insist on it. I like creamed potatoes.

Int: You don't like lumps in it?
Mr Watten: No, I certainly don't. I bash it through and through and again and again until it is really creamed up.

This mutual (or rarely challenged) agreement about divisions of labour and gendered territory in the home maintained recognisable and constant family relationships through the roles adopted and acted out on a daily basis. These examples have shown the different ways that participants have demonstrated a sense of gendered territory within the home and family. Some were quite explicit, using terms such as 'domain' and 'territory'. Others implied gendered location often through how tasks were conducted, such as 'not interfering' in the kitchen and leaving the men to see to the barbecue. What is interesting is the mutual agreement which seems to take place over gendered tasks and territory. Mrs Garside presents one of the few women interested in 'male' tasks, such as tinkering with the car, whilst her husband has almost totally taken over food and meal tasks. These were not a couple who saw tasks or territory as neutral, that is, not gendered. They were a couple who saw the tasks as gendered, but had found a legitimacy in not conforming to gender expectations. Mr Garside's authority over the kitchen was rooted, partly in his prior expertise in catering, and also in the role of 'looking after' his wife because of her illness. This couple were unusual, not in overturning conventional ideas about gendered caring, but by the ways in which they managed to circumvent those conventions in practical day to day domestic arrangements, whilst leaving intact the fundamental idea of caring as gendered.

- Transgressing territory

The territorial boundaries suggested in the preceding section could, in fact, be seen to be breached in most of the participants' family relationships but this tended to be contained within specific parameters. Thus, when wives were ill, or having the children, or caring for significant others, a husband might take over tasks in the kitchen, often under supervision. This change was usually time-limited and, when the time became overdue, problems could arise.

Mr and Mrs Bain (CD M) were both in paid employment (Mr Bain in full time and Mrs Bain in part time) and Mr Bain had been diagnosed just fourteen months earlier opportunistically through a non-related medical problem. His wife had worked in the home caring for their children when they were young and remained the person in charge of the home. Mr Bain, a methodical man who had kept detailed records of the progress of the diagnosis of a number of health problems he had experienced, was knowledgeable about the requirements of his diet, but relied upon his wife to control the practical day to day aspects within the home. His
experience with the Scouts ('We had to cook for them all. As individual Patrol Seconds we cooked on our own fires...') had not influenced his culinary activities in the home, unless his wife was incapacitated:

Mr Bain: Oh yes. I mean from time to time I do get some cooking done. I probably haven't done as much as I could have done but equally one...

Mrs Bain: Equally you wouldn't starve would you? If for some reason I couldn't do it you would.

Mr Bain: Well, I think the famous time when your Dad was ill and… well you had done the preparatory work in terms of buying the food but...

Mrs Bain: Yes, that was Christmas time too.

Mr Bain: I and the kids did the Christmas dinner, when Nicky was ten.

Int: And did you go off and look after your Dad?

Mrs Bain: Well he died so I had to... I went off because he was so ill and they weren't expecting him to survive

Many of the men who took over the cooking when their wives/female partners were unavailable or incapacitated, did so under some kind of guidance or supervision, as can also be noted in some previous quotes. For example, Mr and Mrs Henson (CD F) were both in employment (Mr Henson in full time and Mrs Henson in part time) without children. Mrs Henson had always assumed that she would take responsibility for food, as her mother had before her and offered guidance to her partner when necessary:

Int: So yes, who does all the cooking, or is it something that you share.

Mrs Henson: No. I do it. But Alan does a bit.

Mr Henson: I did it for a month, just over a month, she went to Ireland for a month. So I used to ring up every night!

Int: Oh right. So you are... This is your domain?

Mrs Henson: The kitchen is, yes. But he will cook if I am not there if I tell him what to do.

Mrs Conley (CD M) seems to have been equally patient over the preparatory work she had to put in to allow her husband to 'cook' his own meal when she was out at work:

Int: So what happens in the evening? You are obviously here first?

Mrs Conley: Yes, normally. Sometimes I work at night, I am working tonight actually and in that case I will leave his meal he can cook his own potatoes with it.

Int: Has he ever done much cooking?
Mrs Conley: Yes because... Now, why was he cooking his meals? Oh, that's right, I was working at the Post Office in the evenings a few years back, but that was before he was diagnosed and so he was coming in and cooking and he got quite good at things like lamb chops. I would prepare it but he would come in and cook it. Because you can't have casseroles every night and I was working every night then.

Int: Yes. But even with casseroles you have to plan ahead.

Mrs Conley: Yes. He could manage if he really had to, I am sure.

Int: I get the impression that most men could manage.

Mrs Conley: Yes he could manage. And he does his share now, I mean if ever I am ill he could cook his own meal, as long as I have told him where things are! And he is not one for going and getting a take-away or anything, but of course he can't now anyhow.

However, Mrs Clarke (CD M) showed less patience over having to guide her husband through his catering role when their children were born. She also reveals her husband's preference for doing domestic work which might be described as 'male tasks', a perspective mentioned in the last section:

Int: So when you had your babies what happened then? Did he prepare for himself?

Mrs Clarke: Yes he did. Yes he had a week off after Martin was born and I think it was a bit of a case like 'what Mum had to go through', when Dad was cooking for her, it wasn't bad and he did do it. As long as he could rush up the stairs and say 'what number do I put such and such on?'

Int: So you were sort of leading from...

Mrs Clarke: Yes, I would explain things. It didn't last that long, thank goodness.

Int: But it is quite interesting that a lot of men will say 'Oh I could do it if I had to'

Mrs Clarke: Steve can, yes, but he doesn't. He says 'No you do that bit, I will do the decorating and the gardening and the cleaning of the cars, you stick to the cooking and ironing and the washing'. Which is fine by me.

A number of other participants asserted that meal preparation was shared, but what this actually meant was not always very clear. The arrangement that Mr and Mrs Howard (CHD M) had come to emerged during the interview via a banter which involved the twisting and turning of sarcasm, teasing and protest which, for conciseness, has not been reproduced in full in the following quote:

Int: So you do your shopping together, you go to the shops once a week together. What about the cooking, do you share that?

Mrs Howard: Mostly me.
Int: You do the cooking?

Mr Howard: I give in to her, she is a good cook.

{........}

Int: So what do you do, when you say you share the cooking, does that mean you do it together or you take turns?

Mrs Howard: Take turns.

Int: Right.

Mrs Howard: Sometimes we take turns, sometimes...

Mr Howard: [She] keeps me in the kitchen!

{.....}

Int: So you take turns, how does that work out? Do you have particular days you do it?

{.....}

Mrs Howard: No. If he is up he will make the breakfast, if I am up I will make the breakfast.

Mr Howard: There is no hassle.

{....}

Mrs Howard: So anyhow, like at dinner time we make a sandwich, but I don't know, if he wants a sandwich he will say 'do you want a sandwich?' and go and make one.

{.....}

Int: And then you have a cooked meal in the evening?

Mrs Howard: Yes, about five.

{.....}

Mrs Howard: You see if I have gone round to my friends and he will cook the dinner, then I will tell him what to do, although he will say to me 'what do you want?'

Mr Howard: I like cooking

Int: [ to Mr H] Is this something you have been able to do more of since you have been off work?

Mrs Howard: Oh yes.

Int: Or is this something you have always wanted to do?

Mr Howard: I have always done it. More now since I have been off work
The Howards and the Royles (quoted in the section on men, food and cooking) were the only two couples who did not convey a clear cut notion of gendered tasks or territory, when interviewed. The notion of 'shared' has been seen to be a contested term (VanEvery 1997), which can have differing implications of equity. There were only a few, in this study, who claimed to 'share' and, this often came about through specific events triggering a change, such as illness or retirement.

Mr Howard's culinary activities were couched in terms of preference, rather than responsibility, but may have been contingent upon his employment status. He was still recovering from heart surgery and had only just started making enquiries about finding new employment. Further comments on the distinction between preference and routine responsibility will be made later in this section.

The cases where the couple had chosen to role reverse might be described as the least conforming to a traditionally gendered division of domestic labour. Nevertheless, these cases had, in some ways, followed a conventional path through family life until specific events triggered a decision to change. For example, Mr (CHD M) and Mrs Cotton's description of their role reversal was introduced earlier in the chapter. In their early marriage, before the children arrived, they both worked full time '...and the first one in was to get the dinner, start the dinner'. When they came to reverse roles, Mr Cotton did not see taking over from his wife in this respect as a radical change because he '...had always dabbled' and also recalled a childhood where '...my Mum used to teach us in the old days. How to do things, making pastry...'. Thus a bridge was built between past and present to explain and minimise the level of change, in terms of gender, that had taken place.

The notion of territory is one which has emerged both explicitly and implicitly throughout this study. Mrs Garside was described earlier and in chapter five as the only participant who could be said to have a husband who actively took responsibility for her health and her diet. When explaining why she was happy to relinquish the cooking tasks in the home, she evoked the notion of territory:

Mrs Garside: No, because I would like the men's side of things. I would go out and play with the cars with the boys you see. So I have never felt that kind of territorial kind of situation. And of course being on my own I would quite often have to go out and mend the car on my own, you know. I don't mind them infringing onto our territory.

What is of interest here is that, as described above, whilst experiencing the transgression of conventional gender boundaries by preferring 'the men's side of things', Mrs Garside at the same time endorses the existence of gendered 'territory':

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In comparison to the Garsides, Mrs Batley (CHD F) evoked the notion of the kitchen as territory when she described a need for a form of compromise, as a consequence of the changes that took place when she had her heart attack:

*Mrs Batley: I think we went through a sort of slightly peculiar phase because this heart attack came at the same time as my husband retiring and that has actually caused one or two problems. So we have, now I am more than happy to share my kitchen, but he tended to start thinking it was his kitchen because he tends to take charge, and so we have now come to quite a good arrangement where we tend to take it sort of alternate days more or less.*

It was rare for participants to claim that tasks remained shared and equal continually throughout the lifecourse of the family relationship. For example Mr and Mrs Cotton (CHD M) mentioned above. Also, Mrs Rice (CHD F) who betrayed a wistfulness when she regretted her lack of access to the cooking arrangements now that she was retired:

*Int: But who did the cooking?*

*Mrs Rice: I was coming home at a quarter to seven at night [before her retirement] and I could have eaten at lunch time but I had to eat at night*

*Int: Oh, of course, at school?*

*Mrs Rice: Yes at school. But I had to eat at night because it was the social thing to do*

*Int: So he was doing the cooking?*

*Mrs Rice: He was cooking the evening meals except when my brother came for weekends which he did in the first years of our marriage, when I felt it was my responsibility. I just went berserk [in trying to ensure a good work pension] because I had undertaken - I had gone to a boarding school because I had - well it is a long story, but I wanted to work as hard as I could to have as high a salary as I could before I retired.........So I went to [school], which is up the road.......very pressurised but that meant working Saturday morning, being on call to go on other things for the rest of the weekend, coming home sometimes at quarter to seven, going to collect my brother from the station at weekends and then coming home. Oh it was - well, my husband really had taken over the cooking and he likes doing it, so it was something he could do.*

*Int: So does he still do that now?*

*Mrs Rice: Yes I would say he does - and then of course I have had various illnesses you see, I have had the business of the leg, I had a hysterectomy, I had the glandular fever, I had the heart attack, and he enjoys taking over and doing it really. I mean I do lots of other things and he likes cooking rather than being cooked for.*

*Int: Oh, right, that sounds wonderful to me*
Mrs Rice: It is a kind of little element of caring that you rather miss, because I enjoyed doing that for my brother, but he doesn't like - he likes the roles reversed in that respect. It is quite convenient so I just give up

Int: Sounds brilliant. I would love it

Mrs Rice: But I have my role because I do the pudding and he does the main course.

Mrs Rice had relinquished her cooking role (which she had undertaken for herself and her mother and brother) for practical reasons when she was first married only twelve years earlier. Now retired she regretted the absence of the caring aspect of cooking and meal preparation which she was aware of when she cooked for her family members. Mr Rice, although he had not been allowed to cook by his first wife, had, in fact, begun to do so in that marriage, after his retirement which he decided to do in order to nurse his wife through her final illness.

This case seems to describe circumstances which go beyond merely justifying the transgression of conventional family roles. Mrs Rice had, in the past, been able to indulge her 'little element of caring' when catering for her mother and her brother. Although now retired and more in a position to undertake this role, she did not feel able to because of the role reversal established when she was first married. This, despite the fact that her husband's choice of food was not her own.

Mr and Mrs Burrell (CHD M) had lead a conventional life dividing up the household tasks on gender lines until his heart attack.

Int: But you didn't start doing any cooking yourself at this time?

Mr Burrell: No. Not that I couldn't if I was pushed to but....

Int: It isn't your thing?

Mr Burrell: It sort of lays to one another to do... I do certain things, although she is encroaching on my territory more now!

Mrs Burrell: I do woodwork.

Mr Burrell: But she tends to get a bit over worried at times and says 'you shouldn't be doing this' or 'don't you think you have done enough?'

The ways in which the fundamental nature of these gendered boundaries remained unchallenged is perhaps best illustrated through one of the occasions where a level of disruption was, in fact, acknowledged, and (unsuccessfully) tackled. Mrs Nayme (CD M) was in full time employment, as was her husband. She was a forthright woman who had been very frustrated by the responsibility thrust upon her by her husband's diagnosis with coeliac disease two years earlier. Their children were adult and had left home for
employment or higher education, but had returned to live at home, one with a partner. Mrs Nayme had expressed the view that she should no longer be expected to prepare meals for a house full of adults. She described her attempt to institute a rota for meal preparation which all family members had agreed to follow. The lack of success of the rota she initially attributed to the lack of respect paid to it by family members. However, examining the narrative reveals a complicated mixture of disrespect for the agreement, practical routine and notions of responsibility:

_Int:_ Well you said you started a rota for a while?

_Mrs Nayme:_ We did, yes. No, it didn't last very long. I think it probably lasted about four months. They used to tell me what they were cooking and I used to buy the food. I was terribly frustrated by that.

_Int:_ Really?

_Mrs Nayme:_ Oh gosh I hated it. Stand there all the time and...

_Int:_ In what way?

_Mrs Nayme:_ Well I had to absent myself otherwise I would hover and say 'shall I do that?', 'do you want me to do this?'

_Int:_ Why do you think that was?

_Mrs Nayme:_ I don't know. It probably used to drive them mad. And then - by that time we did have things where Martin would forget and it was his turn to do it and he would sort of say in the morning 'Oh I have got a parents evening so I can't do it'. It got too messy. If they forgot to say something we were sort of left there thinking what are we going to eat tonight, so we gave it up in the end. No, I wasn't very good at standing by.

_Int:_ Well if you are used to being the person who co-ordinates things.....I have heard women say that when their husbands retire they start taking an interest in the kitchen....you know, suddenly the man seems to think it is their territory

_Mrs Nayme:_ Funnily enough that doesn't bother me at all. Quite often David will do something, quite often on a Saturday, 'I guess it's time' he will say 'Oh I will try and do something tonight'. No I find that quite nice. I am quite happy with that, apart from the 'where is this? 'where is that?' because he doesn't know where the stuff is kept. But I think, probably in the evenings, I don't know whether it was just speed or, you know how you are used to doing something every single day so therefore there is a speed at which you work, because they weren't used to it they were so slow.

_Int:_ And if you get into a routine of coming home from work and launching into doing a particular thing?

_Mrs Nayme:_ You are bereft of what to do yourself

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Int: In a few cases when that has happened to me and someone else has taken over I don't know what to do with myself

Mrs Nayme: Exactly. I found it really difficult to think of, well, what shall I go and do, here I am, my hour has gone. I had this time and didn't know what to do, yes, very true.

Mrs Nayme had recognised the unfairness of her situation and had tried to equalise it. It will, however, be noted that this had not stretched to a rota for shopping as well as one for cooking. Nor had she accounted for the lack of practical experience of others in the family, or their lack of commitment to the agreement. More importantly, she had not been able to resist the call of her own expertise and her own sense of responsibility.

The examples presented in this section show traditionally gendered division of domestic tasks set aside, temporarily or permanently, as a consequence of specific events which intruded into the existing organisation of family relationships. The smoothness with which these changes were accommodated varied considerably and some suggested the need for ongoing negotiation. Whilst the gendered nature of the tasks was rarely explicitly referred to, the explanations for how they were organised and re-organised revealed clearly gendered implications.

• *Children and food*

This chapter has shown the complexity with which the roles, responsibilities and relationships were assumed, negotiated and understood within the home by the participants of this study. The nature and form of the family and the family relationship, were maintained as a coherent and distinct entity through everyday family activities. Because the interviews focused upon diagnosis of an adult in the family, and because food and meal preparation tasks, as a general rule, tended to be undertaken by adults in the family, the activities of children in this area were not routinely touched upon. In fact there were only a few participant families who had children in the home at the time of the interviews. Nevertheless, the influence of the presence of children was evident in many of the comments made by most participants who had had children. 'Doing family' also meant 'learning family' in different ways at different points in time. It became evident that there was often an ambivalent period where children, as they became adult, began, in different ways, to take on responsibilities for themselves and sometimes other family members.
The gendered nature of cooking undertaken by adult children in the home was far less clear in terms of concrete daily activities, but more evident in terms of beliefs, opinions or sanctions. None of the families in this study had children who routinely and regularly undertook meal preparation for the whole family. Two of Mr and Mrs Appsen's (CD M) daughters were in a transition period in terms of leaving home. One of them had become a vegetarian and occasionally cooked for the whole family, but not routinely.

[Int: How many children do you have?]

Mrs Appsen: Three. Three daughters.

[Int: And they are no longer at home?]

Mrs Appsen: Well, two are on the door step...

[Int: They come and go?]

Mr Appsen: They sleep here

Mrs Appsen: Occasionally. Well, they go away and they come back again.

[Int: So when they come back is it you who does the cooking?]

Mrs Appsen: Yes.

[Int: Is it always you?]

Mrs Appsen: Normally. But Nancy, our youngest daughter, is a vegetarian, so she is very good and she cooks very well, and of course the food she cooks is suitable for Roger.

Mrs Legston's (CHD M) daughter, when she had lived at home, also came and went at unpredictable times and preferred different food, so started to cook for herself:

Mrs Legston: Yes. Now Amanda is away now, but she was cooking for herself and I gave up cooking for her because I didn't cook the right things. But now we are into pasta and all that sort of thing, I am copying her recipes!

[Int: This was before she left home, she started cooking for her own food?]

Mrs Legston: Yes, because she came in at different times and we would perhaps have had ours at lunch time and I never really knew and once she was working in London, you didn't really know what time. And she would have it out sometimes and I said 'well, you just do it'.

Two families, the Lawtons (CD F) and the Marstons (CHD M), had sons who had started to prepare their own food because their choice varied from that preferred by their parents, but did not cook for their parents. Mrs Lawton, commenting on her husband's lack of interest in cooking, compared it to that of her son, particularly once having left home:
Int: ...I can't remember how much we talked about how much your family have got involved in the cooking?

Mrs Lawton: Well not at all. My husband never cooks anything. Well, he can boil himself a couple of eggs and do himself some bread and butter to go with it, but no, he can't cook anything and he won't. He won't. He won't learn. He doesn't want to know.

Int: Which means food has really been very much your responsibility all the way along the line.

Mrs Lawton: Yes. He has never peeled a potato, never ever. And yet he was in the Army for a while and I always thought they learned cooking there, but no he doesn't do any cooking at all.

Int: You sound as though it would be quite pleasant if other people in the family did get involved with the cooking?

Mrs Lawton: Yes. Yes. But no, they can cook if they want to, they can get themselves very simple meals, you know.

Int: Is this your children?

Mrs Lawton: Yes. And my eldest son, he has lived on his own for about 12 years and he does cook, he will do anything. He did A level Home Economics, so he was quite good anyway, he would make Christmas cakes and all sorts of things.

Int: That must have been nice.

Mrs Lawton: Yes, he was very good at it. I mean I am not saying he would cook a meal for all of us, but if he had to he could do it. He is vegetarian now.

{.....}

Int: And your youngest son is still at home?

Mrs Lawton: Yes.

Int: Does he do any?

Mrs Lawton: Not really. He could do himself say chips and something, but not a proper meal, I don’t think he has ever attempted to do anything like that. But he is. If he is hungry he will get himself something to eat, if you know what I mean? He would perhaps get himself beans on toast or something.

In comparison, Mrs Marston complained that her son was willing to prepare meals for himself when he lived at home, but not to clear up afterwards. Mrs Nayme’s (CD M) attempt at instituting a cooking rota has been examined in detail earlier in this chapter.

Family policy literature (Bernardes 1987) has suggested that, within families, there are social and political expectations about the roles and activities of all members of families, even
children. The participants in this study seem to have had different rules for children as they progressed to adulthood. Although there were a few participants who stressed the importance for young people, both male and female, to be equipped with knowledge of food and nutrition, in fact expectations about such activities within the family home came across as ambivalent. In other words, parents encouraged their children to learn how to cook, but they rarely encouraged them to take a direct responsibility to contribute routinely to family meal preparation. The only instance that seems to have taken place - Mrs Nayme and her rota - was singularly unsuccessful.

Opinions and sanctions were more likely to be expressed by parents about the way their children organised their own homes after leaving the parental home and particularly once they have entered family-type relationships of their own. For example, Mrs Batley (CHD F) said that she was pleasantly surprised to note that her daughter had decided not to return to work after the birth of her daughter.

*Int:* Is your daughter out at work?

*Mrs Batley:* No.

*Int:* She is at home?

*Mrs Batley:* Which I was pleasantly surprised over because she did go to university and she is fully trained and she has done lots of extra training, another degree, and I had a feeling that it might be a case of straight back to work, she was certainly talking along those lines, but once she saw the colour of Bethany’s eyes, that was it and she said ’No, not me’.

In contrast, Mrs Tayte (CHD M), who felt strongly that women should be responsible for family health, compared her daughter-in-law unfavourably with herself over tackling her son’s weight problems:

*Mrs Tayte:* ....And Andrew, well.. he has got a weight problems. He was so nice when he got married.

*Int:* Yes I think you did tell me a bit about that.

*Mrs Tayte:* It is my daughter-in-law really, isn't it. It is him having to eat...Well... I don't know whether he has too or not but you can't take sandwiches on tubes, especially in hot weather, you can't be travelling and taking chicken sandwiches in a tube and on a train and then when he gets to work he hasn't got a fridge. They have a canteen there you see.

*Int:* So he eats in the canteen?

*Mrs Tayte:* And I think he makes up for what he doesn't like... She is not that great a cook my daughter-in-law. Sometimes she is better than others. Andrew is very into
food I am afraid is Andrew. But you can get him into the right food. You know he
has put a bit on before, but he has never been like he is now.

Here approval from Mrs Tayte was contingent upon, not just daughter-in-law doing the
cooking, but also ensuring that this resulted in her son's improved weight.

Children entering adulthood within the parental home can be seen as crossing boundaries
which seem to become blurred when it comes to what parents can expect of them. Mrs
Conley described her own early marriage which was spent living in her parents' home for a
period. The evening meal routine, instigated by her mother, was that, once her parents had
finished their meal, her mother shepherded her father out of the kitchen to make way for her
daughter to prepare a meal for her new husband. '....she would say [to her husband] "come
on Jim, out you go, Gill's got to cook their dinner, Roy's dinner. {....} They divided their
house for us and everything so we had our own space'. The rite of passage of marriage
seems to have legitimised Mrs Conley's rights to the kitchen in her mother's eyes, whilst also
endorsing the gendered nature of meal provision.

The socialisation of children, as discussed in chapter five, for many, meant ensuring that they
learn to behave 'properly', but also implied an appropriateness associated with gender, age
and marriage status, amongst other things. The examples described above represent the
ambivalent location adult children occupy in the parental home until they have achieved a
status other than of 'child'. Again, it would seem that the practical needs of the moment
resolved the tension between the kitchen as territory and the adult child as autonomous.

- Food and families across generations

Beliefs, opinions and sanctions, expressed through descriptions of family activities, also
revealed the interplay between generations of gendered assumptions about family practices.
Within this small study, whilst traditions seemed to have changed and evolved over time, there
was evidence of fundamental values about the nature of the home and family which remained
constant. The notion of family relationship as a combination of territorial location, role
identity and gendered responsibilities seemed to transcend the practicalities and the preferences
of the day to day which might challenge it. Thus more than one participant spoke of mothers
who did not really like cooking and yet considered, as in Mrs Nayme's (CD M) case, the
kitchen to be 'sacred' to herself.

There were many participants who described childhood where there was a very rigid
demarcation between fathers' and mothers' roles. For example, Mrs March (CHD F)
described her father as follows: '...Nothing in the house did he get involved with. Purely he was the provider...' and, indeed, also mentioned that her grandfather would have 'gone straight through the roof' if he had been expected to help out in the house. Being 'the provider' in both generations of Mrs March's family included keeping a comprehensive garden and allotment which had supplied the family with vegetables and fruit throughout the year. How Mrs March and her own husband would have organised their home is not known because Mr March died when their son was very young. However, her son, now married, had moved to greater participation in the home: '...he makes a lovely sponge'.

Mrs Henson (CD F) recalled her own farming childhood as one of 10 brothers and sisters who were encouraged to become involved with household and farming tasks, but remembers that her brothers were exempted from meal preparation tasks.

*Int:* So you had to help. Did you help with the preparation of the food?

*Mrs Henson:* Well, we did actually cook the dinner when we were kids, not too young. When we were back from school we were able to do our own cooking.

*Int:* You were already able to cook?

*Mrs Henson:* Yes.

*Int:* So this was something your Mum made a point of doing?

*Mrs Henson:* Yes, we would cook or change the baby's nappies, we used to have to change the nappies, wash the baby, wash the nappies. It was just handed down, we didn't realise.

*Int:* {...} But what you are saying is that from the community you came from it was expected?

*Mrs Henson:* Well, the men were exempt. My brothers were exempt. They didn't do anything in the kitchen, they did things in the house. The girls had to do it and yet the girls had to go out [on the farm] and help as well!

*Int:* So there was a difference?

*Mrs Henson:* There was a difference in the boys.

*Int:* So the lads could get away with not knowing how to cook?

*Mrs Henson:* Yes they could.

*Int:* I think it is changing now.

*Mrs Henson:* It is changing now, one of my brothers is a fantastic cook. They cook if they have to, they have to cook now so they have to cook for themselves or they have to go out and eat.
Mr Bain (CHD M) commented that his father had no need to cook with so many girls in the home (wife and three daughters) and reveals much about the traditions that continue within Mr Bain's own home (see earlier in this chapter).

A few participants made direct comparisons between their parents traditions and those that they themselves operated in their own families: Mrs Conley (CD M) reported that, unlike herself, her mother was not territorial about her kitchen: 'No Mum wasn't like that because I can remember milling round her while she was cooking. No I couldn't, I hate anybody milling around' (In this her mother seems unusual, with far more participants describing parents with strict ideas about gendered household tasks)

Mrs Brigson (CD F), mentioned earlier as someone whose husband had attempted to try cooking early in their marriage, compared herself to her mother: 'Oh yes, I would say it was my job, the same as Mum always said it was her job, but Dad did a bit. He had to when Mum kept breaking things and was in hospital so many times...'

Mr Scruton (CHD M) had very strong feelings about the value of handed down family tradition:

Mr Scruton: .... I mean you do as your parents have done before you, you don't really know of any other way to do it. You might hear of strange goings on in other families, but I mean the way you do it is the right way always as a young person really. I mean I know there is a certain amount of rebellion among the teenage people and all of the rest of it and I suppose there will always be, but the old established ways are usually the ways that you follow on.

Nevertheless, Mr Scruton's wife made sure that their sons learned to cook: 'Well, Peter could never cook, he had trouble even knowing what to do if I had to go into hospital or something, so I thought the boys are not going to be like that'.

Two cases stand out as striking examples of how the rules of the kitchen were passed directly from mother(-in-law) to daughter(-in-law):

Mrs Conley (CD M) was shown earlier in this chapter as someone whose husband rarely had to cater for himself. It emerged that she was carefully schooled in catering for his tastes by her mother in law:

Mrs Conley: Yes. My mother-in-law has taught me a lot as well with cooking.

Int: Oh right, she was a keen cook?

Mrs Conley: Yes she was a very keen cook. She still is... Well, she can't do a lot now but she is very proud. She was another one that her kitchen was her domain. But she
did teach me because I had to learn to do things how Roy liked them didn't I? Very domineering lady she was.

Int: So she had some notion of how her son should be...

Mrs Conley: Everything had to be done completely and how I had to look after him.

Int: Was this before or after you got married?

Mrs Conley: Before and after!

Mrs Clarke (CD M), also mentioned earlier in this chapter, as a woman who was very concerned to keep her husband to his special diet in a family where the division of domestic tasks was strictly gendered. In the second interview she revealed a strong dependence upon learning from a previous generation:

Mrs Clarke: .... Yes his Mum was excellent with the food and, like my Mum, we always used to go round there once we were married and everybody would be fed up to their eyeballs, yes, lovely, very much so. So I felt that I had a bit of a standard to live up to and I am sure I don't live up to it totally, but yes, I was aware that my Mum always provided a good dinner and so did his Mum and I learned plenty from both mums. Obviously I learned from his Mum what he liked and she showed me the way she cooked things, the way Steve liked it you know.

Both Mrs Conley and Mrs Clarke had a strong sense of family togetherness and, in their different ways, a desire to cater for the needs of the family, both generally, and in the light of their husbands' illnesses. This clearly included inheriting responsibilities formulated by parents

Summary

The influence across generations was very evident in most of the interviews, with many of the participants explaining their own family's traditions in relation to their parent's traditions. Many saw the past as a criterion for the present, as with Mr Scruton's view that 'the old established ways are usually the ways that you follow'. Others, such as Mrs Scruton, whilst not challenging the status quo for her own relationship, determined that this would not be the case for their two sons, 'I thought the boys are not going to be like that'. Change over time, or over generation, developed through the negotiation of everyday tasks, unless as a consequence of major life events, such as retirement or illness, which provided a form of legitimacy for that change.
This chapter has shown how being part of a family is created and maintained through the everyday activities which identify and locate the roles family members adopt. Women in particular can be seen to be constructing the family relationship through their caring roles. From making sure the evening meal is on the table when husbands get home from work, to teaching daughters-in-law the 'proper' food husbands should be cooked, the women in this study can be seen to be 'doing family' and 'learning family'. Nevertheless, the role of men in this study cannot simply be explained by an absence from the undertaking of domestic activities. Whilst this was the case for a number of participants, with men noticeably absent from the kitchen, in many there were less conventional arrangements in evidence or had developed over time. The process of 'doing family' can be seen to have attracted different qualities and characteristics at different points over the course of the family relationship. Thus whilst 'doing family' might mean 'not interfering' in the kitchen at one point, there was the possibility that it might move to 'doing the cooking' at another point, as the consequence of childbirth or retirement.
Chapter 7. The 'special diet' - learned and lived

The previous two chapters have, by focusing mainly upon the data which represent the ways in which the participants organised their everyday lives, provided a backdrop against which the experience of illness can be examined. Mention of the illness has not been absent, but has not yet been central to the aim of the discussion, which has been to understand the nature of the setting within which 'biographical disruption' may take place (Bury 1982, 1991) The discussion of the literature noted an absence of attention to the interaction between the meaning of family as context and the illness experience. The analysis of these data has identified an interplay between how participants understood family practices as an ongoing and meaningful process and the ways in which they chose to construe and respond to the diagnosis of illness. This chapter and the one that follows will place the illness experience centre stage to examine the means by which the illness and one of its consequences, the diet, are absorbed and understood. This process was usually expressed in terms of practical application, but, at the same time, revealed beliefs about family practices and relationships which shaped and coloured attitudes towards and strategies for the accommodation of the new diet.

This chapter is made up of four sections which illustrate the range of ways that participants responded to the new diet. Section one: Gendering advice - going to the dietitian, shows that, from the outset, views about caring in relation to illness, especially over food and meals, have gendered foundations. Those who offered formal dietary advice and those who received it disclosed clear gendered assumptions about who would be responsible for knowing about the dietary requirements of the illness, and, inevitably, who would be expected to ensure it's compliance. Section two: The special diet as a joint project, describes strategies by which participants could be seen to construe the diet as a joint responsibility, regardless of who actually undertook the tasks in question. It foreshadows issues of togetherness and advocacy which follow in the next two sections. Section three: Advocacy, food and illness, reports on the way that, in some cases, the responsibility for caring took the form of acting on behalf of the person with the condition, to enable them to follow the diet. This process, in the home, could be managed with a subtlety which did not draw attention to work done to achieve it, but, when conducted in public, demonstrated powerfully 'caring for' and 'caring about'. The final section: Food and meals as indulgence and togetherness, returns to the sense of togetherness discussed in chapter five and gives an indication of the tension between the desire to retain family food conventions and the constraints of the diet.
• Gendering advice - going to the dietitian

When participants were asked about how they found out about the dietary requirements of the condition, it was usual to hear that formal advice was offered directly to the person with the illness. Spouses were not, in all cases, routinely invited to accompany the person, in order to have the opportunity to become equally informed. The process of referral to a dietitian seems to have differed between specialists, between doctors and between the medical conditions. The CD group tended to be referred to the dietitian in the hospital and usually quite swiftly, but this was not always the case. There was far more variability in the CHD group, in terms of information offered, if any, about diet, and by whom.

Expectations about who needed to know about the special diet, as well as who should make sure it was followed, could be seen to reflect gendered assumptions at the outset of diagnosis. These assumptions could be gleaned from descriptions of how the dietary advice was offered and received. What is of interest to this study is how the responses to the referral to the dietitian reflected a gendered understanding about responsibility for caring. The following four examples illustrate ways in which the process of consulting the dietitian demonstrated fundamental assumptions about the gendered nature of caring for the health of family members.

Mrs Smythe (CD F) was mentioned in chapter five as someone who liked to monitor her family's activities through ordinary everyday activities such as family meals. She and her husband had both been diagnosed with diet related illnesses. Mr Smythe had developed heart disease five years previously, whilst Mrs Smythe had been diagnosed with coeliac disease just three months prior to the interview, after many years of discomfort:

*Int:* Did he [her husband] come with you to the dietitian [about her own diet] at all?

*Mrs Smythe:* No he didn't come to the dietitian, he came with me when I went for the biopsy. Actually I felt pretty bad but he[**]. No he came for those. No, he is very matter of fact and [says] 'Oh well just get on with it!'

Later when discussing her husband's heart problems:

*Int:* And they suggested that it would be a good idea for him to pay attention to his diet?

*Mrs Smythe:* At that time. Yes. They were quite firm about it.

*Int:* This was in the hospital?

*Mrs Smythe:* Yes in the hospital
Int: Did he see a dietitian then?

Mrs Smythe: Yes he did. Well he saw her just afterwards

Int: Right. But before he came home?

Mrs Smythe: Yes

Int: Did you go and see her as well?

Mrs Smythe: Yes, I went along as well.

Int: You went along at the same time?

Mrs Smythe: Yes. They asked me to go because I was the one who prepared most of the food.

It seemed clear that Mrs Smythe did not feel it was essential for her husband to attend the dietitian with her to find out about her special diet. Nevertheless, she does not seem to have questioned the expectation that she accompany her husband to the dietitian to find out about his dietary needs.

Another couple who had to deal with more than one condition between them were Mr and Mrs Abel. Mrs Abel (CHD M) had been diagnosed with diabetes a few years before her husband developed heart disease. When asked about consulting the dietitian the following quote shows the way this couple negotiated responsibility for both of their diets within the context a very clear gender division of domestic tasks:

Int: Did your husband ever come in with you?

Mrs Abel: He came the first time because he took me [by car] and then I went [alone] after that.

Int: Did he come in to see the dietitian?

Mrs Abel: Oh yes.

Int: So he got a chance to hear what she said. {....} I am assuming in your case, you do the cooking?

Mrs Abel: Oh yes.

Int: But it is useful to my mind for the other members of the family to actually find out what is going on, but that doesn't always happen?

Mrs Abel: Oh no, he is quite supportive of this, when it really comes to the crunch he is quite supportive. No, he came the first time and then, well just now he has got the same dietitian. He came back and I said 'Enough of this, you will go up to the dietitian'. So I made an appointment and I went with him the first time and now he goes by himself.
Mrs Abel: No, he didn't see one at the hospital. He definitely didn't, but he had been given a leaflet and said 'This is what I should have' and I said 'We have already got two of those' and I got them out 'Oh' he says! I said that basically he had got to have the same as I did and he would have to watch the sugar in his coffee. He said 'You are nagging me' and I was. So I think I was thinking if he went to the dietitian then he would hear what he had got to have from someone else outside the family. He would just query anything....

In this case, Mr Abel may have accompanied his wife to the dietitian, but he does not seem to have felt he needed to know in detail about her or his own dietary requirements. Indeed, following a diet at all does not seem to have been an issue for him, despite his illness, until his wife made an appointment for him to see the dietitian and insisted that he attend, in the hope that he might respond to that authority. Unless his wife had instigated this it seems unlikely that he would have acknowledged the significance of the diet for his condition.

Dietitians did not always insist upon spouses accompanying the patient, and a number of participants explained their presence as just to keep the patient company. Mr and Mrs Legston (CHD M) went to see the dietitian together after Mr Legston's heart attack resulted in a spell in hospital. However, since then it had been Mrs Legston who had been monitoring her husband's health signs and Mrs Legston who had taken responsibility for monitoring his progress and liaising with the health professionals:

Int: ...because you thought it might be useful going to see her [the dietitian]?

Mrs Legston: Yes.

Int: Is this something that you planned to do some time ago?

Mrs Legston: No, really when you came and I thought, well yes, his cholesterol has gone up so I will go and see what I can do.

Int: Was this at the GP's surgery?

Mrs Legston: Yes.

Int: So what did you do, you rang up?

Mrs Legston: He did it when he went for his [Mr Legston was taking part in a CHD medical trial] test. So I made it [an appointment for a cholesterol test] and he kept it.

Int: Did you go together [to the dietitian]?

Mrs Legston: No, he could have come but he didn't really want to come.

Int: He wasn't that bothered about going?

Mrs Legston: No.
Int: Because he leaves the cooking to you?

Mrs Legston: Yes. But it appeared, you know, I don't fry, I grill things and do boiled and jacket potatoes. I suppose why his cholesterol went up was we will have a few doughnuts and we went on holiday and he did have fried eggs and she had said no fried food. So probably that was what put it out of balance, so perhaps next time he has it, it will be back down again.

Mrs Legston had balanced the need for dietary awareness on her husband's behalf with the context of the variety of activities with which her family became involved. This 'trade-off' will be noted from a quote from Mrs Legston in the final section of this chapter, which mentions activities not conducive to dietary rules, such as holidays. The normality of holidays means: 'You don't think about it, if you are enjoying life you don't really think about it'.

Mrs Jolson (CD M) appeared in chapter six as someone in a very difficult relationship with her husband. She will be mentioned again in chapter eight as one of the few wives who strongly resented the responsibility she carried for her husband's special diet. However, her anger over the poor relationship did not seem to have reduced the responsibility she felt for ensuring that he followed the diet, which was the case from the moment he was diagnosed:

Int: Did the specialist talk about it or did they just sent you off to the dietitian?

Mrs Jolson: Sent us off to a dietitian

Int: And how did you get on there? So you went with him?

Mrs Jolson: Oh yes, there was no point in sending him on his own!

These four examples are taken from both conditions and show a distinctly gendered difference in the ways that caring is perceived and carried out within the families in this study. The visit to the dietitian was ostensibly a gender neutral undertaking intended to ensure that information about the new diet was received and understood. Nevertheless, it can be seen to be understood through a gendered framework within which the women took responsibility for food and meals, and men would rely upon them to ensure they followed the diet. Thus, unspoken but intrinsic was a gendered expectation of how the diet would be 'lived' within the family.

• The special diet as a joint project

A strategy which emerged as an indicator of the lived experience of illness in the family relationship was one which saw the diet, and decisions about the diet, as a joint project undertaken by the family generally, and the couple specifically. In many cases this view was
conveyed through descriptions of what 'we' do about the diet. Examples of this can be noted in a number of the quotes in the previous pages as well as the ones that follow. For many it was just reflected in passing remarks which suggested that both members of the couple had similar aims about the content and the value of the food they ate. For example Mrs Scruton (CHD M) stressed that 'we do eat as healthily as we possibly can' and her husband added later 'If you were to see our supermarket trolley you would find that two thirds of the stuff that is in it was fruit and vegetables' ; Mrs Legston (CHD M) commented that 'we do try, put it that way, but it is very difficult you know', but later said that 'we don't really worry [about conforming to the diet]'. Mrs Scruton might be speaking for herself as well as her husband, in that she had similar health needs to her husband. Mrs Legston however, did not have any diagnosed medical problems which might have lead to an interest on her own behalf. Mrs Batley sums up the perspectives presented by many of the participants, particularly those in the CHD group, when she suggested that 'we do tend to eat much of a muchness, and I don't think of it as me imposing my diet on him because we have tried to come up with what we think of as a perfect eating plan, rather than "don't like that" negative vibes'. That is, a jointly agreed range of food choices which would allow people to eat together without involving separate foods. This had the advantage of avoiding extra work which might come from cooking separate foods, but would also achieve a sense of shared decisions over diet and meals.

The notion of the joint project perhaps stands out more when expressed by participants in the coeliac group. Following a gluten-free diet is not only time consuming and a challenge to the taste buds, it is also costly even with the support of the GP prescription for a limited selection of food items. When a non-coeliac family member talks of the special diet as a joint project this cannot be seen simply as an interest about personal health

Mrs Clarke's husband had been diagnosed with coeliac disease a year earlier and, although he had not experienced severe symptoms, she was very concerned over the possible long term consequences of not following the diet (osteoporosis and bowel cancer). She was keen to keep him on track and did so by experimenting with special gluten free ingredients, as well as being encouraging towards him generally. This was regularly expressed as a joint activity both in terms of attitude and action, even when the action (such as bread making) was undertaken only by Mrs Clarke:

Mrs Clarke: We had the bread on prescription, we started with the bread, and we had lots of free samples from the various outlets, and they were very good, but the bread! Oh dear! Steve didn't like the bread, so I decided to make some and that is what I do now.
Int: That's what you do now?

Mrs Clarke: Yes.

Int: Is bread making something that you have done much of?

Mrs Clarke: No. It was a really new area. So I ordered...well, I have, sort of, six or eight boxes of flour at a time, and that lasts me for six weeks or so and a box will make two loaves which will last him a week, I freeze one and use one. So we do that mainly because he found that any of the bread that we had either the sliced or even the uncooked bread which you then cook in the oven, it is part-baked, he just wasn't so keen on. The part-baked rolls though, he will have, so I always keep a supply of those, I have those ready from the doctor and perhaps at a weekend, if I need to make more loaves, or if we run short, I will open a packet of the rolls and bake them in the oven at the weekend. They are not so bad. I mean the bread can be a nightmare, and it does crumble, but he says it tastes better than anything he can have out of a packet, so...

Int: So how did you as someone who has not been into baking, how did you manage with that?

Mrs Clarke: It is routine now. I hated the thought at first, but now it is part of a weekend job to get the bread done. I mean I expect I could have a massive bake and freeze loaves, but the freezer isn't that big, so I don't tend to. I will just say that it has become a routine now. The pastry was another absolute... Well, that has been a bit of a disaster along the way. He did like the odd apple pie and things, but I am persevering because once again, well, I mean...well, to buy a ready made...obviously everything is not on the prescription for a coeliac, so I would go to the chemist, and I order biscuits and cakes and different things. He is not so keen on the cakes and I have made various cakes out of coeliac cookbooks or the samples that I have had sent through for recipes and...

and later

Mrs Clarke: Yes, once again I have requested to attend [seeing the specialist] because I feel that I remember bits that Steve doesn't because so much is discussed. Yes, so I am hoping that might get Steve back on the right track. And we can discuss the symptoms that are still hanging about and see what he says. But certainly we had a glowing report in the January from the biopsy. My head was swelling! Yes, but it has got to be, also, that Steve can feel happy about it as well. I mean, he realises that he has got to live with it for the rest of his life and he will, he will cope with it, but I don't want him to feel negative about it. It is easy for me to sit here, I don't have to eat all this different food.

Int: How do you... I have heard some people say they don't like to eat certain kinds of foods in front of the person who has the condition?

Mrs Clarke: Yes, I would say that is probably how I feel. Which probably isn't a bad thing. On a Saturday, before he was diagnosed, we would go shopping, and we would have a treat, come back about 11 and have a cup of coffee and a bun, well that has gone now. It probably does me the world of good that I don't have it.

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Int: So you have given up the bun as well?

Mrs Clarke: Yes - a) it was better for me and b) yes, I feel guilty eating certain things. So if I want to nibble I am happy to have a piece of fruit and do it like that. We are probably eating healthier for it I'm sure.

Mrs Clarke, without question, assumed the responsibility for not only her husband's special diet, but also being informed about the health implications of the condition. Mrs Clarke is another example of a wife attending the appointment with the dietitian with her husband in order to keep herself informed. The new diet was seen as a joint project to the level that she saw her husband's positive biopsy as much her own achievement as his. The strategy of giving up 'forbidden' food, or not eating it in front of the person with the condition, was frequently observed in the families where coeliac disease had been diagnosed. In fact, Mrs Clarke even mentioned asking her son to avoid eating fresh crusty bread in front of his father,

Mrs Conley is another spouse who spoke of feeling guilty about eating scones or cakes in front of her husband even when he urged her to do so:

Mrs Conley: Yes, there is quite a bit he could have, but he is quite fussy anyhow. He has never been one for what he calls mixed up meals. He likes something plain, he doesn't like mixed up food. And we have got the lists from Marks and Spencers, so there is not a lot that he can't get really. Some things he has had to give up like our afternoon teas when we go out, we used to like going for scones and things and his parents live in Devon so it used to be cream teas all the time.

Int: Well, you have got to find someone in Devon that knows about gluten-free scones!

Mrs Conley: Yes, we don't bother now, if we go anywhere now we just stop for coffee and we, me as well, don't have a cake of anything. So normally no, I can't sit there and have one.

Int: Is this something you have had before?

Mrs Conley: Oh yes.

Int: So you feel that you don't like...

Mrs Conley: No, although if I have got little Amy with me she has to have a cake and I might have a piece of hers, but that is all. He may go somewhere and have a packet of crisps as long as the crisps are the ones he can eat.

Int: But you feel that you ought to sort of not eat things in front of him.

Mrs Conley: No I don't, I feel very guilty

Int: Does he say...

Mrs Conley: He always says 'No go ahead, you have it'.
"Int: I do understand. It is a difficult one.

Mrs Conley: I would hate it. The first lot of bread that he used to have was revolting, I used to hate cooking it. I didn't know how he could eat it.

Int: Did he say it tasted alright?

Mrs Conley: After a while. He got used to it. He wasn't very keen at first but he said 'well, I have got to eat it'.

Whilst Mrs Conley does not describe quite the strong personal identification with the requirements of the new diet as described by Mrs Clarke, the desire to support her husband by joining him in giving up specific food was very clear.

Interestingly, this gesture of self denial was more noticeable where the man had been diagnosed with coeliac disease, with the female partner mentioning giving up 'forbidden' foods. In the couples where the woman was diagnosed with coeliac disease, this was less likely to be mentioned. It was also noticeable that, in both medical condition groups, where the special diet was left for just one person in the family to take responsibility for, that person tended to be the female partner, regardless of who had the condition.

Mrs Colman mentioned concern and support from her family, especially her husband, but this did not seem to stretch to practical informed action. She was described in chapter five as someone whose husband had attempted, unsuccessfully, to help in the kitchen when she became ill. She had been suffering from a number of health problems as well as unstable angina. When talking about trying to adapt her diet she mentioned changes which her husband had not minded conforming to, but, when pressed further, she revealed mild frustration about having to do this alone:

"Int: .....to a greater or lesser extent you have been trying to pay attention to what you eat amongst other things, how easy was that?

Mrs Colman: And so does my husband, sometimes he will say "You are not supposed to be eating that" and I say "Well, you are!" and he says "Yes well, I am different!"

Int: How do you feel about that?

Mrs Colman: I get a bit niggled at times.

Int: It is difficult isn't it?

Mrs Colman: I think - it is not fair. Sometimes I think, Oh well blow it, I am going to have it, I know I shouldn't, but it gets a bit monotonous when you keep saying no to everything.

Int: And especially if other people are eating things?"
Mrs Colman: Well, that is right!

Later, when asked about the support she could expect from her family:

Int: Do you feel as though you sort of stand out at all?

Mrs Colman: No I don't make a big thing of it if other people are around, I just don't say anything, I won't bother. But if it is just like my husband and I!

Int: On your own! What about if you are being invited over to someone else's house, family or friends, or even going out to a restaurant. Do you feel that they pay attention to the kinds of things that you have to think about?

Mrs Colman: No they just leave me to sort myself out.

{.....}

Int: From what you have described with your husband, he has actually been there, sometimes too much from what you said?

Mrs Colman: Oh yes, He has been really good

Int: But beyond that, the rest of your family?

Mrs Colman: Well, they don't watch what I eat, but they are there if I need them.

Mrs Colman is aware of her family's concern for her, but she expressed no expectations that those others should routinely make any major changes with her, despite the fact that she found it challenging.

The ways in which family members expressed sympathy and empathy have been examined in chapter five, revealing clear indicators of gender differences in the nature and characteristics of the expression of concern. The reconstruction of the diet as a joint project combines 'caring for' and 'caring about' in a way that fits with gendered assumptions of family relationships.

• Advocacy, food and illness

Throughout the course of the interviews for this study evidence emerged of spouses of those with the illness finding ways to enable their partners to follow the diet. Examples of these will have been noted in all of the analysis chapters so far, and will continue. Notable were partners who took it upon themselves to go beyond an active awareness of the dietary needs of
their partner, by acting as advocate for them. This was of particular note in descriptions of eating out in public places. Within the home the lengths to which those in charge of the food would go to facilitate following the diet may not have been evident to other family members. The work required for the new diet may not always be apparent within the pre-existing routines for food and meals preparation. However, a number of participants, particularly in the CD group, told stories of meals in restaurants, in order to show the difficulties that could occur, but also revealing moments of advocacy.

The term 'advocate' is, within the context of this study, being used to describe actions undertaken on behalf of the other person to ensure that person was catered for according strictly to the requirements of the diet. This might have involved, for example, requesting specific food or food information; interrogating the people providing the food (often waiters) to ensure the food is appropriate; complaining if the service was inadequate. It should be mentioned that the identification of 'an advocate' was a matter of degree rather than as part of a discrete group. What was remarkable was the level to which many (usually female, but not exclusively) partners shouldered the responsibility of the new diet. Those identified as 'advocates' were more likely to be proactive in speaking on behalf of partners in public places (such as restaurants) or negotiating on behalf of partners with medical professionals.

As a general principle the diagnosis of coeliac disease was seen, perhaps not surprisingly, as more problematic in relation to diet, than was coronary heart disease. The recommendations for an appropriate diet for the latter were seen by many as not very different from their prior 'normal' diet. The coeliac diet, although never referred to as a medical treatment, (which, in a way, it is) was, nevertheless, accepted by most as a lifetime requirement which, in principle, should always be observed. ('breaking the rules' of the diet will be examined in the next section) It is within the male CD group that the examples of advocacy were most noticeable. The two examples which follow exemplify the ways the role of advocate could be seen to be conducted

Mrs Poynt's husband (CD M) had been diagnosed with coeliac disease one year earlier, but, so far, neither of her children (8 years and 2 years) had developed the condition. Her own diabetes, diagnosed since childhood, she saw as having aided her competence in dealing with illness, as will be discussed in more detail in the final chapter (Sharing and comparing the illness experience). Mrs Poynt was very fluent in her description of her husband's symptoms and the process of diagnosis, in which she took a very active part. She expressed a strong sense of responsibility for her family's health. Although at one point expressing concern about her husband's need to be more aware of his condition, she did not seem to
leave much opportunity for this: 'I feel he should [attend a special event for coeliacs] because it is always me and it is you [to husband] has got the problem, so he should go'.

Mr Poynt did not seem to see the coeliac diet as problematic. It is hard to say whether this was a natural reticence on his part - he was a quiet man who did not have much to say - or whether his wife's comprehensive grasp of the management of the diet had masked, for him, the complications involved. This couple, in their thirties and with young children, conveyed a conventional division of domestic roles. It seemed very clear that he relied upon his wife almost completely to manage his diet, including in public. At one point in the interview, Mrs Poynt gave a very detailed description of one particular family meal in a restaurant. During the course of this event Mr Poynt's dietary needs were negotiated between Mrs Poynt and the restaurant staff. The staff co-operation had been extremely unsympathetic and unco-operative, and she described vividly her sense of frustration, ending:

_Mrs Poynt: Yes, Now I just feel like I can't be bothered any more. I just say you go and say next time. They just look at me and say 'Here she comes, that mad woman, giving us grief'._

Nevertheless, she had persisted with her demands that they ensure her husband's meal did not contain any thing likely to contain gluten, and eventually received a formal apology from the manager.

Mrs Nayme (CDM) was described in chapter six as attempting to instigate a cooking rota in her family. She demonstrated similar characteristics to those of Mrs Poynt, in that she saw her role as including actively representing her husband, even in public, to ensure he followed the diet. As the following quote shows, this was not always as straightforward as it seemed

_Int: [...]I have spoken to a number of people and they.. one woman put it very eloquently, {........} she is very touched by the fact that a lot of her friends and relatives have bent over backwards to try to find out about the condition, make sure they make the right kind of food for her, {........} but on the other hand she doesn't want to be looked at as if she is this woman with this condition.

_Mrs Nayme: Yes. David is quite the reverse. He hates it. He hates having to tell anyone he has got it. I mean I do it, if it is in a restaurant, I will do the talking about it, he would rather not do it, he would rather sit there and stare at a menu wondering if it is OK. He loathes it.

_Int: Well certainly that is the other end of what she was saying.

_Mrs Nayme: Yes, I know what she is saying, 'isn't it sweet that everybody does...

_Int: She feels she has got this word coeliac across her forehead. And I think you are right, there are people and I think there are more men than women who will not say anything.
Mrs Nayme: I find it so unnecessary. It doesn't bother me in the least. I don't have a problem with saying to anybody 'look I can't have this', but he has a terrible problem with that.

Int: But how does he feel about you saying it?

Mrs Nayme: He doesn't mind at all.

Int.: So he doesn't mind you being his advocate?

Mrs Nayme: Not at all. It gets the menu sorted out and that is fine. But of course there are lots of instances when he has to do it himself.

but in the second interview:

Mrs Nayme: Yes it is hard. On Sunday morning we were staying at the Holiday Inn in Stafford and it is a continental breakfast, and on the Sunday morning David is rooting around trying to find a plastic bag and I said 'what for?' and he had brought down a loaf of bread and he wanted to take a number of slices down hidden in his plastic bag so that he could pop it into the toaster down there. And I said 'well, just take the loaf down. And he said 'no, no!' Of course we couldn't find anything to put these in so I said 'Well, I will take the loaf down and we will take slices out and put it in the toaster. But you see he would rather have the number of slices in a plastic bag, hidden them in his pocket, gone up to the toaster, put them in and pretend. Rather than have this loaf sitting on the table.

Int: because they are not very big are they?

Mrs Nayme: No. And I just thought What! It amazes me that he is so concerned about that.

Int: Does he in any way rely on you, effectively, to be his advocate? Or does he find that embarrassing as well?

Mrs Nayme: No he hates that as well. But he is quite happy if he gets something to eat out of it, do you know what I mean? He is happy that it is not him making a fuss and that the food gets there, he is actually getting something to eat, whereas probably he wouldn't. But I wouldn't say he would rely on me, but I don't think he really likes me doing it. But I just think, this is silly!

Mrs Nayme had chosen to ignore any embarrassment her husband might have felt about the attention drawn to him about the diet. Her main concern seemed to be to ensure that her husband followed the diet and she balanced strategies to achieve this with the constraints of her husband's attitude towards the diet. Whilst her husband had to live with the condition, he seems to have relinquished control over how he lived with the diet.

The roles and responsibilities revealed by these families illustrate the complexity of family relationships, particularly with the aim of 'leading a normal life'. The contradiction between the desire to lead a normal life and the necessity to follow a diet for medical reasons is
underlined by the amount of work done by family members who make the process run smoothly. In these two cases the women ensured that their husbands could follow the recommended diet without having to think about it very much. They stand out because the public setting of the restaurant allows the level of input contributed by these wives, \textit{without their husbands having to take responsibility themselves}, to be revealed.

These two examples also draw attention to the juxtaposition of the desire for 'normality' and the necessity for the diet which generate a number of tensions within the construction of the family relationship, which have emerged throughout the thesis.

• \textit{Food and meals as indulgence and togetherness}

\textit{Well, he has only got to say 'Oh it would be nice if we... let's have a Kit-Kat' you know, and that is all I need. I should say 'No'. But I like them as well, I will get a couple and that is it}

\textit{(Mrs Greig CHD M)}

There were a number of activities associated with food and meals which could be construed as expressions of emotion and affection, by the person giving and those receiving. The notion of 'forbidden' food emerged in different ways. Some participants described choosing to deny themselves food their partners were denied. Others evoked the notion of forbidden food as 'indulgence' which might involve a level of breaking or suspending the 'rules' of the diet. The former scenario was more frequently found in families where CD had been diagnosed, whilst 'indulgence' tended to be found within the CHD group. These distinctions are, perhaps, not surprising. The foods excluded from the coeliac diet often result in immediate and distressing adverse symptoms, and so are unlikely to encourage breaking the diet. The diet recommended for people with heart problems is much the same as the policy recommendations to the general public for a healthy diet. This may make it easier to see the diet as 'healthy eating' rather than as part of the treatment for a medical condition, and so allow for the potential to justify ignoring it at times. The examples which follow show the way people attempted to juggle multiple, and sometimes contradictory, aims with a view to maintaining a positive personal family relationship.

Mr and Mrs Royle have already been mentioned as a couple who enjoyed food and eating, particularly doing so together as a family. Mr Royle had had a number of relatively mild coronary events which had required monitoring rather than surgery over the previous fifteen years. He had also been diagnosed with late onset diabetes just two years earlier. Both
conditions relied heavily on diet management. He was very proud of his ability to be strict with himself over his diet. Mrs Royle was an ex-nurse who felt a strong personal pressure to be professionally aware of her husband's health. The tension between the demands for being healthy and for being social is captured in the following exchange:

*Mrs Royle:* We have occasional lapses don't we? When we have visitors and we have trifles, we don't throw the rest down the drain!

*Mr Royle:* No.

*Mrs Royle:* It is a waste isn’t it?

*Mr Royle:* Well no, it is not worth living then is it? Because you know you are not going to be anything, what is the point of living? No I am not saying... but the thing is, for instance, Barbara has just left and we had all that apple pie there, and you know how much I love it and I never touched it.

*Mrs Royle:* No, he has been extremely good. Especially, you must admit, you did get an extra fright about two months ago when your blood sugar went right up. You have been even stricter. You were strict before, but you have been even stricter since then.

The interviews with Mr and Mrs Royle conveyed a distinct ambivalence between their awareness of the importance of the diet, for both of Mr Royle's conditions, and their evident pleasure in food and companionable meals.

Social togetherness seemed to become more important on special events such as Christmas or family anniversaries or holidays. The management of the CHD diet seemed rarely something that couples sat down and planned, even for special events. It may well be only when interviewed that many of the participants in this study actively compared their behaviour on differing occasions. The next comment (underlined) from Mrs Legston about her and her husband on holiday exemplifies the way the context can set the relationship agenda:

*Mrs Legston:* Yes. Well it [his cholesterol level] was quite a bit lower than the 5, so it has gone up a bit.

*Int:* In what sort of period of time?

*Mrs Legston:* Well I suppose it is nearly two years, about eighteen months, so it is quite a while. But as I say, just after Christmas we went to Majorca for two weeks, and we had breakfast there and there were fried eggs, so I suspect that was what put it out of balance. Which was a bit naughty, but there we are. You don't think about it, if you are enjoying life you don't really think about it."

Mr and Mrs Legston were quoted earlier in this chapter as conventional in their consultation of the dietitian. They were a retired couple whose two children no longer lived at home, but who had started to look after their grandson regularly, since their daughter's divorce. Mr Legston
had had heart problems for a number of years, the most serious being a heart attack eighteen months earlier. The treatment had been medication and lifestyle change (diet and exercise). Awareness of healthy eating recommendations, once these became located within the social setting, become part of the relationship process between people. Many participants, like the Legstons, found ways of combining diet awareness with the reality of the social and public setting, as well as a desire for normality (i.e.: not worrying but being sensible):

*Int:* And how do you feel about going out [to eat]? Do you feel reasonably confident in terms of going out?

*Mrs Legston:* Oh yes. We don't really worry. As long as it is chicken or fish we don't worry too much. And I have a cream cake for dessert, or a cream dessert or a really sticky one. But Peter does normally have a crumbly one, he is reasonably sensible.

Many participants expressed these contradictions or tensions in terms of what might be described as trade-offs. Mr and Mrs Scruton (CHD M) felt that, when they were at home, what they ate fulfilled the requirements of the medical conditions they both had. Mr Scruton had had a heart attack eighteen months earlier with treatment limited to medication and lifestyle recommendations. Mrs Scruton began life with 'hole in the heart' surgery and as an adult developed further diet related problems, so attention to diet had been a factor in their lives for many years. Mrs Scruton was responsible for all of the cooking, but they both felt that they were very diet aware. Nevertheless, every Saturday Mr Scruton 'broke the rules':

*Mr Scruton:* I don't eat the fat. Invariably the coating comes off.

*Mrs Scruton:* It is grilled so it loses some of it. We do eat as healthily as we possibly can.

*Mr Scruton:* Except on a Saturday.

*Mrs Scruton:* Oh indeed.

*Int:* What happens on a Saturday

*Mrs Scruton:* He goes mad.

*Mr Scruton:* Well we enjoy eating out anyway, and we eat out... on a Saturday we have a place booked more or less [every week] at our local sporting club, so we pop up there at 12 o'clock and I will have a cooked breakfast.

*Mrs Scruton:* Yes

*Mr Scruton:* Their big breakfast usually consists of a couple of sausages, nice big slice of bacon or a bacon burger.

*Mrs Scruton:* One or two eggs.
Mr Scruton: One or two eggs, not necessarily large, but it is more often one big one, baked beans.

Mrs Scruton: Chips, you have some chips.

Mr Scruton: Yes, and some chips. Now they are invariably the only chips that are eaten in this house during the week.

and later

Mrs Scruton: So it depends on the convenience of the things, but during the week I would say we eat early evening time, and weekends, well, Saturday he has his breakfast lunch and I have a tuna and jacket potato.

Mr Scruton: Roma will have a Coke with her lunch

Mrs Scruton: A diet Coke

Mr Scruton: This is up the club, whereas I will have half a pint of Best. During the week I suppose if I consume any more than two and a half pints that is over the top. I mean I play billiards on a Monday evening, we are in the league and I play away and at home, and if I have half a pint of beer during that evening that is. I know that .. I drive.. and drink when I am thirsty, I don't drink for any other reason. That is it really. I am not a social drinker. I think it is a total waste of money.

Mrs Scruton: Yes. And I will have a glass of wine occasionally, well, usually with Sunday lunch. But we are not alcoholic drinkers in any way.

in the second interview

Int: Yes, so you do go out to eat, you go out on the day that you do the shopping?

Mrs Scruton: Sometimes. And Saturdays we invariably go up to the club for lunch. Now there isn't a great deal of choice up there, but since it is only once a week... now he is very naughty..

Mr Scruton: That is already on the previous statement

Int: Oh that's right, I remember you telling me.

Mr Scruton: It is the gorge of the week. Let your hair down.

Mrs Scruton: Chips, eggs, sausages...

Mr Scruton: But I won't force myself to eat it. If I have had enough then I have had enough and that's it, it doesn't matter what is left on the plate..

Mrs Scruton saw it as her responsibility to ensure her husband's health, but seemed to see his Saturday morning cooked breakfast as a deviation which required only mild criticism and no real sanction. The notion of trade off - the weekly letting of his hair down - may have masked a desire to maintain a regular, familiar activity together. It may also have been more acceptable because it took place outside the home and so outside her domain of authority.
Mrs Batley (CHD F) echoed this convention that the rules might be applied within the home but may be disregarded in public places. Eating out with her husband was 'treat time', and allowed her to disregard dietary demands that she, in particular, found very onerous. She had had a heart attack one year earlier, but also had a weight problem which, as a side effect of the medication for her heart condition, she had been unable to improve. Her concern over this, bearing in mind overweight is seen as a risk factor for heart conditions, can, and has, caused her depression. She dealt with this by trying not to think about it too much:

*Mrs Batley: So yes, in more recent years we have eaten out, but not sort of on a weekly basis.*

*Int:* And is it usually just on the way back from shopping?

*Mrs Batley: Oh no, we do go out for meals, but usually, I would say generally speaking, on a Thursday or a Saturday, but if it is just where we have been into town to... you know, we have had a sort of fairly busy day shopping, then we will do something else because it saves time.*

*Int:* And do you think that has been affected at all, by any sort of dietary constraints that you have had as a consequence of your heart attack?

*Mr Batley:* No, I would say that was most probably more treat time going to [location], because I am quite sure it won't be on the prescribed list! Because at home I do sort of try to keep within reasonable boundaries, but as I say, we eat out, and I try not to think too much about what we are eating.

*Int:* Well a lot of people are saying that it is having to take into consideration all the things that are [***] can be quite...

*Mrs Batley: It can. And there is part of me that, because, I suppose food and eating are fairly important to me, I tend to show how much I care by, you know, preparing as I think nice food, and that sort of thing, so it is quite an important element, and if I didn't allow myself the freedom to break out here and there, I wouldn't be able to stick to it the rest of the time, because life has got to be about living as well as just breathing.*

*Int:* Yes. I take your point. So you make quite specific decisions, you know, I have been good this week...?

*Mrs Batley: Yes, I suppose so, yes.*

*Int:* Well, sometimes the subconscious does!

*Mrs Batley: Well, yes, I was just going to say, I would say that it is most probably... because I think I do try not to worry too much, you know, we have looked at our diet and come up with what we hope is a comparatively healthy intake of food and the types of food that we eat, and over and above that I try not to think about it, but come something like Christmas or... the restrictions are off. It is about us all eating together and having nice food. Well, most probably... I don't know whether it is my age or what, but it almost seems to be a case of if you enjoy it, it is bad for you!
Mrs Batley has already been mentioned in the previous chapter as having to negotiate territory with her husband over use of the kitchen. Here she admitted that food was, for her, a way of showing she cared and that eating out was special for her and her husband. Thus the special diet, however simple, can be seen to prove problematic for a relationship constructed out of shared events for which food was an important part.

The following quote from Mrs Calman (CHD M) draws attention to the way that trade-offs can involve an interweaving of notions of social acceptability and beliefs about the flexibility of healthy eating. When asked how her husband managed to stick to his diet she begins by saying that this is not a problem:

_Mrs Calman: I don't think John is in anyway like that no. He doesn't care. His friends know what has happened and he will say 'I am allowed to eat this, I am not allowed to eat that'. But we don't take it to the extreme. If he has basically eaten properly all week and we are going to friends, if they have done a meal, and, as I say, most friends are pretty good, they know what he is allowed to have and what he is not, but if they have done something that he shouldn't really eat, we don't say anything. I mean, alright, so he has had something that he shouldn't eat, it is not the end of the world. If the rest of the week he has eaten properly, all these little things now and again...I don't think you can do it every day of the week._

_Int: It is hard.... But an awful lot of people say things that you are saying about balancing and making trade-offs._

_Mrs Calman: If we suddenly met some people we had never known before and they invited us to their house, they wouldn't know. And you can't sit there and say 'I don't want that because I am not allowed'. You have got to indulge a little._

Mrs Calman's concern over her husband will be revisited in chapter eight in relation to her input, which was significant, to the diagnosis of her husband's heart disease. Nevertheless this quote reveals trade-offs which involved subtle adjustments she and her husband expected to make which balanced following the diet against allowing indulgences.

Mrs Greig's concern over her husband's health over the years had also been influenced by his heart condition which first began over twenty years earlier. His heart condition became more serious not long before he was due to retire, and, together with an unexpected redundancy, triggered a short period on sickness benefit (which he found quite difficult) until his official retirement. The couple were quoted in chapter six as operating a traditional gender division in the home, with Mrs Greig firmly in charge of the meals. Mrs Greig's response to her husband's heart condition had been to try to combine her desire to fulfil her beliefs about gender roles with her desire to ensure her husband's health. Interwoven has also been a desire to create a sense of togetherness in their everyday lives:
Int: Well, how easy was that to do when the doctor said 'you need to change what you are eating', how easy was that to do?

Mr Greig: It only applied to me so it was difficult. Very difficult.

Int: So were you cooking separate meals?

Mrs Greig: No I still... I adapted my eating to Tony's, if he had to cut out something I would try and to the same, you know, it was togetherness. I didn't want him to feel he was missing out on anything. We cut down drastically on everything that we could and should have done.

This case illustrates the way the business of eating meals often embodies a number of different, if linked, factors important for the promotion of good family relations and smooth running of everyday life. More importantly, for the benefit of this study, it provides evidence, as have the other quotes in this section, of the complex ways that people establish and maintain an understanding of what a family relationship should be over time. Not all of the couples who took part expressed the desire to use food as a vehicle for togetherness, and a number eschewed notions of indulgence or 'breaking the rules' of the diet. Nevertheless, the examples offered here illustrate the part played in many of the families' lives by food and meals as symbols of indulgence and togetherness.

Summary

The data presented in this chapter have shown that what people eat and how they share it can demonstrate the relationships they have with each other, and also the gendered nature of that relationship. What also seems clear from these cases is the many layeredness that any one family activity can incorporate. Mr and Mrs Greig's example shows how a shared meal can indicate assumptions about gender, caring and relationship which are unquestioned but which have accommodated the demands of the illness experience. Mrs Clarke's example shows, amongst other things, how demanding a coeliac diet can be for the person responsible for food and meal production, and yet how wholeheartedly and, again, unquestioningly she has taken on board those demands.

Nevertheless, there are also examples of ways in which affection and togetherness could undermine the observance of the new diet. The Scrutons and Mrs Batley described breaking diet rules in specific contexts - interestingly, outside the home. Mrs Calman, on her own when it came to making decisions over breaking diet rules which she found frustrating, nevertheless felt her family were there for her when needed. Thus, the introduction of a new diet into the family relationship, however important to the health of the person concerned, for
the participants of this study, was subject to the nature and expectations of the existing family relationship.

The themes which draw together the seemingly differing perspectives of these cases reside in notions of gender and the desire to feel normal. The participants in this study conveyed their feelings for and about each other in a number of different ways, often through simple, seemingly minor, actions which, over time, have become cornerstones of the relationship. The disruption caused by the consequences of these illnesses has been accommodated through the structures and practices which constitute family life, and, largely, within conventional assumptions of gender identity.
Chapter 8. Negotiating symptoms, conditions and family life

This chapter examines the process of identifying and then living with the illness from the point of view of family relationship. The previous chapters have examined the nature and construction of the family and its lived experience specifically as related to food and meals. The introduction of a special diet recommended as a form of treatment for a medical condition has provided the vehicle for this debate and, in this chapter, this process is considered in detail. Data will be presented which show the ways in which participants understood and managed the emergence of symptoms, the diagnosis of the medical condition and the recommended dietary treatment.

Although it is the case that food is increasingly being seen as a factor in the promotion of health and even the prevention of illness, it is not usually construed in terms of treatment for an existing illness. As has been noted in the literature, from a sociological point of view, activities around food and eating have more commonly been seen as a means through which identity and relationship are established, developed and communicated (Mennell et al 1992, DeVault 1991). In fact, examination of these data suggests that this continues, however serious the event. Within this study, the introduction of a new diet for medical reasons can be seen, usually, to endorse gendered assumptions rather than challenging them.

It has also been noted that health tends to be seen as a personal, rather than a public, responsibility to be embedded in the individual lifestyle behaviour of the population at large (Annandale 1999, Paterson and Lupton 1996, Nettleton 1995). Certainly, the participants of this study, once diagnosed, treated and offered advice, were largely left to maintain and monitor the ongoing behaviour necessary to prevent the return of their symptoms, and, possibly, the development of further serious disease. The nature of the two medical conditions in question is such that it was possible for practitioners to suggest and for the participants to believe that they would be able to go on to lead a 'normal' life.

The process of becoming ill and becoming well will be shown within the context of established family relationships where factors such as age, children, employment, and, most significantly, gender, have played an important part. The interplay between gender and the family relationship can be seen to underpin the approaches taken by family members in dealing with the unexpected intrusion of illness. The emergent theme of 'normality' will be shown to be the yardstick against which family practices, whether routine or novel, were developed and judged. The notion of normality is at the forefront of this analysis, in a process by which both
the expected and the unwelcome could be seen to be absorbed and understood over time. The
dynamic nature of a process of maintaining 'being normal' can be seen to be an essential part
of promoting continuity and coping with change within families.

Section one: Being healthy - not being ill, traces reactions to symptoms; the ways in which
symptoms and risks were managed, ignored, accepted, and the process of diagnosis. The
tension between the desire to lead a normal life and dealing with symptoms before diagnosis
will be examined. This is explored through the ways in which the participants could be seen
to construe the notion of health and the notion of illness in everyday life. The second section:
Being ill - being normal, describes the attitudes towards the illness and the diet once it had
been diagnosed and explained, and also dilemmas encountered in dealing with the
repercussions. The tension found in reconciling normality and illness, examined in section
one, remain but take new forms. This is shown through descriptions of strategies used to
minimise difference, but also feelings about what it means to both patient and spouse to have
to deal with the illness. The final section: Sharing and comparing the illness experience,
draws attention to an unexpected but significant characteristic of a number of the people who
took part in this study. As explained in the methodology section, the process of assimilating
illness into family practices was, for a number of participants, not new or unique. Multiple
conditions were evident in a number of families interviewed, as will have been noted in
passing in previous chapters. This section examines the effects of dealing with more than one
condition, both positive or negative, for the family relationship.

It is, perhaps useful, at this point, to reiterate in summary some of the characteristics of the
two conditions, offered in detail in the Methodology chapter, as a preface to this final data
analysis chapter:

The social characteristics of the two conditions, coeliac disease (CD) and coronary heart
disease (CHD), as experienced by these participants, had some clear distinctions. Most of the
people with CD described many years of non-diagnosed symptoms which had worsened and
so precipitated the diagnosis. This was often followed by a distinct and considerable
improvement in a sense of well-being as the symptoms disappeared. In contrast, many of
those with CHD described a sudden and unexpected 'bolt from the blue', often in the form of
a heart attack, sometimes followed by surgery. Although many felt they had fully recovered
from such debilitating experiences, some reporting continued feelings of incapacity, and
others had had significant change thrust upon them, such as early retirement. It is also, of
course, the case that CD requires only dietary change as treatment, whilst diet is only part of a
range of interventions used to treat CHD, and has not always been seen as a significant one.
However, of those with CHD, a number had experienced minor heart problems over many years which had worsened more recently leading to more intrusive treatment. Again, in contrast, a number of those with CD were diagnosed opportunistically through unrelated medical interventions, and had not suffered severe or long term symptoms. These factors, and the long term life threatening implications for both conditions, allow parallels to be drawn between the experiences of both groups. Thus, whilst there remains considerable medical differences between the two conditions (as well as the type of diet) and how they, in essence, might be construed, the embodied experience of the two conditions generates many and significant similarities. The participants convey ways of understanding the condition as an illness, and the diet as a treatment which cannot be separated from the practicalities and ideologies within which their everyday activities functioned.

The literature has revealed the ambivalent and contradictory ways in which both 'health' and 'illness' can be construed (Annandale 1999, Nettleton 1995). For the purposes of this study, 'being healthy' is being defined as the absence of symptoms, and 'being ill' as the experience of symptoms which have been legitimated by diagnosis by a medical practitioner. These definitions have not been formulated through responses to a specific question addressed to all participants. It is the descriptions participants have provided of the process of experiencing symptoms and reaching diagnoses that have formed the basis of these interpretations. The diagnosis of a medical condition may be seen as marking the turning point between the experience of symptoms and the experience of treatment, but is imposed upon a set of ongoing experiences and meanings which are the family relationship. Examination of the interplay between these beliefs about health and illness within the context of the family relationship help to shed light upon the ways in which participants in this study have chosen to construe the health of members of their families, including their own.

- **Being healthy - not being ill**

The definition of health as being symptom-free is of note when looking at how a number of those with CHD construed a heart attack as unexpected. Many also considered themselves to be healthy despite being aware of risk factors, as two (Mr Howard and Mr Calman) of the following three sets of quotes reveal. Both Mr Howard and Mrs Batley were clearly aware of the existence of risk factors in their lives.

Mr Howard (CHD M) was only in his late forties when he '...got like this...well something different in my chest. It wasn't a vicious pain, just something different...'. Mr Howard's
view was that he was very fit and, as a welder by trade suggested that 'in my line of work I think everybody would say if you get pains in your chest it is natural if anything...'. Nevertheless, he decided to mention it to his GP, who sent him for tests which swiftly resulted in heart bypass surgery. He and his wife described how shocked and surprised he was, despite a history of heart problems on both sides of the family and a life time of smoking.

Mrs Calman (CHD M) also described her husband as very shocked after she had persuaded him to consult the doctor about the chest pain he was experiencing:

Mrs Calman: Yes, I drove him up there. He walked quite happily to the assessment unit and they did an ECG and said 'you have actually had a heart attack'. Which I think was sort of more of a shock to him than me.

Int: But you were pretty sure?

Mrs Calman: Oh I was pretty sure yes. I was almost sure what had happened.

Int: So when he didn't want to go to the doctor's why do you think that would be?

Mrs Calman: Because he is never ill. Before then he was never ill. He has always been such a strong fit man. Never ill. Hates going to the doctor's. Hates taking tablets. Absolutely detests it. He is just one of those people that it never happens to him, it is always other people.

Int: And did he have an explanation for the pain?

Mrs Calman: He kept thinking he had pulled a muscle or strained himself, because he does a lot of heavy lifting at work so that is what he put it down to. But as I say it was when she [the doctor] said it was indigestion and I thought 'no it is not'. I left him and he was taking these tablets and I thought 'What is going on, you must go back, I think it is angina'. But I don't think at that stage he realised that angina could lead to a heart attack. I don't think he did. It wasn't until he got home and I started explaining it and we started reading about it that he then realised......

{.....}

Int: So when they told him that he had had a heart attack how did he react to that?

Mrs Calman: Um...I think, because he doesn't say a lot and because I know him and I saw the look on his face, he was shocked, he was frightened

Mrs Calman has been mentioned in previous chapters as someone who took a great deal of trouble to help her husband eat well, after he developed heart trouble. He had been a smoker with poor eating habits when his wife was not at home to cook the meals, had high cholesterol and a family history of heart trouble. This quote indicates that monitoring his health had been her responsibility well before he became ill.
Mrs Batley (CHD F) when describing her own heart attack commented:

Mrs Batley: I assumed it would sort of go and you know indigestion and it didn't seem to be going so I sat down on the stairs of Marks and the security man came over and asked if I wanted some first aid, at which point I sort of got to my feet and said 'no I am fine' and we left. We walked back to the car which was in [name] car park, so it was a bit of a walk, very, very slowly and neither sitting down nor walking seemed to affect it at all. It would just get worse. Got in to the car and my husband said 'I will take you to the hospital' and I said, 'Oh no I will be fine, all I have got to do is go home and lie down and I will be alright'. I mean with hindsight I can't believe how stupid I was because I have got so much history of heart problems in the family.

Int: Really. Your parents?

Mrs Batley: Yes.

Int: Both parents?

Mrs Batley: Yes.

Int: Brothers and sisters.

Mrs Batley: Yes, my brother died at 48 of a heart attack, So as I say it was stupid of me really not to... But I think it is one of those things you know - it is not going to happen to you, it happens to other people.

Mrs Batley, in her late fifties, was overweight, had given up smoking only three years earlier after a lifetime as a smoker, and had also had cholesterol problems which were identified approximately 6 years earlier, by her GP during regular visits to the Well Persons Clinic.

Those with CD were more likely to describe a lifetime of uncomfortable, if not severely distressing, symptoms. What is, perhaps, more surprising is that many recognised the lifelong nature of those symptoms only in retrospect. Others chose to identify themselves as 'not ill' despite quite disabling experiences, such as severe diarrhoea resulting in being housebound, or regular vomiting after every meal, and both associated with weight loss or long term low weight. Mrs Nayme (CD M), describing her husband's view of his symptoms said: 'Well he actually said he has always had what probably you and I would describe as diarrhoea but he thought was normal', and Mr Unwin (CD M), who made the point that 'You don't think of these things until something happens to you' suggested that 'You ignore everything until you get it and then you do something'.

Mrs Henson (CD F) had, in fact, been diagnosed opportunistically through an unrelated routine smear test which had resulted in the need for surgery. The surgery revealed severe anaemia which was not improved by the prescription of iron tablets. Eventually, after two years, further tests identified CD. Following a gluten free diet had relieved Mrs Henson of a
bloated stomach, although 'Really I didn't know the difference. I was like that all the
time until I changed my diet. It was natural to me'. She had also put on a considerable
amount of weight after being slim ('skin and bones') all her life. Mrs Henson's partner and
sister, who both attended the first interview, added that being sick after meals was routine for
her since childhood, as was fainting a lot, which had reduced since starting diet.

Mrs Kelner (CD F) was particularly vivid in her description of how 'you never know you are
ill until you kind of collapse all over' This view was encouraged by her doctor - 'she had
never thought I was sick. Because you are not lying on a bed and not taking time off
work, you are fine'. As a consequence:

'...I really didn't think I was ill. My own doctor said it was women's problems and
watch what you eat and I basically just believed all that. So that when I went to the
hospital that time, I thought "Oh my God what am I doing here?" and when he said "I
think I know what is wrong with you" I thought "What!" It was quite a revelation'.

The issue of whether "women's problem's" should qualify for illness status is one for debate
elsewhere. Suffice it to say that, for the purposes of this study, this quote indicates the
strength of the belief that symptoms only become illness when legitimated by a medical
professional. Mrs Kelner was an articulate professional woman who had suffered these
symptoms to a greater or lesser extent throughout her life. She had been prescribed folic acid
for ten years prior to the diagnosis of CD, because blood tests regularly registered her as
anaemic. She had made her own connections, since her diagnosis, between the condition and
the loss of two babies, one stillborn and one shortly after it was born. In all of this neither she
nor her GP saw her as 'being ill'. In fact it was her partner whose concern over her led him to
press for further referral:

*Mrs Kelner: I had been taking folic acid religiously. I could eat three meals, and I
would bring up three meals at once. All of a sudden I though "I feel sick" and I would
throw up, feel better and carry on. I didn't have time off work and I thought I was
lazy when I felt tired and in the end it just got to the point that in the end Joe
insisted that I go back to the doctor's.*

Nevertheless, Mrs Kelner was a positive woman who, as noted in previous chapters,
indicated the importance to her of family activities, especially around the production of meals.
She was very appreciative of the support her family gave her.

This was unlike Mrs Lawton (CD F), who also had had a lifetime experience of non-
diagnosed symptoms which had affected her pregnancies, but found herself on her own when
it came to juggling her symptoms and her family duties:
Mrs Lawton: I suppose really all my life I have had lots of different things but nobody ever put two and two together. I was always anaemic. Very, very anaemic. When I had my last baby I had to have a blood transfusion five weeks before he was born because he was so anaemic.

Int: Did you have trouble in all your pregnancies?

Mrs Lawton: With anaemia yes, but the last one was very, very bad. And even though I took iron tablets it didn't make much difference and they just said that I didn't absorb iron.

This problem, as well as tummy aches and indigestion, had troubled Mrs Lawton since childhood, but had become considerably worse at times, and which, in the previous year, eventually resulted in the diagnosis of CD. She commented upon the fact that she had been unable to make a connection between the food and the illness, despite evidence when seen in retrospect:

Mrs Lawton: As soon as I went on this diet I was just a different person. It was just like instant being better. I just got better straight away. And I have never had...Since I have been on this diet I have not had a ..Because I often used to feel sick after eating a piece of cake or some biscuits and it would pass off and I never really thought it was that that was making me feel ill.

Int: You felt queasy but you weren't actually sick?

Mrs Lawton: No but felt queasy. Because my husband on a Saturday morning, he used to go over and get the paper and he always said to me 'do you want anything from the bakery?' because he would bring back us all a doughnut or a bun or whatever and I remember I would say 'Oh I will have a cream bun, or I will have a doughnut', and I would have it with a cup of coffee and then about half an hour later I would feel awful and I would think, well it can't be that bun, you know.

Mrs Lawton was mentioned in chapter two as someone whose husband had no interest in contributing to the domestic tasks in the home. Mr and Mrs Lawton had had two children, but she had also had one child still-born and four miscarriages. When she found herself pregnant at the age of 37 this was unexpected and was the most problematic full-term pregnancy:

Mrs Lawton: ....We had the tests and they said he was normal and I asked if they would tell me the sex and they said it was a boy, so apart from being ever so anaemic and not feeling on top of the world, he was born and everything was normal, he was normal, a normal birth and he weighed six pounds and ten ounces, which wasn't that small really, considering how I was.

Int: Indeed.

Mrs Lawton: He was fine. But after he was born I was terrible as regards... I had this problem, bad, I was forever-lasting running to the loo, all the time. I can remember in the morning when he was like a tiny baby and I would be bathing him and we never had a cloakroom downstairs then and I would have to tear off to the
toilet. I just used to take him out of the bath, wrap him in a towel, put him in the carrycot. While I tore off to the loo and he was only like a few weeks old. And then I would come back and carry on again and then I would have to tear off again and do the same again. I had quite a few weeks like that and I went to the doctor and told the doctor and still he did tests and couldn't find anything wrong and then it passed....

Nevertheless Mr Lawton, although helpful with the shopping, had, traditionally, never been involved in any culinary activities in the home. This did not change when his wife's symptoms grew worse:

Int: So even when you were feeling really poorly last year, when they diagnosed you, you were still keeping the kitchen running?

Mrs Lawton: I did. I still just about managed to cook him and Emma a meal every day, because she didn't give up her little cottage until the end of August and in September I started to get better. So it was May, June, July, and into August that I was really bad, so Emma wasn't at home so it was only my husband and Lloyd, but I still cooked every evening and I just used to dish myself up about that much and then I couldn't even want that. I just didn't feel like eating.

Int: Well, when you are feeling that ill.

Mrs Lawton: Yes, it was a terrible struggle it really was, to do it. He used to wash up for me...

The examples provided so far illustrate, not only the extent to which both symptoms and risk factors can be ignored as indicators of existing or potential disease, but also the setting within which such a viewpoint can exist. Mrs Lawton was the least able, of these examples, to ignore her symptoms, but does not seem to have relied upon practical help from her family. Within the family, the well person or the ill person is also the mother, the father, the spouse, the child. These are identities which do not always allow concessions to be made for illness, especially if not formally recognised. In this light, denial by the person with the symptoms (or risk factors) or by other family members, especially with a lack of formal diagnosis, can, perhaps, be understood.

However and in contrast, in many cases, seeking medical help, as with the making of lifestyle changes, was enabled by the actions and attitudes of other family members. In both medical conditions, a number of those interviewed mentioned a partner pressing for further help from medical professionals. This kind of help was usually, but not always, welcomed. For example Mr Flow, who was interviewed as part of the CD group but had also had experienced a heart attack, described the lead up to his heart trouble:

Mr Flow: Yes I felt really bad. And of course... I think it was the Tuesday after that, I went and saw her on the Friday, and my own doctor was away at the time, and on the Tuesday morning I felt bad in the morning, I didn't want to get up and she [Mrs Flow]
said 'I can send for the doctor'. But I said 'No, don't bother'. She said 'I am going to'. And my daughter came and insisted as well. So they sent for the doctor and he examined me and said 'Right we will get you into hospital...'

Mrs Calman (CHD M) has been mentioned above, when her comments illustrated the shock her husband experienced when told he had had a heart attack. In fact, the diagnosis of her husband's heart condition was strongly influenced by her independent input. When the GP diagnosed indigestion in response to her husband's description of chest pains, she described taking the situation into her own hands: '...a fortnight later it was no better so I sent him back because I had my own suspicions it was angina...'. She explained her reasoning: '...Because I know what he is like. He doesn't describe things properly to doctors and I had seen him so I guessed what it was. I sent him back'. She took this further '...Well, I actually phoned her [the doctor] up. I said I know what he was like and he doesn't describe things properly so I actually told her the symptoms and she agreed with me'

Mrs Calman was not a nurse, but worked at a hospital as an administrator which gave her access to information which, she felt, had aided her in this.

Mrs Wheen's (CD F) experience was unusual but, I suspect, not unique for someone who had lost considerable amount of weight for no apparent reason. She explained: '...my father was alive at that time so my Mum and Dad came through and they thought I was anorexic'. and: The first time I was diagnosed my brother was staying with me the first year and you [to mother] got him to check up on me? later: 'everyone was saying to me "are you anorexic?" "are you eating?" and my brother was telling them I was eating and even my aunt, {...} she was checking up on me. Everybody was checking up on me to make sure I was eating".

Mrs Jolson's experience of her husband's illness had been difficult and long term, as had her relationship with him, as was noted in previous chapters:

Mrs Jolson: I had realised that he had symptoms which needed investigation as long ago as 20 years.

{.....}

Int: Did he talk to you about it? Did he say 'I don't feel well'?

Mrs Jolson: Never. Never ever.

Int: Never said he didn't feel well?

Mrs Jolson: No, there was never anything wrong with him. There was never anything wrong with his motions. Everybody smells like that, that was normal.

Int: Oh dear. Was he sick at all?
Mrs Jolson: No, just diarrhoea. He used to go three or four times a day.

{.....}

Int: So presumably that had been the case most of his life?

Mrs Jolson: That must have been the case. But it didn't come to my notice and particularly until after we had had the children, which were adopted, after the children were older and were about five or six and as they began to grow I began to be less [***] then so I became more and more aware, particularly when we wanted to go out with the children. We would just go to the front door and he would have to rush back and go to the toilet again. And we would get down the road and he would have to rush back and go again.

{.....}

Int: And through all this time he said 'it is not unusual, that is normal'?

Mrs Jolson: He didn't say very much at all. It wasn't happening

Int: Right, I see. So you were trying to talk to him about it?

Mrs Jolson: Yes. So I gave up.

Mrs Jolson went on to describe the deterioration of her husband's health which she saw as concurrent with the deterioration of his involvement with herself and their children. The trigger for his diagnosis was being turned away when he tried to donate to the Blood Transfusion Service, on the grounds of severe anaemia. 'They referred him to a GP and that shocked him'. Mr and Mrs Jolson will be referred to again later in this chapter as a couple whose poor relationship, in Mrs Jolson's eyes, paralleled her husband's denial of the existence of his illness.

The examples in this section have been given to show the level to which potential illness could be ignored, until receiving medical confirmation. Other examples have indicated the level to which the input of family members (usually spouses) could influence the diagnosis of the illness. The quotes and descriptions also show the value attached to professional diagnosis. The majority of participants, during the period prior to the diagnosis of the medical condition, seemed to have felt some reluctance to acknowledge being ill (or at risk) by the person with the condition. Sometimes this was presented as the consequence of the absence of a legitimate medical diagnosis. Many only acknowledged the presence of symptoms (or risks) in retrospect, after diagnosis.

The significant factor is the nature of the family relationship which could influence the behaviour of those within it and which indicated the complicated interplay between family life and the nature of illness. A desire to 'be normal', which, it is argued here, equates with
'being healthy', within the family setting evokes responsibilities significant to particular roles and relationships. For many of the participants of this study, the disruption caused by the intrusion of illness was not a discrete or abrupt change from wellness to illness. The characteristics of the illness, together with the social meaning through which the participants construed their lives, found them choosing to ignore indicators (symptoms or risk factors) of the presence of (potential) illness. The location of the family relationship can be seen to be a major influence upon how the participants made the movement from 'being healthy' to 'being ill' without disrupting too much the state of 'being normal'.

- **Being ill - being normal**

  ...since I have been what you call being ill

  (Mrs Hulse CHD F)

The previous section has charted the ways that family members travelled from the experience of adverse symptoms or adverse health indicators towards the diagnosis of a medical condition and on to the treatment. A number of participants (both CHD and CD) reported the assertion offered by medical practitioners that they would be able to 'lead a normal life', provided they followed the treatment suggested. The contradiction which comes from juxtaposing 'being normal' with having a disease was never articulated by participants, whether by the person with the condition or their spouse. It was, however, evident in the processes they went through in trying to accommodate the requirements of the diet within the family relationship. It was often evident in the ways they underplayed problems and presented positive perspectives. It was also to be detected in the different ways they promoted the desirability of 'being normal' and how that state could be achieved.

Dealing with a new diet is a very different process for the person diagnosed with CD compared to CHD, for reasons already discussed. The people who had to deal with the CD diet commented upon the challenge of a gluten free diet, with many suggesting that it took at least a year to come to terms with all aspects of it. Much of this had to do with learning how to operate the prescription system, identifying gluten free food when shopping, finding out about the new ways of cooking, and other practical activities. Nevertheless, overall, most felt that they had successfully come to grips with the mechanics of the diet. This success was often articulated in ways which conjured up a perception of little change and low disruption, despite some evidence to the contrary.
Mr and Mrs Unwin (CD M), mentioned in chapter two, with their lifelong catering experience, agreed that: ...it was plain sailing once they diagnosed it...'. as did Mr and Mrs Bain (CD M): 'Yes, we found the adjustment reasonably straightforward. Certainly at home, that is the comment I would make'. Mrs Smythe was described in chapter three as dealing with her own diagnosis of CD, as well as her husband's heart disease. Nevertheless when asked about dealing with two diets responded...'I have got used to them. If they had both come at once that would have been more difficult, but after five years [her husband's illness] we have got used to it'. The notion of coming to terms with the condition and the new diet in a positive manner are echoed in her final words: 'So I think you have just got to smile and get on with it'.

Those people who had to deal with CHD, perhaps not surprisingly, rarely saw the diet as daunting. A few reported that diet had not been mentioned by the medical practitioners. The CHD diet is the same as that recommended for general health and, as such, was seen as less problematic to find out about or to cook. The main problem area for this diet, in practical terms, was avoiding those foods seen as unhealthy or 'naughty', as mentioned in the previous chapter in relation to indulgence and togetherness. The notion of 'a healthy diet' was one that all CHD participants aspired to, some feeling that they had, in fact, achieved this even before the advent of the heart disease. For example, Mr Royle (CHD M) felt that: 'As a family we were very sensible because we never ate junk foods, we never brought that', and Mr Howard (CHD M) was sure that: '...we have always been health conscious and we have always watched what we have eaten in the last few years, like everybody else'. In fact this couple identified the influence of their own 'health conscious' children in the improvement of the family diet:

Mrs Howard: Christopher will not eat anything without... He picks up everything and he's like that, reading everything on the carton and what have you

Int: Was that before he left home?

Mrs Howard: He has always been like it.

Mr Howard: They have always been very fit, the two of them.

Mrs Howard: Jason was not so bad, eating...

Mr Howard: Oh Jason was a good eater.

Mrs Howard: He is a good eater, but he doesn't eat a lot of fatty things, he doesn't eat sweets.

These examples reflect the positive approach that most participants expressed about taking on board the requirement to change diet. Nevertheless, what was decipherable as fundamental to
the practical side of incorporating the new diet into existing family food and meal traditions, was an image of the normal family relationship, within which familiar activities took place.

This is not to say that the notion of 'normality' was always clearly defined or totally achieved. A sense of 'being normal' was expressed explicitly in some cases, but could also be inferred in a number of ways. The most frequent was when the idea of 'not being different' was used. In an exchange about how difficult it might have been to accommodate her husband's new diet if the condition had been diagnosed when their children were quite young, Mrs Clarke (CD M) went on to say: 'Yes. But what I try and do is not make him feel that he is different to us or remind him. So, if we have chicken with a sauce over he is quite happy to have the chicken on its own, he is not one for lots of creamy saucy things, so he is quite happy with it plain and simple.' In a similar vein, Mr Garside (CD F) pointed out that his wife's 'diet, as far as I am concerned anyone who comes here I can sit anyone down at the table and I give them a meal which they would enjoy and which Maureen can eat and nobody will know the difference or that Maureen is on a diet...'. And later '.And also making the person look the odd one out, you might as well do the whole lot so there is no difference'. These two participants, both very sympathetic to their partner's situation, were also willing and able to take time to create a 'normal' environment around food, in which no-one felt 'different'.

Mrs Nayme (CD M), in chapter two, was described as frustrated at the failure of the family rota for cooking she tried to set up, but in chapter three as acting as an advocate for her husband in public, to ensure that he was able to follow his diet properly. Her description of her husband's reaction to feeling different is, perhaps, the most telling:

*Int:* But it must be terribly frustrating for him....

*Mrs Nayme:* I guess it is. He is more embarrassed by it {.....} He wouldn't make a fuss if he couldn't eat anything {.....}

*Int:* So you had a discussion with him about it?

*Mrs Nayme:* Yes, you see he is terribly embarrassed by it all. He hates the fact... I mean, we joke, the biggest joke was David would say 'Well I am the one who is normal, it is the rest of you that are wrong' and when he was diagnosed the kids just said to him 'Who is normal now? We are normal, you are the one that is not'. And that is his philosophy on life, he wants to be normal. So therefore, in a situation where he is the odd one out, he loathes it, he hates it.

Mr Nayme relied very heavily upon his wife's advocacy on his behalf, and seemed to trade-off his embarrassment against her intervention on his behalf in public. In the home, where
embarrassment was no longer an issue, Mr Nayme, it would seem, felt he could ignore the implications of the diet on the assumption that his wife would take on that responsibility:

*Mrs Nayme:* Actually in the home cooking has never been a problem and I don't find it too hard. The interesting thing which has happened recently, two or three times is, David assumes that everything I bring into this house is alright for him, and that is funny because he actually got something out of the cupboard the other night and sat there eating it, and I had actually bought it for me, you know, one of these fat-free or 90% fat-free packet of crisps, and he assumed because I bought it he could have it and I had to say to him, not everything I buy is OK for you.

This story carried even more significance when she went on to say:

*Mrs Nayme:* This is David's cupboard here, Everything in here he can have, he keeps all his pasta and all that sort of thing in there. I put in there the biscuits, the biscuits you get on prescription are horrid, so I usually go in the health food shop and buy some and he can have sweets, and he can have little dried fruits and nuts and I buy that sort of stuff and put it in there.

*Int:* So is that new, having a cupboard especially for him?

*Mrs Nayme:* No, we did it from day one.

It was clear that Mr Nayme could avoid awareness of his condition by relying on his wife to enable him to do so.

Embarrassment about feeling different revealed a gendered element related to notions of strength and maleness in comments from two participants. Mrs Smythe spoke of her husband and Mr Cotton spoke on his own behalf about their feelings over having to leave their wives to carry heavy items which they felt they should be responsible for. Mrs Smythe (CD F/ husband CHD) commented: 'It was about eight weeks I suppose when he went back [to work] because he had to drive and he had to lift all the cases, and then to begin with, for the first few weeks back he didn't do the lifting, which was embarrassing for him, in fact, because for a man to have his wife carry all these cases!' Mr Cotton (CHD M), in a similar vein, said: 'I mean if I wanted to do anything and I guess that was the worse thing, carrying things, I couldn't do that and you have a feeling of going into the shops and getting the shopping and the wife having to carry it and you get people sort of looking at you as though [****] but I still didn't like it'.

The desire to appear normal and unchanged by the intrusion of a disease was also evident in the assertions made by participants about a 'return' to normality after a period of adjustment. Again, this manifested itself in different ways for the two conditions, but conveyed similar
intentions. Mr Scruton (CHD M) drew attention to the need to return to a normal life, whilst at the same time recognising the daunting nature of this aim:

*Mr Scruton: Things are awfully difficult...For someone to say 'there you are, you are fit, off you go', because this is a mental condition to have to overcome. The fact that sooner or later you have got to walk down the road and go to the paper shop on your own, sooner or later you have got to make a decision to get into a car and drive it. And these things are troublesome to say the least, when it comes to... You think to yourself 'what are the options?' I either do it and get away with it, or I do it with the best of intentions and what happens if I collapse on the way down there? You know.*

*Int: I guess it is disconcerting because if you haven't had any indicators beforehand then you haven't got any yardsticks to go by?*

*Mr Scruton: No, you don't realise just how fine the thread is between being there and not there.*

{*.....*}

*Mr Scruton: But I think I said, {*.....*} that after four or five days at home I decided that there was only one way of overcoming this concern of being on ones own, that I walked down the road a mile or so, caught the bus into [Town] and came back and felt as though I had challenged the Devil and got away with it.*

{*.....*}

*Int: So is that something you would want to say to people?*

*Mr Scruton: Oh yes without a doubt. Return to your normal activities as quickly as possible.*

*Int: But would you say something about the fact that returning to your normal activities could seem quite a big step?*

*Mr Scruton: Yes definitely. It is a challenge. You are either prepared to accept the challenge and live as you did, or you are prepared to say, well, I am going to shut myself away in cotton wool.....*
Mr Royle: '...and he [the specialist] said 'Unless I knew that you had had a heart attack you could have fooled everybody. For your age everything you have done fantastically well. Nothing wrong with you so be sensible...'

The implication of 'leading a normal life' is strong in this specialist's reported comments. However, a few with CHD commented upon the conjunction of the medical condition and the ageing process and the difficulty of separating out the two. Ageing, however, on the few occasions it was mentioned, seemed to have been accepted as normal in a way that dealing with the consequences of a medical condition was not. Mr Royle went on to say, about his most recent heart attack:

Mr Royle: Yes, I went back to work. My job is mainly just a desk job and no, I went back to work. But obviously now I realise that I am not, I definitely had...Previously we thought this heart attack, last heart attack I didn't know. I didn't have in mind that I had a heart attack, there was no restriction, or I can't live. But now, yes, if I do something for a slightly longer basis I do get tired and my body tells me, yes, I do need a rest.

Despite the fact that many participants claimed that the new diet had become a way of life, a number, like Mrs Wheen (CD F) admitted that 'Yes, and it can get you down if you let it, but I won't let it. It did the first year, I mean I was very frustrated in the first year, but not now'. But she also confessed that 'Oh yes, you have got to think about it all the time, but it becomes a way of life, and that is your life'. Again, notions of 'fighting' as a recovery strategy emerge here (Bury 1991, Pinder 1988), but also an indication of the tension between normality and illness as a way of life.

The ways in which family members contributed to the process of 'normalising' life with a medical condition and a special diet has been reflected in many of the extracts presented. Sometimes this was expressed as a project which the couple worked on together, as discussed in chapter three, so that they could share the responsibility. This, at the same time, moved the location of that responsibility from the individual to the relationship. The choice and preparation of food and meals as a way of communicating affection, feelings and beliefs can be seen to be an important part of this. This was manifested in a number of forms, such as: choosing to eat the same food at meal times, indulging the breaking of rules, and as in the case of both Mrs Conley (CD M) and Mrs Jolson (CD M), to make a (symbolic) clearance of 'harmful' foodstuff as shown in the following two quotes. When asked what advice she would give someone newly diagnosed, Mrs Conley said:

Mrs Conley: The first thing is to join the Coeliac Society and you get the book. To get started. And probably empty their cupboards and get rid of things like Oxo cubes. They need really actually to go through their cupboards and throw out things like I
Mrs Jolson, when describing the traumatic experience of her husband's diagnosis, indicated how daunting her family responsibilities were, of which her husband's diet was the most recent:

Mrs Jolson: That was probably on a Monday or a Tuesday when we went to see her [the dietitian] and, of course, bearing in mind I had my 83 year old mother here and I worked full time, so I was [***] at that stage, and I was arranging for carers to come in [for mother] and I had this man [her husband] who did nothing else but go to work, come home and sleep. I had to come home and clear out the cupboard of everything he couldn't have and try to plan meals. Something separate for my mother who was very particular and fussy about what she ate, {....} and then something for us.

Mrs Jolson was unusual in stressing the distress and disruption she felt at having to shoulder the responsibility for her husband's new diet, and thus his health. As has been commented in more than one chapter, she closely linked this with their relationship generally.

These participants have provided evidence that transition into legitimate illness was, generally, accompanied by a willingness to embrace the requirements of the diet. Few of the people with the condition rejected the need to change diet, and those who were tempted to do so were encouraged and manipulated into complying (even Mr Jolson) by family members, mainly partners. Nevertheless, underpinning what was often a complicated and demanding process, particularly for those in the CD families, was a tendency to underplay the impact of what was expected of them. Even in the cases where the participants acknowledged the emotional and practical demands they encountered, these were usually seen in a positive light and as of a diminishing nature. Changes were often portrayed as contributing to a notion of 'a normal life' which differed very little from what had gone before.

• Sharing and comparing the illness experience

The last two sections have highlighted the desire that participants had to minimise the impact of the illness and to promote the idea that family practices had changed very little, despite the demands of the diet. A theme of 'normality' has emerged as a way of understanding the ongoing everyday lives into which illness intrudes. However, although the construction that is placed upon 'a normal life' implies 'being healthy', rather than 'being ill', this can be misleading, as has been noted in the literature (Annandale 1999, Blaxter 1990, Morgan et al 1985). In fact, an unexpected factor encountered within this study, was the number of couples who, at different points of the lifecourse, found themselves managing more than one
illness within the one family. A table in the Methodology chapter has presented detail of the incidence of multiple conditions in the two groups, in which only sixteen of the families had just the researched medical conditions present. In thirteen families the person with the researched condition had one or more other conditions and in seven families both members of the couple had different conditions. The other conditions involved varied considerably in terms of seriousness (although none were what might be described as trivial), a few had been diagnosed in early life, whilst others more recently than the target condition.

Interestingly, the number of medical conditions present within the family, whether experienced by just one or both members of the couple, was not an indicator of perceived levels of difficulty. In fact, as will be seen, a number of participants displayed a remarkable level of stoicism in the face of accumulating physical deterioration. Multiple conditions in one person were more common in the coeliac participants. There are certain other conditions which, although not inevitably linked, are more likely to be developed in the same person (Cooke and Holmes 1984, Walters et al 1994). Diabetes and eczema have been recognised medically as linked with CD. Within this study colitis, irritable bowel disease, stomach ulcers, Crohn's disease and thyroid problems were experienced by people with CD. Problems with fertility and pregnancy were also mentioned frequently.

This section discusses the implications other conditions had for 'normal family life'. Multiple conditions could be seen to act as both advantage or burden to the accommodation of, or living with, the researched condition. It should be noted that multiple medical conditions within the one family setting had not been anticipated prior to the interviews and emerged only very gradually throughout the course of the study. As a consequence, a systematic record of the range and incidence of diagnosis of other conditions through the lifecourse was not made. It has also been assumed that the desire to underplay the dilemmas created by the incidence of illness, which became evident over the course of the interviews, also influenced mention of these experiences. Notwithstanding these limitations, for the purposes of the central enquiry (that is, how was the recommended diet managed and experienced) the presence of other conditions contributed an additional factor to be considered. The contribution made by references to other conditions for the understanding of how these participants dealt with illness is to be found in the ways in which they highlighted aspects of the family relationship process.

Mrs Poynt (CD M) was mentioned in chapter seven as having been diagnosed as diabetic as a young person, as had her mother. In her early thirties, she had two children of eight years and two years. She spoke confidently of her own ability to manage and control the insulin treatment she self administered. This extended to manipulating her own sugar levels to ensure

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that she was unlikely to become hypoglaecemic (this can result in losing consciousness) under specific circumstances, especially when she was alone with her children.

Mrs Poynt: Yes it is a healthy diet, lots of fruit and lots of vegetables, although I have to eat my potatoes and my carbohydrates to keep the sugar levels right

Int: Yes, But I remember you saying you tend to keep them up a bit?

Mrs Poynt: Yes. Then I get told off. I keep them up if I am working or whatever, but if we are all together then I really do stick to it and when I was pregnant I was really really properly controlled. It should be between 4 and 7 and it is always like 8, I don't let it go way over. I don't want to go into hospital.

It should be mentioned that this action is not recommended by doctors because there are long term risks attached. Mrs Poynt also used her medical awareness to make a lay diagnosis of her husband's symptoms. She had believed he also had diabetes because the two conditions have some common symptoms and described pressurising him into asking the GP to test him for this. This proved negative and she expressed disappointment that the GP did not take this further. In fact his symptoms were eventually recognised when his sister, who had had the same symptoms, was diagnosed with the condition. Sadly she was later diagnosed with cancer and had died only a month before the interview. Mrs Poynt will appear again later in this chapter describing her contribution to ensuring her husband followed his diet, which she felt had been enabled by her own illness experience.

Mrs Rose appeared in chapters five and six as someone at ease with her management of her own multiple conditions. She was diagnosed with diabetes as a young woman and gave a vivid description of coming to terms with this, with very concerned and protective parents:

Int: So was it a real problem? I mean you were sixteen, you were in hospital for six weeks and you had to use a syringe and you were told you had to be really strict. Presumably you were living at home with your family?

Mrs Rose: I was living at home with my family. My mother and father were so good. My father, he is now ninety-seven and he still blames himself for me being a diabetic.

Int: is there diabetes in the family?

Mrs Rose: No, I am the only one,. But my mother had everything weighed to the last half ounce.

{.....}

Int: So you say that when you were a child your parents grew their own and so you had a lot of fresh fruit and vegetables in the house?

Mrs Rose: Yes.
Int: That must have been really nice?

Mrs Rose: It was very handy, I knew what I was getting.

Int: And well before all of these messages of 'got to eat more fruit and vegetables' you were there.

Mrs Rose: Yes I think really, considering I had diabetes, I think I was pretty healthy because of the way in which I was brought up. Two parents who were very very supportive and on those days I can remember my insulin, my father would make sure it was done on the dot, at a certain time, and of course when the hour changed, you know with Greenwich Meantime, about three weeks beforehand he would alter it so many minutes each day to bring it into line. They were so... Well I suppose they were so upset and uptight about it they just wanted everything to be correct which in those days was a good thing, you did have to be very strict on those days.

She went on to describe a very confident approach to life despite being left by her first husband to bring up three young children alone, and later developing arthritis and coeliac disease. Her current partner's attitude towards her health was described in chapter one as one of concern and support. In this section, it is the confidence with which she described her ability to juggle illnesses, that is of interest:

Mrs Rose:.....I spoke to a specialist once and I said about this, at a later date, I said I found it very difficult because we used to eat out a fair bit and there was always the problem of saying 'I am a diabetic', but now I find it even more difficult. He said 'Well you can always have an omelette'. I said 'If you think I am going to sit there watching them eating nice things and I am going to have an omelette you have got another thought coming'. He said I could work round it and it was something I had to work out for myself and he said occasionally I might have something, a hidden object that I may not be sure about, and he said it will make me feel rough for a couple of days but it won't do any real damage. But he said if it comes to the point where I have to choose between gluten-free food and a diabetic meal, he said I am to forget I am a diabetic for that day.

Int: Really

Mrs Rose: Yes that was his advice and the advice from my own doctor

Int: The coeliac condition...

Mrs Rose: The coeliac would make me much more ill than the diabetes would. If I had something, say, sweet then all I have to do is to take a little extra insulin, which I can do for myself with no problem at all, I can just up it or lower it.

Int: And they assume that you will be realistic about this because they are supposed to be... I mean the thing I have learned about a number of conditions is there are short term effects and long term effects, and it seems to me that diabetes and coeliac have similarities in that they both have short term and long term effects?
Mrs Rose: Yes. If you make a mistake you will be over it in a couple of days with no problems at all.

Int: In terms of coeliac and diabetes?

Mrs Rose: Yes both, But if you abuse both on a regular basis then you are going to have a lot more problems. You are going to be ill.

Int: In a way that you can't deal with just by taking insulin or whatever?

Mrs Rose: Yes.

Int: So when they say...When the doctor says well if there are times when there are difficulties then it won't do you any harm, they are also relying upon the fact that you will be sensible?

Mrs Rose: Oh yes. Because he said that with the coeliac they do a blood test and from that they can tell right the way back to your last visit whether you have had any problems.

Mrs Rose's confidence was helped by regular checks from the specialist (because of her multiple conditions) and a very supportive GP. Nevertheless she also cites experienced self monitoring throughout her life, within a supportive family:

Mrs Rose: Not really because I know that if I do something wrong it is me who is going to feel ill. I think to be perfectly honest since I have had the coeliac there is only one time that I have had any [problems] and that was where somebody had seasoned a steak. Because I usually say 'no seasoning on anything' because even white pepper has got flour in it you see, and you have to be so very careful. And he [the specialist] said to me really we don't have much trouble with you' and I said 'well for my own sake because I feel so lousy if it does happen'. And of course when I say diarrhoea it is a totally different type of diarrhoea than if you have an upset tummy or a bug or anything. I know the difference and I can tell straight away.

[..]...

Mrs Rose: ....When the children were young I had a bit of trouble because obviously the body alters where you are carrying the children and we had an absolutely marvellous routine, I wasn't living here then, I had a next door neighbour, I was just up the road and nine times out of ten I would be going into a hypo when the kids were eating their meal or something so they just 'come on kids', pick their meal up and walk next door and she would cope with it and I would be whisked off to hospital and things like that. But really in those days life was a bit different, I had three young children within six years and you didn't go out.

towards the end of the first interview

Mrs Rose: .....I think the fact that I had so many years of having to look after myself anyway on my own, it has made me much more confident in myself. And the boys are very much like me because they grew up for most of their lives without their father and they do care for me. They worry about me, they take care of me.....
Two women participants described their own conditions, Mrs Flow (CD M) a hiatus hernia and Mrs Scruton (CHD M) heart problems, a hiatus hernia and colon problems, as providing useful knowledge and nutrition practice for dealing with their husband's dietary needs. Mrs Flow's husband was recruited as a person with CD, but who also, it emerged, had had a heart attack.

Int: ....So they talked to you about diet when you started to have the heart trouble and how did you see that? I mean did you find that difficult or did you ...When you were told about the kind of diet to follow for a heart condition?

Mr Flow: It wasn't difficult but...

Mrs Flow: What we found it was hard to see was we had already been on it.

Mr Flow: We were fairly healthy eaters other than the amount of meat we were eating. You know, I could have cut down on cakes and biscuits and things but most of the time we were fairly healthy but as I say the amount of meat was a by-product of the work I was in.

Mrs Flow: Well there are lots of things I couldn't eat because I have a hiatus hernia so we had already cut out things. I won't have it {***} so when this...

Int: When did you start with the hiatus hernia?

Mrs Flow: Ages.

Int: A long time.

Mrs Flow: Yes. I was thirty-seven then and I had had it and {***}

Int: And you were advised to follow...

Mrs Flow: Oh yes, I had to cut out so much because I was feeling so ill and we did. And as I say, like fat I could never eat anything with fat.

Mr Flow: Yes that was one of the things with my diet was to cut the fat off and I used to enjoy a bit of fat, as you do, you know.

Int: Yes.

Mrs Flow: If I put him some chicken and there is some skin left after he has finished I will say 'where is that skin? Have you eaten that skin?'

Mr Flow: And I say 'There wasn't any on there to start with'

Mrs Flow: I do take it off, but then I will say it to him!

Mr and Mrs Flow can be seen to describe the way the CHD diet worked for both of them through a jokey banter which also reveals the gendered nature of family responsibility. Mr Flow had been a butcher by profession, which might imply a nutritional awareness, but the
above exchange suggests that the person responsible for knowing about healthy food was Mrs Flow.

Mrs Scruton identified her own heart problems - she was a 'hole in the heart' baby - which had required a lifetime attention to diet, as helping her to address the demands of her husband's diet.

Int: So do you think it has changed much? You say you have always eaten healthily, can you give me some notion of how you have become aware of healthy foods... I know that when we were all young healthy eating wasn't something we were made aware of in that way we are now?

Mrs Scruton: Yes, well I suppose we have been fortunate in a way because, not only with the heart problem I was born with, but also I developed a spastic colon and a hiatus hernia...

Int: How long ago was that?

Mrs Scruton: Well I have had the spastic colon...

Mr Scruton: twenty years?

Mrs Scruton: Well, eighteen years. Quite a time. And then of course you are put on quite a high fibre diet and that of course is good with hearts as well. I can't be bothered to mess around with two lots of food, I do sometimes but not often, so it means to say that he gets the benefit of this as well. So it means he is eating a healthy diet which should be good for the heart. I eat it because I think the heart needs a bit of encouragement too and it is the colon and trying to keep it the right way, so we do eat quite healthily.

These quotes are examples of participants who construed and presented positive ways in which they had accepted the experience of multiple illness within the family. These views came from the perspective of the pragmatic and everyday, and one for which gendered roles were revealed to be significant. Three of these women were retired, one early due to ill health, and one was a young mother. All expressed views which indicated traditional beliefs about gender roles. It has already been noted that Mr Flow had taken over much of the meal preparation and baking since his retirement, a move entirely acceptable to his wife. Nevertheless it was his wife who took overall nutritional responsibility for both herself and her husband:

Mrs Flow: ....But as for food, I have to be fairly careful, well we both do you see. It is the two of us and when we go out for a meal I say to them 'is there so and so in that' or 'is there so and so in this' and then it is 'I will have that'.

The family relationship, as it proceeds through the lifecourse, can be seen to have an important influence upon the ways that the management of multiple illnesses was organised and
understood. Less positive experiences were also reported, but also reveal management processes which were strongly gendered and grounded in a sense of family duty.

For example, Mrs Brigson (CD F), now a widow in her sixties, developed thyroid problems in childhood and also arthritis, Reynauds disease (a circulatory problem) and coeliac disease in her forties. In chapters two and three her story helped to illustrate ways of construing gendered tasks. When talking about being diagnosed with coeliac diet, she described her husband's reaction as less than supportive:

**Int:** So tell me about what it was like when you first came home, you told your husband and he was obviously very upset.

**Mrs Brigson:** Yes, because he said to me 'what about my pastry?' Bert loved my pastry and every week I made up a pound of pastry. Every week. Whatever, come rain or shine. Whatever was going on.

and later

**Mrs Brigson:** Well to be honest I couldn't afford it. I said to Bert 'I can't afford to do two lots a week, not for you and for me'. He said 'Well you get yours free' and yes, I did get it free but I said I can't afford that straight away. And, in the end, well, of course, he went off his food any way at the finish. But he always said that the stews tasted different and 'I won't have that' because the flavourings that I used, I mean, I think he was getting a bit... you know......

This emphasis upon Mr Brigson's needs was exacerbated when he developed heart problems culminating in triple bypass surgery and then kidney failure requiring dialysis:

**Mrs Brigson:** Well, now we come up to the menopause and the fact that I was bleeding something dreadful, and I was sitting there one day in the doctor's surgery in the hospital and he said to me 'I think you will have to have a hysterectomy' and I said 'No chance'. He said 'What do you mean? and I said 'No I am not having that. For a start you doctors, all you want to do and first thing anything like this happens you want to rip the womb out, no and I am not having it. Also my husband is a very sick man, he is not well at all, he has got heart problems as well and he needs me and I am certainly not going to get any help from him if I have to rest up'......

Mrs Brigson was not convinced that surgery would help her own menopause symptoms. She was also aware that recovering from major surgery could have compromised her ability to continue caring for her husband and so decided to refuse the surgery for herself.

Mrs Tayte's (CHD M) story provides an unusual contrast. Mr and Mrs Tayte were both retired, but had taken a conventionally gendered employment path. Mrs Tayte gave up full time work (which she enjoyed) when their children began to arrive and only ever returned to part time work. Her husband remained in full-time very demanding work which involved unpredictable hours and travel abroad. This couple were recruited through Mr Tayte's
experience of heart disease. He had been diagnosed with angina six years earlier (since his 
retirement) and had more recently experienced a minor heart attack at the same time as 
gallstone problems, neither of which required surgery. In contrast, Mrs Tayte had had a 
number of medical problems including three hernia operations, a hiatus hernia, a serious 
stomach virus and diverticulosis, all of which she revealed at a very early stage of the first 
interview. Her husband joined this interview but was discouraged by his wife from 
contributing much. Her view of her husband's condition was largely dismissive and she 
hinted at misdiagnosis by the medical profession. This exchange followed a very detailed 
description of Mrs Tayte's illness history:

**Int:** It must have been a dreadful year what with one thing or another?

**Mrs Tayte:** No I am alright, this is the point...

**Mr Tayte:** What with me and [****] before this is when I had the heart attack

**Mrs Tayte:** Well, you thought it was

**Mr Tayte:** And I had the same thing again....

**Mrs Tayte:** No he didn't.

**Mr Tayte:** I went out to the car and I just couldn't breathe again

**Mrs Tayte:** I think he had a panic attack

**Mr Tayte:** I just couldn't breathe again

**Int:** And of course it is hard to say. The thing is if it is a panic attack then you won't 
have them again, but if it is angina then you will have one again

**Mrs Tayte:** You see my husband has never had a pain in his chest, never.

**Mr Tayte:** But in the hospital neither had any people that I was in with.

**Mrs Tayte:** Well, they do, angina is the pain.

**Int:** I think you have to... I mean I am not an expert by any stretch of the imagination 
{......} it is amazing the different symptoms that will lead to different end products 
{......} So you just don't know

**Mr Tayte:** I didn't go in then... I had this burning up here an he gave me something for 
indigestion and [****] but come the Friday I just couldn't sleep at night and I would 
come downstairs with a terrible pain here and I was like this across this table most 
of the night and I [****]

**Mrs Tayte:** No he was due to go ... because he had complained of this burning thing, 
the doctor had told him to go and have a scan of the upper stomach now because he 
had this sort of thing, this pain or whatever it was...

**Mr Tayte:** Terrible pain.
Mrs Tayte: I got the doctor, he made me get this doctor and he wasn't very pleased at being brought out... anyway he wrote a note and said he thought he should go over to [name of hospital] and get a second opinion, but the pain was down there and nothing to do with his heart, but we went over there and took the note in and was there seven hours waiting and I had just come out of hospital myself.

{....}

Mr Tayte: As it was I waited three and a half hours and they had cleared all the drugs that I had had the night before and eventually got me through and gave me an injection for the pain and then the next day they said 'Do you realise you have had a heart attack?' and I said 'No'. And they said 'Has anything funny happened to you?' and I said 'Well, shortness of breath and my wife in hospital last week and then during the week when I went shopping...

Mrs Tayte: This is too long a story to get involved in this time but the point is he had a problem with the fellow over the road, but he has left now.

Now in their late sixties and retired, this family relationship seems to have been built upon a wife and mother firmly located within the home and a husband whose employment required total commitment to the workplace whenever this was demanded. Mrs Tayte had developed expertise not only in her domestic role - being nutritionally aware, being expert in cooking and baking, as well as being aware of the children's needs - but also juggling the effects of the demands of her husband's work upon family events.

Int: .....Because you were saying when you were cooking, it must have been quite difficult when your husband came back late...

Mrs Tayte: Oh don't!

Int: Was that quite often?

Mrs Tayte: Yes too often

Int: And what would you do about eating?

Mrs Tayte: I had a terrible time actually. My next door neighbour who hates cooking, doesn't cook at all now, never has cooked much, her husband does the cooking now, she said to him 'I don't know what it is to have anybody coming in late for meals'. So she knew. You see when Mark went to the grammar school he started to play chess, he is a good chess player

Int: After school?

Mrs Tayte: Yes, after school, then he became chess captain eventually. He won all these things at school, they were all top of the ladder, and then of course, it got that he was going to play at another school so he wasn't coming in. And sometimes my husband had to go and pick him up. And it was a bit of a...

Int: Trip?
Mrs Tayte: yes, well it was tough for all of us really because I didn't like reheating food for him either......

Int: But that must have taken a bit of managing {.....}

Mrs Tayte: That's right yes. I have had it all my life actually. Even when Andrew went to the bank. He went to the bank and he wasn't coming home until... Well any time up to eight pm at night and we were really hungry waiting sometimes. I was dieting then, the Cambridge diet I told you about, that was a bit tough. We sometimes had to wait and I wouldn't cook the meal unless it was chilli which I could re-heat, or spaghetti bolognaise sauce which I could reheat fairly well. I didn't really like reheated stuff so I had to hang on to his. So all my life I have had problems with food.

Mrs Tayte made it clear that she had soldiered on despite her own health over the years, but seemed unwilling to acknowledge the potential for her husband's ill health. Mrs Tayte was the only female spouse who seemed to actively deny the existence of her husband's condition by casting doubts upon the accuracy of the medical diagnosis.

This denial did not seem to have had negative implications for his diet because her confidence in her ability to produce healthy meals for the family generally seemed very apparent. However, Mrs Tayte is unusual in that she did not seem to take specific responsibility for ensuring that her husband's behaviour avoided further heart incidents. This may have been more possible because Mr Tayte's heart incident was relatively minor. However, Mrs Tayte's perspective may have also been influenced by the nature and character of their family relationship. As stated earlier, this couple had a clearly identifiable traditional division of roles. However, Mrs Tayte also had experienced long term chronic illnesses throughout a large part of their married life. Normality within this family relationship was that Mrs Tayte managed her own illnesses, whilst ensuring the health of her family. The 'sick role' in this family seems to have been the property of Mrs Tayte rather than her husband.

My final example in this section is Mrs Rice (CHD F), who appeared in chapter one illustrating difficulties encountered when role reversal was seen to interfere with the satisfaction drawn from gendered tasks. Here her story describes a dilemma consequent upon role reversal. Mrs Rice was diagnosed with CHD after a heart attack. She was also aware of her husband's potential risk for the same condition and registered some frustration over her husband's lack of willingness to incorporate CHD diet recommendations into their meals:

Mrs Rice: .....I have read all the leaflets assiduously, I have followed the very good [hospital] ex cardiac problem course {.....} because I had been following all the advice on high fibre and lots of fruit and lots of vegetables and brown bread, all my life more or less, so I was there really. My husband, I don't know where I slip this in, he is
over-weight and has high blood pressure, so he ought to follow a similar diet and, generally speaking does, though he does differ.

and later

Mrs Rice: .....But he [her husband] loves food shopping. He more or less determines what we are going to have, but he will ask me what I want and then more and more I have begun to say 'well you have that and I will have this', because he would have...He would have... He loves meat and I want to eat less meat, and his doctor... He has high cholesterol and he has high blood pressure and before he goes to see the doctor in six months he [****] well there you are. I mean this is one of the kind of things you are studying no doubt there is a limit to how much you can influence others, you have just got to let them get on with it. So as far as me looking after him by saving him from himself, I have given up. But he is good as far as I am concerned because he will remember what doesn't have dairy products in it when I have forgotten......

and later

Mrs Rice: I am trying to think about what happened in the early part [of their marriage] there was no time for consultation really. But you see John must have a roast dinner on a Sunday, and you must have a big roast to make it worthwhile even if there are only two of you. Now if you have a big roast that means you have got cold meat on Monday, it means you have got shepherd's pie on Tuesday and you have got some meat let over on Wednesday and it doesn't leave much room in the rest of the week to eat other things.

Int: So you just sort of slipped into that?

Mrs Rice: I just slipped into that. Because that leaves Thursday, Friday, Saturday. I would eat pasta and rice, but we are still kind of negotiating.

Mrs Rice reveals the double dilemma of trying to conform to a togetherness of eating the same food as her husband, something she knows he would prefer, but also the desire to improve their nutritional intake, something he does not seem to want to take on board. The fact that Mr Rice has been responsible for the practical aspects of meal production in this home does not seem to have extended to nutritional responsibilities for himself or his wife.

The families quoted in this section are drawn from those where multiple medical conditions have offered an additional challenge for the couples to deal with in a family setting. Most saw aspects of the experience of one illness as helping the process of managing new illnesses. Some found the presence of more than one illness in the home a burden. The incidence of more than one illness in a family, may have meant extra responsibilities for monitoring health and attention to symptoms and treatment, but it did not seem to have affected the processes by which these are conducted. Most of the (female) participants quoted here used their own illness experience to inform the ways they catered for their spouses' illness. Even Mrs Tayte,
who did not seem to recognise the existence of her husband's heart trouble, nevertheless did not neglect his nutritional needs generally. However, they all revealed the significance of the family relationship for the ways that the illness were construed and managed.

Summary

This final analysis chapter has shown how the image of the family relationship can be seen to be preserved through the accommodation and assimilation of life events, specifically the medical condition. The desire to preserve a sense of normality in the face of distressing symptoms, as well as after the diagnosis of a medical condition, can be seen to rest on assumptions about the nature of the family relationship.

This chapter has drawn attention to the interplay between the family relationship and the illness experience, both before and after diagnosis. The participants in this study, in both illness groups, show the strategies that can be used to construe symptoms and consequences of illness as minimal and manageable. An expectation of 'normal' health informs both the way the people with CHD chose to ignore the risk factors, and the people with CD ignored minor symptoms, until the medical conditions were formally confirmed. Even those with severe symptoms endured and carried on as normal, as Mrs Kelner made plain: 'you never know you are ill until you kind of collapse'. Thus 'being healthy' can be construed as encompassing considerable discomfort and potential risk.

The role of the family relationship in dealing with symptoms, both CHD and CD, can be seen to be important, sometimes crucial. Many were persuaded into demanding medical help, some relying upon the active intervention of partners to ensure a correct diagnosis, as Mrs Calman demonstrated 'I actually phoned [the doctor] up..... so I actually told her the symptoms and she agreed with me'. Once the illness was diagnosed, the family relationship provided the setting which, by it's nature, a sense of normality could continue. The overall message conveyed in the early stages of the interviews tended to be that the new diet was not a problem and that 'being healthy' was easily achieved. This was conveyed largely through 'not being different', which seemed to mean not being different from other people, but also had an implication of not being different from the way it was before. This was highly dependent upon the active help and support of other people in the family, particularly the person responsible for food and meals, the home manager. Not being different, or 'being normal' was constructed out of familiar, ordinary, unremarkable activities on a day to day basis. These implications of no change in activities, and the content of activities, renders
invisible the work necessary to create this sense of continuity over time and despite events. Mrs Conley and Mrs Jolson describing 'clearing out the cupboards' to accommodate the new diet provides a striking illustration of this.

As has been noted, even the presence of multiple illnesses in the home did not, in itself, seem likely to bring about major differences in the processes by which illness was accommodated. In fact, many construed this as helpful in building confidence and providing information to deal with the new condition and diet. The families in which the illness and the diet was acknowledged as problematic, were, nevertheless, constituted through family roles and responsibilities which drove assumptions about what needed to be done and how undertaken.

The gendered nature of this caring is very clear, with active intervention in the process of diagnosis, or the treatment, most notably instigated by female partners. However, it also seems clear that this is not simply a matter of women doing caring and men not doing caring in the home. The concern and support of male partners is in evidence here and in previous chapters. Explanations for the management of care could be found within the nature of the caring styles that families negotiated and developed over time. The next chapter will draw together the themes revealed during the course of the analysis chapters. The discussion which follows will attempt to draw out meanings embodied within everyday activities, such as tasks and activities around food, which facilitate or constrain responses to illness in the family.
Part four
Discussion and conclusions
Chapter 9. Living a normal family life

Introduction

The aim of this study has been to explore the ways that the adult members of the participants' families managed the dietary recommendations for one of two medical conditions within their ordinary everyday lives. The conditions in question (coeliac disease and coronary heart disease), although very different medically, were chosen because they both had the potential for, ostensibly, complete recovery, if medical advice was followed. Coeliac disease (CD) is relatively rare within the British population, whilst coronary heart disease (CHD) is a major cause of illness and death in Britain. The treatment for the former is purely dietary, whilst the treatment for the latter can range from diet and other lifestyle changes, to medication, to surgery, and often takes in all of these. Nevertheless, it was not unusual for the participants to report that the medical professionals they encountered had conveyed the view that, if patients followed the recommended lifestyle changes, they should be able to 'lead a normal life'.

At the outset it was assumed that there would be a tension between the expectation of being able to 'lead a normal life' and the necessity to make specific lifestyle changes (in the case of this study this means diet) as 'treatment' for the rest of the 'patient's' life. This tension is born out of the contradiction between the assumption that to be 'normal' means to be 'not ill' and the requirement to follow a medically recommended diet for life. It was felt to be likely that this tension would be reflected in the ways that participants chose to manage and monitor the diet.

The nature of the family setting, structurally and ideologically, is both significant for the understanding of social life and also multilayered in terms of the lived experience of social life. Much of the literature which has examined the content and the form of 'the family' has acknowledged the important part played by gender (Morgan 1996, 1999, Gregory 1999). The ways in which tasks and activities within the family setting tend to be construed in gender terms, even where there is no clearly gendered division of domestic labour, have been examined widely. There is no doubt that these divisions remain and seem likely to continue to a greater or lesser extent in most homes (Charles and Kerr 1999, Finch and Mason 1999, Arber and Ginn 1999). That these divisions remain relies as much, if not more, upon the embodiment of gendered identities within day to day lived experience, as it does upon a convenient way of allocating daily tasks. The design of the study reflected a major interest in
the part played by gender in the process of accommodating and assimilating the new diet associated with chronic illness within the family setting.

The study of the family has also identified the home generally, as well as specific activities which take place in home and family, as predominantly female. Whilst the explanations for this can be seen to be largely economic, the classification of the private domain of the home as female and the public domain of paid work as male remain evocative and entrenched. In fact, whilst the public world of paid work has been penetrated convincingly, if not completely, by women at most levels, the home and family remains a female world as responsibility and as territory. Whilst it was assumed that the participants who would take part in the study would reveal evidence of gendered divisions in the home, an important question would be the level to which this would be clear and unequivocal.

Within the home the roles and responsibilities assumed by those who live there act as indicators of individual identities and group relationships. Thus the repair of a piece of household equipment or the preparation of a family meal, as well as fulfilling a practical necessity, also demonstrates the ways in which each family member identifies themselves (as, for example, mother, wife, woman) and the ways they relate to each other. The activities that take place in the home represent an on-going process of maintaining continuity whilst accommodating change along the lifecourse. A roast meal prepared for Sunday lunch for a family made up of two adults and their young children may be much the same in content as the one prepared for a family made up of a retired couple and their visiting adult married children and their own families. The meaning which might be extracted from the activities which took place in order to prepare and consume those two Sunday lunches may vary considerably. For example, the former may involve introducing and establishing the preferences and practices of that particular household and generation. The latter, in contrast, may be highlighting the transfer of traditions across generations, whilst recognising the differences between generations. Nevertheless, both settings may be involved in the socialisation and education of young people into the norms and values of society generally. During the course of the data collection and analysis procedures of this study, the implications of what might be seen as simple family tasks around food and meals for the understanding of social processes began to emerge.

The literature has shown the increasingly ambivalent feelings that women have for the location with which they tend to be identified - the home and family. Since Ann Oakley (1974) broke the news to the academic world that women found housework at best boring and at worst generating feelings of frustration and entrapment, research has gone on to show that this, whilst true in essence, is not the full story. It has been revealed that many activities within the
home could be seen as fulfilling and creative, but at the same time, irritating and undervalued (Swift 1997). Much of the (unpaid) work undertaken by women in the home involves the care, in different guises, of other family members. 'Caring about' others in the family can be seen as a (welcome) option for all family members. 'Caring for' other family members is often seen as the prerogative of the female adults. 'Caring for' others to ensure their continued health or to help them recover from (chronic) illness is frequently seen as a responsibility most appropriately undertaken by women, as wives and mothers, and in the home. Again, care and concern for children and other adults is often demonstrated through actions performed for and on behalf of other family members, as well as through overt expression. In other words, it is done routinely and is often seen as just part of the 'normal' task of running the home. As the data collection progressed, the gendered nature of care in the family setting was clearly reflected in the ways in which the participants described how they organised (specifically food) tasks in the home. During the data analysis it became evident that gender was also part of a process of communication which was as much family relationship as it was individual identity.

The coming together of health and illness on the one side and food and diet on the other side, within the family setting, pivots on the notion of caring. The production and consumption of food, although increasingly seen as important for preserving individual health, is not usually seen as a form of treatment for a specific illness. This enquiry into the management of diet after the onset of specific chronic illness built upon previous research (Henson 1996, 1998, Gregory 1999) which recognised the significance of family processes for the management of diet change. This study delves further into the interplay between domestic process, gendered identity and illness experience. It was assumed that this study would reveal gender differences in both action and understanding in relation to diet management in families, especially when it concerned chronic illness. The choice of two medically distinct diseases, both in terms of medical makeup and recommended diet, suggested that there would be noticeable differences in how the consequences of these two conditions were accommodated within the family arrangements. The decision to recruit half of the participants from couples where the man had been diagnosed with the condition and half where the woman had the condition was also expected to highlight gender differences. Indeed, as has been seen, differences have been found in terms of gendered domestic tasks, reactions to the medical conditions and the gendered experience of the person with the condition. Many of these endorse findings in previous studies, such as those of Charles and Kerr (1988) and DeVault (1991), who have noted a continuous expectation that women should be responsible for the provision and production of food and meals with the home. However, more important, I feel,
has been the identification of the complexity and multilayeredness of family life across these two conditions within which gender plays a crucial, but only partial, role.

What seems clear, and will be argued in the following discussion, is that the family is an important social institution within which significant social processes are acted out. Family practices influence and are influenced by other social processes – gender, health, illness, childhood, parenting, and many others, both within and outside the family setting. This influence is conveyed through the lived experience of the everyday and is subject to contingency and contradiction over the lifecourse. Thus it is the similarity of choices and ways of understanding which are as striking as the differences between gendered or illness behaviour evident in the relationships revealed in this study. Morgan (1996) has suggested that 'the family' is a process rather than an entity, and, as such, urges the use of terms such as 'family practice', rather than 'the family'. For the purposes of this study, the term 'family relationship' as well as 'family practice' provide the most illustrative terms around which to understand and explain how the participants construed their lives and actions. It was within the family relationship that the nature and form of mutual caring could be negotiated and renegotiated, using gender and family membership identity as markers for boundaries and territory, for role and responsibility. Gender and family membership identity was conveyed through descriptions of day to day activities, specifically those to do with food, diet and meals. It is suggested here that the acting out of everyday, sometimes mundane domestic tasks and activities constitute individual and family identities, through understandings of 'the normal family life'. The participants in this study conveyed clear understandings of 'the family relationship', as a significant social norm which they used to frame their own family practices.

This study was made up of a small sample of forty-one families (62 participants) with an age range of late twenties to late seventies. Nevertheless, over two thirds of the participants (44) were over the age of 55 years, which may have had implications for the conclusions drawn. The suggestion that current cohorts of younger women are no longer channelled into domestic life choices compared to older cohorts (Walby 1997) implies that future families may see changes in women's employment experience. This may have implications for the level to which women may expect or be expected to take full responsibility for tasks in the home. However, there is little evidence to suggest that, whilst women increasingly may be undertaking full-time paid employment, changes in either women's or men's participation in domestic labour are anything but slow and partial (Sullivan 2000). Certainly the four younger female participants with dependent children still at home, who took part in the study, made employment choices similar to those of the older participants who tailored their
employment experience around their children, and took primary responsibility for domestic tasks. More importantly, there is a consistent theme which can be traced through all of the participants' contributions which suggest that constructions of the family relationship display a gendered nature which relies upon notions of the natural and the normal to sustain it.

It is the theme of normality which moves through the meanings and understandings that these participants convey, of their own family lives, particularly in relation to food and meals, even in the event of chronic illness. The processes by which the participants had organised and conducted their family lives over time provided the means by which the contingency of chronic illness was construed and managed. The discussion which follows uses as its frame the four concepts, outlined in the introduction and discussed in the methodology chapter, which informed the direction and the content of my analysis: (family) relationship; caring (for and about); negotiation (family practices); selfhood (gendered and family identities). The theme of 'being normal' will be used to consider the processual nature of family practices, specifically for diet related to illness. 'Being normal' can be seen to be a significant part of the process by which participants both 'do gender' and 'do family'.

'Normality' - a definition

People construe their lives in terms of the known and the predictable, which they understand through their everyday experiences. Gidden's notion of 'ontological security' (Tucker 1998), discussed in chapter one, offers a theoretical basis by which this desire for the familiar and the certain can be explained. The cultural norms identified by sociologists as having specific characteristics related to social categories such as class, race, age and gender, are acted out on a daily basis within the context of home, work and other social networks. The characteristics attached to specific classes, races, ages etc. may be drawn from the behaviour of people within those categories, but are understood by the people who display the behaviour as personal and special. The term 'miner' may (still) generate pictures of a male oriented form of employment drawn from specific geographical and class locations. It is understood by the miners themselves through the everyday experience of not just what they do at work, but how they and others construe that occupation. The term 'family', in the twenty-first century, as discussed in the literature chapter, conjures up notions of love, marriage (still), parenting, caring. These social roles construct tacit and informal rules and norms which offer a sense of stability through recognised and legitimised routines. Despite the fact that 'the family' has also attracted criticism related to oppression, abuse and manipulation, it is still seen, and used,
as the expected, the normal, form within which most people will live for large parts of their lives, across the globe.

Again, the literature review suggests that the form the concept 'family' takes may vary from culture to culture, but, I would suggest, family members understand the concept through their everyday interactions and relationships. 'Family' is not just what they are, but what they do, with, to and for each other, on a day to day basis. Family life, whether delightful, painful or dull, can be seen as, simultaneously, unique - to each individual family group - and universal - having common, predictable, familiar characteristics and behaviours (Bernardes 1997). Each family group operates to a set of expectations, or norms, which, to a greater or lesser extent, recognise those universal norms.

The concept of 'normality' is being used within this analysis to represent the way in which the people interviewed for this study conveyed their understandings of what was expected, familiar and accepted as socially legitimate activity and behaviour within their family settings. As mentioned earlier, when enquiring into matters generally seen as ordinary and everyday, what is expressed by participants is rarely seen - certainly by them - as striking or noteworthy (Cunningham Burley 1990). The data analysis suggests that, even within the context of the diagnosis of a medical condition, there could be found a desire, at least to try, to restore a sense of 'the normal'. An interesting comparison may be made with the work of Prout et al (1999) in their study of the household management of childhood asthma. They have noted that it is the maintenance of ordinariness which becomes paramount in the goal of achieving 'a normal life'. This aim has, paradoxically, promoted the use of medicines over the lifestyle changes required to accommodate other medically recommended preventive measures. It is clear that 'normality' can become a significant factor in the process by which people choose to respond to illness in the family setting. Within the context of my study, lifestyle (that is, dietary) changes were not neglected, but constructed and construed in ways which minimised the perceived impact upon the family relationship. Normality was seen as 'the same as other people', but perhaps more importantly, 'the same as what went before'. The two medical conditions in question, even where requiring major surgery, were often seen, or presented as, capable of allowing the person to 'lead a normal life' afterwards. Some research has reported that how people and their spouses conceptualise the level of debility caused by a medical condition is not always directly related to actual disability (Schott and Badura 1988) Whilst some of the participants within this study admitted to life changes which occurred as a direct consequence of the diagnosis of the medical condition, all described their experiences within the family setting in terms of a process of absorbing the requirements of the condition into existing family practices. Most participants described this process in positive terms which
tended to downplay any difficulties which it might create. They reported that life had changed very little, the process of change had been accommodated relatively easily, normality had been resumed. A few participants found the consequences of the diagnosis of the condition very disruptive, and were angry and distressed by this. Nevertheless, the distress expressed was grounded in the disruption to the everyday life they had been used to, and to which they were attempting to return.

Two terms have been borrowed from developmental psychology: processes of 'assimilation' and 'accommodation'. Piaget, in attempting to theorise the development of intelligence in the child, describes an adaptive process by which new experience is assimilated into the mind, combined with the accommodation of the mind to new experience (see Richmond 1970). A parallel is drawn between this process and the normalising process by which continuity and change is absorbed into family life. The emphasis of this study, the management of the medically recommended diet, focused specifically upon activities related to food, meals and eating. These activities can be seen to have involved the changing of family activities to accommodate the new diet, and, where felt to be necessary, making changes to understandings about the diet - assimilation - to allow existing protocols to remain. Nevertheless, a minimising of the extent and the effect of those processes was frequently observed.

The theme of 'normality' can be found to weave through the narratives of the participants as they relate the ways in which they experienced and organised diet, food and meals from day to day and over the lifecourse. The insinuation of illness, whether suddenly or over time, into the lives of these participants can be seen to have been disruptive to a greater or lesser extent. The dietary advice which formed part or all of the treatment for the illness had implications for the practical routines and habits of all family members, although for some more intrusively than for others. Because food and meals are fundamental to both the practical and the emotional constructions of family life, there can be discerned a tension between the need to pay attention to the demands of the diet, and the desire to preserve the continuity, actually and perceptually, of ordinary family life.

Family relationship

Within the context of this study, the family relationship can be seen as a norm within which ordinary everyday activities took place. The symptoms, the medical condition and the recommended diet were experienced, understood, interpreted and sometimes even rejected
from within a relationship which had established and recognised roles and responsibilities. Inviting participants to talk about managing food and meals in the family setting revealed a sense of 'family' which was significant for both personal and group identity. Comments about the nature of their own families reflected the universal - Mr Morton (CHD M) speaking of his childhood: 'we basically had quite a normal happy family life', and the individual - Mrs Poynt (CD M), also speaking of her own childhood: 'I think it was just normal, normal family life, Greek style', and Mrs Colman (CHD F), describing a harsh childhood: 'it sounds a terrible family, doesn't it?'

However, it was also the case that the sense of family relationship as recognised, predictable and on-going (whether positive or negative) was implied rather than stated. By this is meant that participants conveyed their notion of family relationship through action rather than overt definition. Mrs Howard's (CHD M) assertion that: 'You are a family if you have a meal on the table', exemplifies the use of the family meal, discussed in chapter five, to embody a sense of family relationship. The family meal as a regular and routine family activity was, clearly, not achieved by all participants all of the time. Nevertheless it can be seen to be construed by most as an important symbol of family unity, subject to the contingency of other (legitimate) family pressures. For example, paid employment of husband and father was seen as legitimate reason for the absence of regular daily family meals, or his absence from that meal. The importance of the family meal, as described by participants, can be seen in the dual purpose of it as an (enjoyable) family event, and as a means for monitoring children and partner's health and progress. Those few participants reporting distressing family lives, commented upon the comparison of their own experience with an assumed positive alternative, for example, Mrs Garside (CD F), describing a distressing childhood: 'you weren't sitting down to a nice meal with a nice family or anything like this'.

There was some evidence of change over generations in terms of what could be construed as 'normal' family practices. For example, a number of participants described their parents' domestic arrangements as organised upon strictly gendered lines which they had not introduced into their own adult lives absolutely. Some encouraged their children to make changes to traditions that they themselves had followed. For example, Mrs Scruton (CHD M), commenting on her husband's inability to cater for himself: 'Well, Peter could never cook ....... so I thought the boys are not going to be like that'. Nevertheless, the tradition of family arrangements was not seen to be questioned by participants of this study. Mrs Greig (CHD M), commenting upon her daughter's feeding arrangements with her own children: 'Because...... my youngest daughter, their Mum, is....totally the opposite.....junk food, out of cans, pizzas...' expressed surprise at this: 'But she wasn't brought up like that Susan,
and that is why I can't understand why she has turned out like that....'. In contrast, Mrs Flow (CD M) described, with approval, the change in her daughter who was rebellious as a child: 'We went though an awful stage with her, yet she is the one who is strictest' [with her own children]. Thus the family relationship can be construed through what family members do as well as what they are. The gendered nature of the family relationship will be discussed in more depth later in this chapter, but here is noted as a major factor which could be seen to influence the character of the family relationship. When Mrs Jamson (CD F) said that she was 'a homemaker', this meant that she was a wife and a mother, but this was expressed, amongst other things, through her desire to please her husband, by learning and preparing the kind of food he liked.

The literature confirms that it is within the home and family setting that informal care not only tends to take place, but is expected to take place (Graham 1989, 1999, Thomas 1995, Stacey 1988, Wilson 1989). Issues of caring are at their most potent when associated with dealing with the consequences of illness, but are perhaps most insidious when it comes to the ordinary activities of providing and eating meals. The ordinariness of food preparation and meal organisation conceals the responsibility and commitment embodied in caring activities. The gendered nature of domestic tasks, particularly food and meals and the strong association made between women and caring in the home, means major implications for women as spouses and mothers. Even within the most traditional home, where tasks and activities seemed strictly gendered, where roles and responsibilities seemed clearly recognised, it was not unusual, as has been noted, to find an evolving of what was seen as 'normal'. The onset of illness, whether sudden or gradual, had the potential to challenge views about gendered roles and responsibilities. In fact participants were found to use a range of ways of preserving a sense of normality, whilst dealing with the demands of the condition and the diet associated with it, which relied upon the gendered nature of the family relationship. This relationship, seen as the normal, conventional, expected location for everyday life, could be seen to have provided the structure which guided and framed the illness experience. The participants did not have to express a desire for predictability over time because they could assume this through the acting out of their daily domestic tasks and activities. The ontological security offered by these routine and repeated family practices places particular responsibility upon women to create a setting with which they are so closely linked, as will be demonstrated in the sections which follow.
'Caring for' and 'caring about'

The literature review discussed Thomas' (1995) analysis of the concept of caring which showed it to be a very broad concept made up of multiple perspectives, not all of which are addressed in studies of caring. The nature of caring' was identified as the perspective most appropriate for this study, and is seen as constituted through two components: 'a feeling state (emotion, affection, love) - 'caring about' someone, or an activity state (work, tasks, labour) - 'caring for' someone' (Thomas p652). The distinction between these two components provides a useful vehicle by which the nature of caring in the home, particularly for those with an illness, can be examined. The focus of this study has been primarily activities and behaviour associated with responsibility for the health, safety and well-being of another member of the family which are construed as 'caring for'. It was, however, inevitable that the manifestation of emotional relationships in families, that is 'caring about', would be inextricably linked.

'Caring for' activities were in marked evidence in the ways that 'home managers' described the responsibilities they shouldered in order to ensure the health and well-being of their families. This ranged from the meal set on the table the moment a husband arrived home from work, to decisions to take part-time paid work to ensure being home for the children. These kinds of tasks and decisions could be seen to fall mainly, but not exclusively, on wives and mothers, most of whom saw this as both expected and acceptable: Mrs Greig (CHD M) 'It [cooking as her 'job'] always has been..., he has never had to cook himself unless I have been laid up or in hospital'. There were just a few cases where husbands took over all or part of the domestic 'caring for' tasks, most notably Mr Garside (CD F), whose prior catering experience had allowed him to ensure his wife's special diet: 'It is mainly Ian, he kind of takes over,..... Organises me'. The 'caring for' associated with the special diet meant, for example, learning about the new diet and often acquiring new culinary skills. This was particularly the case for families with CD. It also often meant ensuring that appropriate food was always available in the house and incorporating it into existing family meal patterns.

The work involved in these provisioning and meal preparation tasks could be seen to be considerable in a number of the participants' homes, although not always acknowledged as such, even by those shouldering the responsibility. In the case of Mrs Clarke (CD M), for example, she described (in chapter seven) a complex process of necessary planning ahead in both ordering and preparing food for her husband. Nevertheless, she saw the demands of the diet for her husband as more of a burden that her own responsibilities: 'I mean, he realises that he has got to live with it for the rest of his life.....but I don't want him to feel negative about it. It is easy for me to sit here, I don't have to eat all this different food'.
It is within contexts such as this that the line between 'caring for' and 'caring about' becomes blurred.

The notion 'caring about' is less easy to identify in that it often involves the feelings and intentions behind 'caring for' activities. VanEvery's (1995) critique of the artificial division between the instrumental and the expressive in the family relationship finds an interesting confirmation within the experiences of many of these participants. Mr Garside's desire to ensure that, even when formally entertaining friends, he could produce a meal that would not reveal the difference between his wife's diet and their guests' meal, was as much an indication of his 'caring about' his wife's identity as about 'caring for' her dietary needs. The only unusual aspect of this example is the bringing together of 'caring for' and 'caring about' aspects of family life within the male partner's role. 'Caring about' is clearly not exclusively the realm of women, but seems to have different opportunities for expression. In this study, 'caring about' for most of the men seems to have been largely limited to worrying about the welfare of their wives, with little or no opportunity for developing it into active caring tasks. Many of the women who took part in this study saw the kitchen as their 'territory' and meal preparation and organisation as fundamental to their roles as wives and mothers. In addition, of the few men who had taken on the task of preparing all, or part, of their meals, only one, Mr Garside, demonstrated evidence of the monitoring 'caring about' aspects of this work. There was some evidence of men (as well as women) offering 'caring about' support to partners who were uncertain about seeking medical help over undiagnosed symptoms: Mrs Kelner's partner (CD F), pressing her to seek advice from the doctor about her rapid weight loss had commented 'people will think I don't feed you!' Women, however, can be seen to be better placed to accommodate both 'caring for' and 'caring about' into 'a caring nexus, both constituted by and constituting...ideas of family and gender' (Morgan 1996 p111).

The family setting as a location for caring can be seen to generate complex and sometimes contradictory activities which did as much to establish and maintain gender roles and personal identity as they did to ensure the health and well-being of the people involved. Expectations about norms of caring can also be seen to be about norms of gender identity. However, it is clear that, if notions of gender were embodied in caring activities, tasks within the home could be seen to demonstrate caring as 'normal' and 'natural'. Indeed, the ways participants made changes to who undertook those tasks, or even how they were conducted, were achieved within the framework of existing, recognised, gendered family relationships, rather than by overturning those traditional norms. For example, Mr and Mrs Cotton (CHD M), who had reversed roles when he was pressurised into early retirement due to his heart problems, did so for practical economic reasons, not in order to challenge or redress any gender inequalities in
their relationship, which had followed a very conventional division of domestic tasks. Where such changes were resisted or regretted these could be seen to be for conventional gender related reasons.

Caring as a norm expected to be present within the family setting, usually by women, and particularly related to illness, has been a theme discussed in the literature review chapters. Significant for this analysis has been the quality of 'naturalness' that has been attached to the assumption that caring was female. It has been suggested that this parallel has been behind choices women make not to pursue the male model of full-time uninterrupted paid employment, allowing them to become the primary carer within the home and for children. Whilst the reasons behind such choices may be more complex (McKie et al 2001), this stereotype may well be behind the assumptions made by medical and health practitioners, as well as many of the participants, that it would be women who would bear the main responsibility for ensuring that dietary advice associated with chronic illness was followed. It is these 'being with' qualities that Graham (1984) has identified as 'consum[ing] most in terms of time, money and energy' (p150), and which I suggest remain the most invisible of the gendered caring that takes place in the home.

The interplay between agency and structure highlighted by Finch and Mason (1993) in their notion of 'developing commitments', they suggest, generates responsibilities that 'become structural features, in that they both constrain and facilitate future actions' (p173). As such these responsibilities (in this study this means the everyday catering for the family's dietary needs) can be seen to constitute a family relationship within which gendered caring is fundamental but flexible.

*Negotiating family practices*

The term 'negotiate' has been defined as: 'to treat (with another) in order to make a bargain, agreement, compromise', and also 'to arrange, bring about, or procure by negotiation' (The Concise English Dictionary). The public use of the term is often seen as a formally conducted overt transaction reflective of the former definition. However, the private use of the term when made by participants in this study resembles more the latter. When participants spoke of how the needs and preferences of different family members were accommodated, they rarely gave the impression that this was conducted formally or finally. For example, Mrs Rice, whose husband had taken over their meal preparation when they married, in describing her difficulty in influencing the content of their meals commented: *I just slipped into that* [her
husband deciding meal content]. I would eat pasta and rice, but we are still kind of negotiating. The term 'negotiate' was not, in fact, always actually used to describe this process of finding out, considering, and compromising which lead to the organising of family activities. Nevertheless, the process by which some form of consensus was achieved can usefully be referred to as 'negotiation'. Mrs Batley described the ways she and her husband dealt with the changes which were triggered by the combination of her heart attack and his retirement: I think we went through a sort of slightly peculiar phase because this heart attack came at the same time as my husband retiring and that has actually caused one or two problems. So we have, now I am more than happy to share my kitchen, but he tended to start thinking it was his kitchen because he tends to take chargey and so we have now come to quite a good arrangement where we tend to take it sort of alternate days more or less. This compromise suggests a process of the testing out of territorial boundaries and of flexibility of roles which was ongoing and interpretative, rather than clear-cut and permanent.

This tacit process of ongoing negotiation exemplifies the ways many participants seemed to conduct their family practices. Family practices, of which caring makes such a significant contribution, could be seen to be achieved through a complex process of presumption, dependence, rapport, and, occasionally, direct communication. The sense of 'naturalness' which has been associated with the family generally, and gendered caring in the home specifically, and discussed in the literature chapters is of significance here. The 'being with' aspects of family life allow an awareness of family members needs and preferences to be built up over time and are the prerogative of the person responsible for servicing those needs. The concept of the 'alert assistant', discussed in the literature (Williams 2000, Charmaz 1991) also reflects these observing and monitoring aspects of the family relationship which provide a major, but largely silent, part of family negotiation. At the same time these actions create and reinforce the sense of 'being a family' in ways that are described and prescribed by society at large. The enduring image of 'family as natural', which has survived academic critique and lived diversity, does so through the ontological security of 'gendered caring as natural' and 'family relationship as normal'. Thus, whilst each family relationship may 'negotiate' the minutiae of their individual family practices, this will be conducted through the everyday lived experience, and accomplished tacitly rather than explicitly. 'Natural' caring refrains from formal discussion as does romantic love eschew the pre-nuptial agreement.

Underpinning the taken-for-granted in family negotiation are assumptions of gender in terms of role and responsibilities which also rely upon notions of the natural. The implicit character of negotiation in family relationships contributes to the invisibility of 'caring about' activities
undertaken by women particularly. It has been noted that, whilst men were not excluded from caring activities, and notwithstanding the caring that the men in this study had become engaged in, the limited access that they had to practical caring activities meant that it became highly visible when they undertook it. Mr Garside's (CD F) active participation in food preparation for his wife special CD diet, was, in fact, no more than many of the wives of men with CD undertook. It was most notable because he was the only husband to become so involved in those tasks. Most of the couples who took part remained within a conventional view of gendered caring. For example, Mrs Howson (CD F) explained: 'No normally they always left the choice of meals to me so that wasn't a problem up to a point because I could still cook what I wanted for them...' and later 'I think they were just quite happy really, I mean I never heard anything. Obviously I would say "do you fancy so and so today?"...' In contrast, Mr and Mrs Burrell (CHD M), who both had diet related medical conditions, interviewed together, expressed both an awareness of each other's medical needs and concern over each other's health status. They both commented upon the advantage of support from partners: Mrs Burrell: 'Well I think both sides have to be willing to adapt their habits, and Mr Burrell: 'Yes I think compatibility would have to be a vital factor'. Nevertheless, this couple had operated a clear and gendered division of domestic tasks, with Mrs Burrell priding herself on her culinary abilities and her husband in charge of the DIY household tasks.

The negotiation process by which these gendered tasks and activities were achieved was, as has been argued, not only frequently unspoken and assumed, but also incorporates the potential for both continuity and change over time. The interview structure encouraged participants to remember their own childhood experience of food, meals and eating, as well as that of specific moments in their current family relationship. Many also made spontaneous comparisons between different events and traditions over time, including across generations. The interview setting encouraged discussion of family arrangements usually relegated to the taken-for-granted, and were, in fact, described within this sense. Nevertheless it was evident that negotiating family practices was learned and conducted over time and over generations through everyday observing, monitoring and remembering, and against a backdrop of social assumptions about gender and about family.

Everyday 'normality' seems to have been established through negotiation which was rooted in ongoing understandings of what 'should' be. To any family relationship at any point in time came a range of 'shoulds' which evolved into what worked for that particular family group. This is not to say that the 'normal lives' which had been negotiated seemed always satisfactory to all of the people who took part in the study. A number of cases stood out as
accommodating unsatisfactory compromise, the most dramatic being that of Mr and Mrs Moreton. My field notes confirm that Mrs Moreton seemed to be thinly disguising irritation during my first interview with her and her husband. During the three weeks between the two interviews she had left her husband. (I hoped that the interview and her decision were coincidental!)

Negotiation is therefore, here, being seen as the means by which people organise their lives, but which also acts as a process by which they normalise their lives. The social norms of what 'the family' should be acted as the backdrop against which participants negotiated the everyday and the new or the unexpected (such as illness), using past expectations with present patterns and future plans. The literature has suggested that the activities which take place within the home constitute the relationship located there (Graham 1999, 1984, Bowlby et al 1997, Morgan 1996, Finch and Mason 1993, DeVault 1991). Caring activities undertaken within the home have a special meaning for the construction of gendered relationships and gendered identities (this will be developed further in the next section). The negotiation that takes place within this context contributes to the dialogue through which this meaning takes shape.

**Gendered and family identities**

This study has generated data which confirm gender as a major factor in the creation of both individual and family identities. Participants revealed strong indications of traditional views about gender roles and responsibilities, evident across generations. This could, however, be seen as not just simply a matter of established divisions of domestic tasks on gender lines set in concrete throughout the course of a marriage relationship, or transferred untouched over generations. In fact, these participant's relationships could be seen to be relatively (but variably) flexible, with evidence of change and some contradiction in conventional gendered roles. These differences were not, however, introduced into family relationships on ideological grounds and left the traditions beliefs about gender roles largely intact. Nevertheless, gendered identities could be seen to influence and be influenced by the nature and form of the family relationship, as well as being subject to contingency, whether welcome or unwelcome. Thus, when Mr Cotton (CHD M) was thrust into the 'home manager' role as a consequence of early retirement due to ill-health, he embraced the task of experimenting with baking, praised his wife for her managerial skills in her late career, but worried about: 'getting the shopping and the wife having to carry it ..... but I still didn't like it'.
The gendered nature of the family and the activities within that setting have highlighted the ways in which individuals can be seen to identify their roles through the activities they undertake. The literature has suggested that, within the home and family, gender provides a central contributor to the shaping and operating of family relationships, and this has been born out in the data. Nevertheless, when West and Zimmerman suggest that 'It is not simply that household labor is designated as 'women's work', but that for a woman to engage in it and a man not to engage in it is to draw on and exhibit the "essential nature" of each' (1991 p30), this both explains the nature of gendered divisions in domestic activity and masks the complexity of gendered family relationships. It seems clear that the way that participants in this study understood personal identity was, in many ways, through what they did and who they did it with within the family setting, rather than simply what they were. Personal identity and family identity combined in the form of wife, mother, father, husband, cook, carer and individual, and many others. A number of participants who took part in the study explicitly described themselves as occupying specific roles (being 'a homemaker' Mrs Jamson CD F) or having intrinsic characteristics (being 'family conscious' Mrs Smythe CD F). Far more implied this kind of identification through the unquestioning assumption of specific tasks and responsibilities.

Similarly, the literature has located caring, whether for or about, as fundamental to the construction of 'family relationship' (Thomas 1995, DeVault 1991, Graham 1984), acting as both a cause and a consequence of its function and form. This is particularly striking in the event of illness in the family. In this study, the introduction of illness added another dimension to the gendered nature of caring in the family setting, but was understood and managed within an existing frame of reference. The existing family relationship had created understandings about what should and could be expected from different family members, resonant of Finch and Mason's notion of 'developing commitments' (1993). Assumptions about caring in the family extended to any contingency - expected or not, welcome or not. Thus, when Mrs Jolson (CD M) heard about the potential diagnoses of her husband's symptoms she could assume that: '..if it is cancer it is going to be down to the hospital, if it is something else it is probably going to be down to me.' Whilst Mrs Greig (CHD M), reassured by her husband's survival from long-term heart disease could comment: 'he is still here so I must be doing something right'. If the caring role in the family relationship includes responsibility for family meals (which it tends to do) this has implications for a new diet-related demand on her (usually female) time and expertise.

Morgan (1999) has urged the conceptualisation of 'gender' through 'the active knowing agent'...[within]....'immediate situations or historically shaped structures'(p28). He suggests
that recognising the interactions which take place between 'family' and 'gender' which can construct, obscure or modify, provides the complexity and the flexibility needed to understand how people understand their social worlds. Construing gender as a process (Morgan 1996) acknowledges the day to day lived experience which constructs and reconstructs personal and family identities routinely and over time. It also pays attention to the interaction between structure and agency which may explain entrenched views about the acceptability of gender inequalities within the family and elsewhere. However, within the context of this study, views about gendered roles and responsibilities might be described as contingent rather than entrenched, subject to family (and probably other) processes rather than ideological beliefs.

The processes by which the participants of this study constructed their lives and accommodated the intrusion of chronic illness might be said to have relied upon an understanding of both personal and family identities for which gender was just one (usually very important) contributory factor. Their family practices could not be described as gender neutral, but, nevertheless, were equally not reducible simply to gender. What seemed important for these participants was that their lives were functioning in an orderly predictable manner. The relief that many of them expressed at being able to continue with a lifestyle that was manageable and (seemingly) involved little change was often couched in terms of the welcome ordinariness and normality of their lives. Mrs Scruton could stress that she felt their diet had not had to change as a consequence of her husband's illness: '...it isn't really a diet, it is what we eat naturally, we don't think about it, that is the way it has always been'. Whilst Mr Royle, explaining that he and his wife enjoyed both cooking and eating, commented that 'it is difficult to give that up having done it most of your life', but could go on to tell of offering advice, to a friend who had also had a heart attack, to 'lead a normal life, unless you want to say "thank you I have had my life, that's the end of it..." ...but be sensible, listen to what your doctor says...don't cheat yourself, don't try to pretend that it will be OK...'. Dealing with illness in the family setting could be seen to be a juggling of what went before, what the illness required, and how a sense of change could be minimised, largely by women. In this, 'gender' and 'family' can be seen as interacting processes which construct understandings of relationships as lived experiences over time.
Conclusions

This study has had the aim of understanding the processes by which people in families manage the experience of chronic illness, specifically in relation to dietary recommendations for medical reasons. At the outset it was assumed that gender would be a significant factor in this examination, particularly in the organisation, production and consumption of food and meals. The position of the 'home manager' (that is, the person mainly responsible for food and meals in the family) was the main focus of the study, and it was assumed that this person was most likely to be female. Over the course of the study it became clear that the place of 'the family', or rather, the 'family relationship', although important as a location for social life, equally significant was its constitutive role. It became important to pay attention to the way that the meaning of 'family' as well as the meaning of 'gender' contributed to the ways that the participants made sense of their lives.

An examination of the literature has, amongst other things, indicated that the nature of the family has been seen as both an influence upon and influenced by activities around meals and eating which take place within that setting (DeVault 1991). This has not been the case when considering the experience of chronic illness. Work by Graham (1984, 1999) and by Thomas (1993, 1995) has drawn attention to the significance of the nature and form of domestic work to the monitoring and maintenance of health within the family setting. Much of the research on the experience of chronic illness has acknowledged the impact upon the home and family of the incidence of illness. It has also recognised that it is frequently, if not exclusively, women who have had to bear the burden of caring for the chronically ill in the home (see Bury and Anderson 1988). Nevertheless, what has not been identified is ways that the processual nature of the family contributes to the form, function and meaning of illness experience in the home.

An influential contribution to the understanding of the illness experience has been the work by Bury (1982, 1991) through his notion of 'biographical disruption'. He draws attention to, not only the different ways that the patient may chose to deal with the disruption of illness, but also the meaning that the patient, and others, may chose to place upon it as a disruption to personal identity. Gareth Williams (1984) has also highlighted the significance of the lived experience through the 'narrative reconstruction' undertaken by patients when asked about the cause of their disease. This move to conceptualise the illness experience as part of an ongoing lifecourse experience which patients wish to make sense of has been a major contribution to locating the person within the illness. It has also pointed the way for research which addresses the processes by which every day activities specifically related to chronic illness construct meaning and locate contingency within that meaning.
This study provides a useful contribution to this perspective. The data analysis identifies the 'the family' as a powerful social institution which endures through the dual purpose of the functional and the constitutive. The family relationship acts as the socially acceptable location within which people may conduct their private lives. The caring and socialisation of children, the nourishment of the family and the emotional support of spouses are seen as most appropriately conducted within the private realm of the home and family. These tasks and activities also provide a means by which individual and group identities can be created and endorsed. The organisation of family life can be seen to be conducted through a process of normalising family practices which are construed as predictable and stable, whilst encompassing change and uncertainty.

The family relationship provides both a setting and a process by which social norms and individual identities can come together within predictable yet flexible practices. It can, nevertheless, be said that 'a sense of self is a product of the public roles that we play, not a cause of them' (Tucker 1998 p77). Giddens has drawn upon Goffman's conceptualisation of social life as performance in order to capture its active processual nature. 'Routines create social integration, and social encounters must be formed and reformed in everyday life, through mutual talk and actions in particular contexts' (Tucker 1998 p78). Within the family setting people act out their personal and group identities for the purposes of the private family relationship, but also to inform and prepare for their public social roles as well.

The participants in this study varied in terms of their satisfaction with the nature and form of their family relationships, but all seemed to recognise as legitimate the view that it was within the family that caring and support should take place. Activities around food and meals were construed as functions of family life to which, wherever possible, they should adhere. Although participants were not asked directly to define their family relationship, their descriptions of their family practices around food and meals constructed images of relationship as 'family'. The demands of the special diet, especially for those in the CD families, conveyed not just the amount of work involved in catering for that diet, but also the extent to which members, particularly the female, of the family were committed to provide that support routinely.

The care and support given to the person with the condition by family members was also variable and could be seen to be strongly determined by gender. Wives of men with either of the medical conditions in question were more likely to provide active and committed support to their partners (the 'caring for' tasks), often leaving them with little to contribute to their own self care. Husbands were far less likely to become actively involved in the provisioning and preparing for the special diets of their wives. The 'caring for' work in these family
relationships was most likely to be undertaken by wives and mothers, routinely absorbed into their existing family responsibilities. This is not to say that male partners did not become involved in caring for work in the home, but this was more likely to be time limited and contingent upon specific events. 'Caring about' work, the being with, monitoring, remembering, was less visible and less clear-cut, but still largely remained the province of women.

Nevertheless, it is clear that the support from spouse to spouse, in families generally but particularly in the face of chronic illness, cannot be seen to be determined purely on gender grounds. Nor was it the case that gendered divisions of domestic tasks were simple, conventional or permanent. Encouraging participants to reflect upon their lives as children and through early marriage and parenting, as well as in the present, revealed family practices which were developed and evolved over time and which were subject to social norms and the contingency of the moment. Most of the women who had given up work to care for the children did so partly because it was what women did (women's work), partly for social and economic convenience and partly because they thought they would enjoy the role (or some of these). Changes to this arrangement, whether temporary or permanent, were made partly for social or economic necessity (childbirth; retirement), partly because a legitimacy for the change had been identified and partly because they thought they would enjoy the changes (or some of these).

Gender has provided a major determinant for these strategic decisions about who should be responsible for caring in the home and who should undertake full-time paid employment. It has not, however, been gender alone that has defined the shape and form of family life day to day or permanently. Understandings about family relationships utilise gender, but also kinship, age and many other social distinctions, to promote a sense of continuity and stability over time. Family practices, as a means by which social life could be organised and understood, interacted with gender and these other factors, to produce the daily social encounters deemed necessary for the social integration mentioned above. These encounters may be regular and routine but they are not formulaic or inflexible. They provide the pivot upon which agency and structure interact to both constrain and sustain every day life as 'normal'. The participants in this study conveyed a sense of stability yet flexibility in terms of how they understood their family lives and their individual identities within the setting of the family relationship. The experience of illness and the requirement of the special diet generated demands upon family members that were variable in both actual and perceived difficulty. Those responsible for food generally and the diet specifically did not deny that this demanded time and commitment, but construed those demands within the context of existing family
practices and responded to them accordingly. Thus, in Gidden's sense of ontological security, they could construct and lead 'a normal life'.
Reflections and projections

This study is of a size (small) and type (qualitative) which makes generalisation to a wider population inappropriate, despite the age range, gender balance and variety in backgrounds of the participants. Nevertheless, the study has identified the complexity with which ordinary everyday life is conducted and the multilayeredness of the meanings conveyed through and demanded of (seemingly) simple everyday family practices.

The process by which the participants were recruited was, ultimately, adequate, but left spaces which, particularly within the female CHD group, limited the potential for fully understanding the experience of this specific group. The experience of the six women within this group does not seem to have been radically different from those of the women with coeliac disease, in terms of family relationship or caring within the context of illness. However, from a health promotion point of view, this is a group that would benefit from further enquiry (if only to see women more fully represented within the coronary care clinic) but also from a methodological point of view as a group unusually difficult to recruit to take part.

The decision to conduct relatively unstructured interviews was particularly valuable in making space for thoughts and opinions from participants, most of whom were, over the course of the two interviews, able to convey an extensive and broad ranging picture of their lives as a process of constant negotiation and construction. Without this openness to the ordinary as well as the contingent in the interview, it is unlikely that the processual nature of the family relationship, and the emphasis upon the normal as a way of construing family practices, would have emerged. However, this lack of structure and emphasis upon the ordinary and the everyday was disconcerting to a number of participants and inhibiting to a few. Thus there was a strong pressure upon the researcher to create a rapport with respondents to facilitate their contributions which was variable in its success. A few participants were not amenable to this approach which begs the question, how can the views of this kind of participant be properly represented, if the nuances of the enquiry cannot be adequately represented in a more formal approach, such as a set of clearly structured questions? The dilemma is not easily answered but requires consideration for future enquiry.

Also not fully reflected within the study, because the focus has been upon the 'home manager', has been the experience of male partners of women with chronic illness. The nature of the research design has meant that the men recruited to this study have been limited to male 'home managers' and/or men with the medical condition. Male 'home managers' were rare in this group, and, the literature suggests, are likely to be rare in the population at large. Nevertheless, the views and opinions of male partners, whether involved in food preparation
or not, is likely to be significant for the organisation of food in the home, and so warrants examination.

Of the people who took part in this study, only five couples did not have children, although only nine of those with children still had them living at home, and of those only four couples had children who were young and dependent upon their parents. This means that the discussions about caring made in many of these interviews were either concerned with the care of adults, or descriptive of past rather than current experience. It is likely that the experience for parents with young children of the management of the consequences of chronic illness will be different from couples no longer responsible for the care and welfare of the young. Certainly this seemed evident from the few participants of this study with young children, most notably Mrs Hufton (CD F), who had the double burden of her own and her eight year old son's coeliac diet. A study focused upon this age group (that is, couples with children of school age and younger) would provide a particularly valuable direction for future research into the experience of chronic illness. Clare Williams work (2000) on families with children with diabetes and asthma has provided a good example of this, but does not focus specifically upon issues of food and diet.

A study focusing upon young families would have the potential to incorporate the issues of particular relevance to the general care for children whilst managing chronic illness. It would also provide the opportunity for examining this aspect of caring within the context of changes in the paid employment of women. Managing child care in a political climate which promotes the potential for widespread full-time employment, for both women and men, brings complicated demands organisationally. The intrusion of chronic illness, whether for adult or children, introduces yet further difficulties and dilemmas for which sociological study would provide a worthy contribution.

The potential for future research in this area is broad and fruitful. Mentioned above are just a few brief suggestions drawn from aspects of the current study that might be seen as incomplete or not adequately investigated. It is, however, clear that sociological consideration of the experience of chronic illness would benefit from further enquiry into the nature and the meanings attached to 'the family' as a setting and as a process within which it is lived and managed.
References


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238


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Appendices

Appendix 1. Interview guide: medical/health professionals

Appendix 2. Participant information

Appendix 3. Employment range

Appendix 4a. Interview guide 1 'housewives' (ethical approval)

Appendix 4b. Interview guide 2 'housewives' (ethical approval)

Appendix 4c. Format for first interview (final version)

Appendix 4d. Format for second interview (final version)

Appendix 4e. Consent form

Appendix 4f. Information sheet.

Appendix 5. Coding examples.

Appendix 6. Vignettes of participants
Appendix 1

Interview Guide: Medical/ Health Professionals

A. Procedures:

I understand that the passage of time from the diagnosis of a condition to the recommendation and the maintenance of a new diet can vary considerably. I would like you to tell me about your understanding of:

i. how a special diet is introduced and monitored

ii. the extent to which a set of standard procedures are followed, or to what extent it is a negotiated process

B. Perceptions:

Changing diet is known to be difficult to do, even when medically recommended, and by the most committed of people. I would like to hear your ideas on:

i. the reasons there might be for these difficulties

ii. what ways these difficulties might be overcome

iii. whether there are roles and responsibilities that members of families have or assume that tend to influence diet management, whether positively or negatively
Appendix 2

Diet Management in Families

Participant Information

Name.................................................................................................................................

Address.............................................................................................................................

...........................................................................................................................................

Telephone...........................................................................................................................

Description of Medical Condition....................................................................................... 

...........................................................................................................................................

Description of diet................................................................................................................

............................................................................................................................................... 

Age(tick) 25 - 34........35 - 44........45 - 54........55 - 64..........65+....................

Partner's Age (tick) 25 - 34........35 - 44........45 - 54........ 55 - 64..........65+................

Years married/living as married........................................................................................

Number of dependent children living at home (not in employment)

................................................................................................................................................

Employment (Please include whether in full-time/ part-time/ retired/ housewife student).

................................................................................................................................................

Partner's employment (also as above)................................................................................

................................................................................................................................................

Most recent educational/training qualification.................................................................

................................................................................................................................................

Nationality..............................................................................................................................

................................................................................................................................................
### Coeliac Disease

<table>
<thead>
<tr>
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<th>Female</th>
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<tbody>
<tr>
<td>Analytic Chemist</td>
<td>Care Assistant</td>
</tr>
<tr>
<td>(Engineer)</td>
<td>pt Office Manager</td>
</tr>
<tr>
<td>Civil Servant</td>
<td>pt Sales</td>
</tr>
<tr>
<td>Commercial Manager</td>
<td>pt VDU Operator</td>
</tr>
<tr>
<td>S. Empl. Gardener</td>
<td>S. Empl. Secretary</td>
</tr>
<tr>
<td>(Butcher)</td>
<td>(pt Bank Clerk)</td>
</tr>
<tr>
<td>Systems Engineer</td>
<td>pt Probation Officer</td>
</tr>
<tr>
<td>Electrical Contractor</td>
<td>Electrical Contractor</td>
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<tr>
<td>Mechanic</td>
<td>pt Trainee Pharmacy Asst.</td>
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<tr>
<td>(Caterer)</td>
<td>(Caterer)</td>
</tr>
<tr>
<td>Manager/Gardener</td>
<td>(Secretary)</td>
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<td>pt Sales Assistant</td>
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<td>Security Work</td>
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<td>Storeman</td>
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### Coronary Heart Disease

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<tr>
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<tr>
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<td>(pt Cleaner)</td>
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<tr>
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<td>Care Assistant</td>
</tr>
<tr>
<td>(Engineer)</td>
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<td>(Office Cleaner)</td>
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<tr>
<td>(Managing Director)</td>
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</tr>
<tr>
<td>(Design Manager)</td>
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<td>(Telephonist/Receptionist)</td>
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<td>(Teacher)</td>
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* Occupation before retirement indicated by brackets
Appendix: 4a

Interview Guide 1: Housewives (Ethical Approval)

As I explained when we made the appointment for this interview, and you will have read in the information sheet sent to you with the consent form, I am interested in how people manage a new diet that is the consequence of a medical condition. I would like you to talk about your experience of starting and maintaining the diet that you/your partner have been recommended, and how you feel about it. I have a number of areas I would like to ask you about, but you may have some that have not occurred to me as well.

1. Background:
   - to the condition ) provision of information
     ) sources of information
   - to the diet ) support systems
     ) other

2. Practicalities of changing to new diet:
   - food choices
   - shopping
   - food preparation
   - cooking
   - meals

3. Fitting diet in with family:
   - changes made by ) dieter
     ) home manager
   - Attitudes to ) others

4. Maintaining diet over time:
   - what was helpful
   - barriers
   - changes
   - compromises
   - future plans/expectations
Interview Guide 2: Housewives (Ethical Approval)

You will recall that at our first meeting I asked you to talk about a number of issues around the management of your own/your partners special diet. Since then, as a consequence of the interview and others that I have been conducting there are some areas that I would like to ask you a bit more about. You may also have some things that have occurred to you since our meeting that you would like to tell me about.

1. Background - Thoughts about comments made at the first interview
   - to the condition ) provision of information
     ) sources of information
   - to the diet ) support systems
     ) other

2. Practicalities of changing to new diet - Thoughts about comments made at the first interview
   - food choices
   - shopping
   - food preparation
   - cooking
   - meals

3. Fitting diet in with family - Thoughts about comments made at the first interview
   - changes made by ) dieter
     ) home manager
   - Attitudes to ) others

4. Maintaining diet over time - Thoughts about comments made at the first interview
   - what was helpful
   - barriers
   - changes
   compromises
   future plans/expectations

5. Additional ideas, thoughts, experiences not mentioned at the first meeting
Format for first interview (final version)

1. Description of diagnosis procedure:
   - symptoms
   - time taken to diagnose
   - Experience with medical/health practitioners
   - feelings

2. Place of food and diet within process
   - advice received/who from
   - involvement of partner, family
   - difficulties
   - food priorities as compared to other issues (treatment; everyday life)

3. Family routines around food and meals
   - who does what (meal preparation, shopping etc.)
   - integrating illness/diet into family routines
   - changing life patterns - expected/planned; result of illness
   - feelings
Appendix 4d

Format for second interview (final version)

1. Family background
   - childhood experiences around food
   - parent's roles/work
   - school early life
   - siblings/ other family
   - major changes
   - influence on present day experience and practices

2. Who do you tell - family; work
   - advantages/disadvantages of telling/not telling
   - attitudes at work/home - support/help

3. Eating out
   - management/ organisation
   - experiences/ changes

4. Advice to others
Consent Form

UNIVERSITY OF SURREY

The management of medically recommended diets

This project is concerned with the way diet which has been recommended as the consequence of the diagnosis of a medical condition is managed within the family setting. The focus is upon two types of medical condition: Coeliac Disease and Coronary Heart Disease. We will be collecting information by interviewing the family member mainly involved in food and meals, on two occasions over three weeks. The interview will be taped, subject to the agreement of the participant.

The information provided by participants will be treated with complete confidentiality. Codes will be used to identify individuals within any tests generated by the study, and these will not be available beyond the research team. Participants may withdraw from the interview at any time.

If you have any queries about the study please contact:

Susan Gregory
Department of Sociology, University of Surrey, Guildford, GU2 5XH

Tel: 01734 268346 or 01483 300800 Ext:2805

I should be grateful if you would sign below to confirm that you have read this information and have agreed to take part. Please retain one copy for yourself.

I agree to take part in the University of Surrey study "The management of medically recommended diets". I understand that the information I give will be held in confidence, and that I can withdraw from the study at any time.

NAME..............................................................................................................DATE............
(Please print in full)

SIGNED...........................................................................................................
UNIVERSITY OF SURREY

Medical Conditions and Dietary Advice:
the management of diet change within the family setting

Susan Gregory

This research will look at how people in families manage dietary advice when a family member has been told they have a medical condition. I am looking at people with coeliac disease and coronary heart disease. When a person has been told that they have this kind of condition, they often expected to be able to lead a normal life, provided that they follow the advice and treatment they are given by the doctor, nurse or dietitian. Advice about a new diet as part, or all, of the treatment of the medical condition can, however, mean making major changes to shopping and cooking and meals. This can sometimes affect all members of the family, one way or another, giving everyone something to think about in relation to food. It may mean the whole family's meals may have to change, perhaps what they eat or how it is cooked. Even if the whole family's meals do not change much, there may be other changes to meal preparation and meal times. If there is just one person in the family who does the shopping and the cooking, which, even today, there often is, it is likely that the new diet will affect her quite considerably.

Research conducted over the last four years supports the idea that the family can be very important when a family member has to change to a new diet, and that family activities and habits can both help and hinder the process of change. Equally, different family members can find it quite inconvenient and irritating. Nevertheless, when the diet is part of the treatment of a medical condition, it is not unusual to find family members going to considerable trouble to help the person get used to their new diet. This research aims to find out more about how family members manage these kinds of changes, what is helpful and what causes problems. I am especially interested in talking to the person who does most of the shopping and cooking (the home manager).

I hope to interview members of families where someone has coeliac disease or coronary heart disease, and would like to interview the 'home manager' on two occasions (separated by three weeks) for approximately one hour each interview. The interviews will normally take place in the participants' homes. (If the interview takes place in the university travel costs will be reimbursed). The interviews will be taped provided the participant agrees.

The information provided by participants will be treated with complete confidentiality. Codes will be used to identify individuals within any tests generated by the study, and these will not be available beyond the research team. Participants may withdraw from the interviews at any time.
<table>
<thead>
<tr>
<th>15 Colman</th>
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<td>description of 1st attack</td>
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<td>husband smoking</td>
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<td>family history of illness</td>
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<tr>
<td>siblings health 259</td>
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</table>
Interview Mrs Colley 12.5.98

INT: How long ago did you get the first attack?

MrsC: It was 94 I think it was. Yes I am sure it was 94, January. I had just come home from work, I had been working at the airport, helping out with the money situation sort of thing and I had done the late shift and I came in and said 'I think I will make a cup of tea' and I sat there and all of a sudden I felt all peculiar and the next thing I knew was.. Well they thought I was dead because I had just passed out completely and they got the paramedics and took me to Heatherwood and I was in there overnight and seemed alright. It wasn’t too bad you know.

INT: Did they do a test to see if it was a heart attack?

MrsC: Yes.

INT: And did they say whether it was?

MrsC: No they said it was an angina attack and then..

INT: Did they give you any medication?

MrsC: Yes I still take them, I have got a spray and all sorts of tablets which I am trying to get rid of. I am on ****. I must admit I used to smoke so I have packed in smoking. I packed up after the second one but it didn’t last but after the very last time which was a year ago last November I was in hospital for days then and I ****

INT: Were you a heavy smoker at all?

MrsW: I don’t think so. About 15 I suppose.

INT: 15 a day?

MrsC: Yes 10 or 15.

INT: Which isn’t a huge number.

MrsC: No it isn’t. Maybe more at weekends when there are people around you know.

INT: Does anyone else smoke?

MrsC: Yes my husband smokes, he still does. But he is trying to cut down. He has cut down quite a bit.

INT: Yes. It is that much harder when you have got other people around you smoking isn’t it?

MrsC: Yes. But I just stopped. I said well that’s it, I am not going to have another one and I didn’t. I didn’t do it gradually or anything I just stopped. I mean there are times when I fancy
one but .. I must admit I did try one once and it was so horrible I ...

INT: So when you had the first angina attack you were just in hospital overnight but did you see a specialist in the hospital or ..?

MrsC: No they put me under Dr Blackwood and made an appointment for me to just go to the hospital just for a check-up.

INT: And they gave you medication from that point?

MrsC: Yes, they gave me isosorbid?? And aspirin and a spray, I have got a spray instead of the tablet. But I found that after a while the aspirin had *** dissolved ones and didn’t agree with me so I had to change it to the coated because I was getting terrible pains in my stomach.

INT: Yes they do sometimes. So how long between .. Did you say you have had four attacks over the last six years?

MrsC: Yes the last one I had last November, that was quite a bad one and then they settled me down in the hospital and I had another one while I was in there. They couldn’t really make up their minds whether it was a heart attack or not. They thought it was a heart attack and then they decided afterwards it wasn’t a heart attack.

INT: So they did some tests?

MrsC: Oh yes they did all the tests.

INT: And decided it wasn’t a heart attack.

MrsC: Yes they said it was unstable angina because I had been asleep when these had happened except for the first, I have been asleep in bed and I have woke up with this pain.

INT: So the pain has woken you up?

MrsC: Yes.

INT: So the pain has woken you up and then you have collapsed?

MrsC: Yes and had to call paramedics.

INT: So have you either at the hospital or at your GP been given any advice around diet at all?

MrsC: Well Lesley, after you come out of hospital because she came to see me in the hospital the last time, and she said it was a heart attack as well, really, you know. She has a rehabilitation class and she discussed all sorts of things like diet and ..

INT: So she came to see you at home?
MrsC: Yes she came to my home and then there was a course at the hospital for so many weeks.

INT: So you have been going to that?

MrsC: It discussed what you should eat and what causes all these things. But I still go... She also does an exercise class. Well they do several she and Jenny I think it is but I go on a Friday. But I have also had an angiogram and that was clear. Well I say clear, the doctor who did it he said that my arteries were a little bit irregular. Anyway he said I could come off the tablets, take a week to come off the anatol, cut it down to half and then come off and come off the isosorbid??.

INT: And this has all happened since your most recent attack?

MrsC: Yes. And Lesley said nothing ... she didn’t think anything would show up on the angiograms but that doesn’t mean to say that there isn’t anything wrong. It could be the little capillaries that something happens to them that causes it.

INT: And this has all happened since your most recent attack?

MrsC: Yes. And Lesley said nothing ... she didn’t think anything would show up on the angiograms but that doesn’t mean to say that there isn’t anything wrong. It could be the little capillaries that something happens to them that causes it.

INT: Well clearly your doctor and Lesley feel that you still need monitoring?

MrsC: Yes. I said to Lesley - I told her all about it and I said well I suppose really I can’t come to your class anymore. And she ‘Oh no I didn’t expect anything to show up’ because I was doing my exercise alright.

INT: Right I see yes.

INT: So how long will those classes go on for?

MrsC: I don’t know. They seem to go on indefinitely. As long as you..

INT: As long as you want to go on and feel the need for it?

MrsC: Yes

INT: And do you have chats to Lesley regularly about what she thinks about your process?
Appendix 6.
Vignettes of participants
Coeliac disease
(female)
Mrs Brigson was a widow in her sixties. She lived alone but her sister lived close by and they saw each other every day. They had a younger brother who lived not far away who they also saw frequently. Despite her multiple illnesses since childhood, she was in paid employment as a furrier, which she loved, for many years until she retired, mainly to look after her husband as he became progressively ill, requiring regular dialysis.

She had been widowed for six years, and was diagnosed with coeliac disease during the course of her husband’s illness, which seemed to have taken priority over her own. He seems to have been quite a demanding man to whom she felt a strong duty to care for. She did not want to talk about her son, and hinted of family problems. Her relationship with her two siblings seemed very close and she spoke of them warmly. She was a very positive woman, despite her health and other problems, speaking very positively about her childhood, her work and her current relationships with her sister and brother.
Mrs Garside was in her mid fifties and married for the second time. Her first marriage was many years before and had only lasted a few years. She had brought up her only child, who was adopted, alone. She was retired, mainly for health reasons. Mrs Garside had been troubled by the symptoms of coeliac disease since childhood, although it was not diagnosed until she was in her mid forties. She also described a very difficult childhood with a violent father. Her current husband was very protective of her.

Mrs Garside seemed a very calm, gentle and relaxed. She was very open about the details of her illnesses. She became tearful about the diagnosis of colitis which was less easily controlled. She had been recommended surgery to which she was reluctant to agree.
Coeliac Disease Group (Female)

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<td></td>
<td>Angina</td>
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<td>Henry</td>
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Mrs Hampton was diagnosed with coeliac disease eighteen months earlier but felt that she had probably had the illness for many years having suffered from a lifetime of stomach problems.

Mrs Hampton seemed a very shy retiring woman who seemed quite embarrassed about talking about her symptoms. A major concern for her had been what to do outside the home - in shops, restaurants, and on holiday, particularly in terms of how she could rely on them not to breech her diet. Notions of ‘cheating’ were totally rejected and great attention to detail over the diet was adhered to at home.

This was the last person interviewed and the second interview was not carried out when it was cancelled on a number of occasions at very short notice and the interviewee proved difficult to pin down to a new date.
Ms Henson was diagnosed with coeliac disease opportunistically after treatment for an abnormal cervical smear identified her as suffering from anaemia which did not respond to iron treatment. She said that she had never felt that she had been ill prior to the diagnosis, although after following the diet she noticed a number of changes: weight gain, disappearance of a bloated tummy experienced since childhood. She revealed over the course of the interviews a history of underweight, sickness and poor health generally. The first interview took place with her partner, and her sister who was visiting. Her sister commented that as a child she was notorious for fainting for no reason that anyone could identify. Mrs Henson conveyed as strong sense of family feeling particularly in her childhood in a large farming family. She and her partner had started their relationship with a traditional division of domestic tasks, but showed some evidence of her partner becoming involved in aspects of food tasks, especially if he was on his own. They made strong attempts to eat the same kind of food when they ate together, with her partner moving towards her food preferences.

Ms Henson seemed a reserved woman who was softly spoken and allowed her sister speak for her during the first interview, although she expressed firm personal views from time to time, and in the second interview which was conducted alone.
Mrs Howson was in her early sixties and has never worked outside the home. She had also felt her role was to take care of the family. She had two sons, one of whom had spina bifida and still lived at home with her. She seems a very domesticated woman and continued to take the responsibility for the meals that her she and her son ate together every day.

Mrs Howson seemed a very reserved woman who did not like to draw attention to herself or be seen to ‘make a fuss’. She did, however, seem clear about her own needs and how she might go about ensuring these. She was concerned to ‘do the right thing’ over the diet. This she said she achieved through planning ahead, managing, and managing without if necessary. She preferred not to discuss or explain about the diet when she was in public, and spoke of people’s ‘eyes glazing over’ if she talked too much about the condition. She felt that she had incorporated her special diet into her life with very little difficulty. She felt that, when her husband became ill (CHD) and began to demand a special diet, he was ‘going over the top a little’
Mrs Hufton and her husband were in their late thirties, and had been together for 10 years having married six years earlier. She and her 5 year old son had been diagnosed with coeliac disease at more or less the same time, at the time of the birth of her baby, who was at the time of the interview six months old. She has experienced a lifetime of bowel and stomach problems which she had come to attribute to the disease.

Mrs Hufton was a very fluent woman and was keen to talk in depth about her illness. She seemed both forthright and cautious about her situation, in that she was clearly angry about the amount of time taken to diagnose the condition, but was reluctant to criticise the medical profession. She found the diagnosis both a relief and a dilemma. She felt that the diagnosis was a vindication for a feeling she had had that people felt she was a hypochondriac. However, trying to deal with a complicated diet, for herself and her young son, whilst also looking after a new baby, was very demanding. She also seemed unclear and concerned about her ‘rights’ and how much she could demand information and support. She found that being able to act on behalf of her son gave her ‘ammunition’ to be able to assist her in ensuring that both of their needs being met.
Mrs Jamson was diagnosed with a number of conditions, some of which may be related, four years earlier, just two years before her husband’s sudden death from a heart attack. She currently lived alone, but had three children, two of whom were adopted and had reached adulthood and had their own homes. She had a daughter who had had serious mental and emotional problems since her birth, and who had been in a special home since having a breakdown after her father’s death. She said that she and her husband loved children and would have liked to have had many. She expressed a very strong sense of family and a traditional view on how domestic tasks should be divided and conducted.

Mrs Jamson had a very jolly, friendly manner and laughed a lot. She had had an overweight problem since childhood, which was unusual for coeliac disease, although not for diabetes. She seemed to deal with her many health problems with a positive but fatalist manner. It was late in the second interview that she revealed her great sadness at losing her husband and not being able to have more children, and about her daughter’s illness.
Ms Kelner had been with her partner for 11 years and had no children, but eventually revealed that she had lost one child within two weeks of the birth and had one miscarriage. She made her own link between the illness and the miscarriages but had not attempted to have this confirmed. The diagnosis of the illness was just three years earlier, but had followed many years of considerable discomfort which gradually became worse and which her partner helped her to pursue diagnosis more forcefully. She described a history of inadequate medical attention from her doctor in a matter of fact manner which conveyed an awareness of the GP’s fault, but without anger or resentment. She made the point that during the many years of physical discomfort (vomiting and diarrhoea) she took this to be ‘normal’ and to be ‘ignored’, a view confirmed by her GP who suggested it was ‘normal women’s problems’. She still preferred to try to avoid attention to be drawn to the illness, especially in public, and would ‘cheat’ if necessary.

Ms Kelner came across as a friendly, welcoming, positive woman reluctant to talk about difficulties. She and her partner shared the domestic tasks, except when her parents and sister’s family visit (which occurs frequently) when the women joined together to create the family meals.

Mrs Kelner attended both interviews alone.
Mrs Lawton was diagnosed only twelve months earlier, but after many years of considerable discomfort, which became much worse at certain periods of time, especially during and after the birth of her most recent child. As well as her three children she had had four miscarriages. She had made some connections with the illness and her symptoms in retrospect. She had one adult child living at home who had returned temporarily.

Mrs Lawton seemed a quiet woman who did not offer much without prompting. She had a fairly traditional view about domestic tasks, apart from a mild comment about envying women whose husbands did the cooking. Her husband had done no cooking even when she was looking after their young children, but he accompanied her shopping, taking responsibility for checking labels and saying what she could and could not eat.
Coeliac Disease Group (Female)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rose</td>
<td>12 (2nd marriage)</td>
<td>3 (none)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Margaret</td>
<td>Coeliac Disease</td>
<td>8</td>
<td>55-64</td>
<td>Retired (School Assistant)</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
<td>44</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arthritis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sid</td>
<td>Nil</td>
<td>N/A</td>
<td>45-54</td>
<td>Surveyor/Teacher</td>
</tr>
</tbody>
</table>

Mrs Rose had retired mainly due to ill health, but had dealt with diabetes since being diagnosed in her teens. She had become something of an expert of both CD and diabetes, organising local support groups, and acting as an informal advisor to people sent to her by her GP, who lived just a few yards away. She was married for the second time, but had three children from her first marriage. Her first marriage lasted only for a few years and she was left to bring up the children alone. She described making sure that her work did not interfere with her parenting responsibilities, by working in a school which allowed her the same time off that her children had.

Mrs Rose was clearly not in good health but she seemed a very positive and active woman who seemed assertive, organised and with a strong independent approach to life. She described a husband who left the domestic side of life in her capable hands and who worried about making sure they did not take risks over her health. She was traditional in her views on the organisation of domestic life. She made light of her difficulties without reducing the impact, and was rather proud of being an expert and helping others.
Mrs Smythe was the participant most recently diagnosed with coeliac, and so was still coming to terms with the complexity of the new diet. She mentioned some discomfort for a period of time beforehand, but this was either minor, or seen so by Mrs Smythe. She had also had to deal with the consequences of her husband’s heart attack five years earlier, which may well have precipitated her to learn her husband’s work as an (children’s) entertainer and to take on this work. Prior to that she had not undertaken much in the way of paid work outside the home. The family shared her husband’s parents home with her mother in law for some years, during which time she deferred to her mother in law’s authority in domestic tasks (there does not seem to have been any difficulty in this), but when they moved to a house of their own, but took mother in law with them, Mrs Smythe became the person in charge of these responsibilities.

Mrs Smythe was a friendly but formal woman who underplayed her difficulties and was not easy to draw into talking in detail. Her general view was very positive and her manner ‘very English’, in terms of manner and accent.
Coeliac Disease Group (Female)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whelan</td>
<td>Divorced / lives with mother</td>
<td>1 (none)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elizabeth</td>
<td>Coeliac Disease</td>
<td>10</td>
<td>55-64</td>
<td>GP Practice Manager</td>
</tr>
<tr>
<td>Mother</td>
<td>Nil</td>
<td>N/A</td>
<td>d/k</td>
<td>Retired</td>
</tr>
</tbody>
</table>

Mrs Whelan shared her home with her mother and had not been married for many years. She first developed the symptoms which were eventually diagnosed as coeliac disease when she was in a relationship with someone. She attributed (in retrospect) the emergence of the symptoms as a consequence of a change in diet created by her then partner’s interest in a more exotic diet compared to her previously very basic food preferences. She also described the concern of parents who lived some distance away at the time, and who encouraged her brother (who stayed with her for a period of time) to monitor her eating habits for possible anorexia. It took approximately two years of severe illness before she was successfully diagnosed.

Mrs Whelan was a softly spoken reserved woman who was not easily encouraged to speak of her experience in detail. She underplayed her difficulties which, there were indications of major problems. She mentioned a break down following the break up of the relationship mentioned above, with a possible cause being her own illness (‘he couldn’t handle it’). She mentions a daughter and a granddaughter that she saw regularly and how touched she was by her son in law’s family’s trouble take to cater for her special diet. Her overall view seemed to be that the diet was the individual’s responsibility, who could not expect people to cater for. This was strongly illustrated by a monthly event where she and friends went out for a meal as a group, but which she would not join if they chose a type of restaurant (such as a pizza house) which would not have food she could eat. She had no expectation that they should try to make sure that she was catered for.

Mrs Whelan’s mother joined her for the second interview, which offered a different view on how the family felt about the process of diagnosis.
Appendix 6.
Vignettes of participants
Coeliac disease
(male)
Mrs and Mrs Adasen were both in full time employment, but Mrs Adasen was on a flexitime arrangement. They had three children at home of school age. Mr Adasen was diagnosed with coeliac disease 6 months earlier after a period of about ten years of gradually worsening symptoms. Prior to that he had been diagnosed with irritable bowel syndrome and offered treatment that he saw as mostly inadequate.

Mr and Mrs Adasen attended both of the interviews, and were not an easy couple to interview. They seemed very reserved, cautious people who are not very talkative at the best of times (Mr Adasen said as much towards the end of the second interview). Neither spoke spontaneously or responded to prompts much either.

Superficially they seemed fairly traditional about domestic tasks with Mrs Adasen responsible for meals and managing food, whilst trying to juggle different family members food preferences. She also spoke of banning her husband from the kitchen when they were first married. Nevertheless there seemed to be a very pragmatic theme to their decision making. Mr Adasen was quite knowledgeable about his diet and clearly had not left the total responsibility to his wife, as some participants did. He took responsibility for making sure he ate the right food and kept it separate at social events such as barbecues. It emerged that as a child he was the eldest and expected to help out with food preparation, unlike his brothers, unlike his wife who learned about cooking after finding herself in a home of her own.

They seemed to have taken on the new diet quite well and did not complain about the difficulties, even though these were the early stages. There seemed an overall impression (rather than it being overtly stated) that they were more flexible, sharing tasks and responsibilities more than was at first implied.
<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appsen</td>
<td>30</td>
<td>3 (2 but see notes)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lindsay</td>
<td>Nil</td>
<td>n/a</td>
<td>45-54</td>
<td>pt Office Manager</td>
</tr>
<tr>
<td>Roger</td>
<td>Coeliac Disease</td>
<td>9 months</td>
<td>55-64</td>
<td>Retired (Engineer)</td>
</tr>
</tbody>
</table>

Mr Appsen had only recently retired and also diagnosed with Coeliac disease at around the same time, after some years of discomfort. They had also noticed other improvements that they did not realise was linked to the condition, such as a form of eczema which had disappeared completely. They seemed to have operated a fairly conventional division of domestic tasks throughout their marriage, with Mrs Appsen giving up paid work to care for the children for about ten years and saying that she did not see herself as a ‘career woman’. Nevertheless, she had continued the work she took up when the children were old enough and had no plans to retire. When asked about the cooking she teased her husband about taking up the cooking to which he gently protested that she had set him a number of other tasks to do whilst she was out at work. Mrs Appsen seems to be the person who makes the decisions about what was eaten and when in the home, so she seemed to be both responsible and in control of the domestic arrangements. They both, but particularly Mrs Appsen, felt that family meals were important.

Mr and Mrs Appsen had three children who were adult and in paid employment and were described as having left home but come home again from time to time. Two were staying at the time of the interviews. One was a vegetarian, and occasionally cooked for the whole family. Mrs Appsen commented that she found her daughter’s vegetarianism more difficult than her husband’s diet.

Mrs and Mrs Appsen attended both interviews, and seem a very friendly relaxed jolly couple who got on well together and with their children. Mrs Appsen took the lead in the interviews, but they both made contributions to the discussion correcting and consulting each other as they went along.
Coeliac Disease Group (Male)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
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</thead>
<tbody>
<tr>
<td>Bain</td>
<td>32</td>
<td>2 (1)</td>
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<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael</td>
<td>Coeliac Disease, Heart problems</td>
<td>14 months</td>
<td>55-64</td>
<td>Civil Servant</td>
</tr>
<tr>
<td>Ann</td>
<td>Nil</td>
<td>n/a</td>
<td>45-54</td>
<td>pt Sales</td>
</tr>
</tbody>
</table>

Mr Bain was diagnose with Coeliac Disease just over a year earlier after a long period of symptoms without a correct diagnosis. Mr Bain was able to give me a detailed description of the complicated path he took to diagnosis as he kept all of the relevant details carefully recorded in a file. He was a precise methodical almost ponderous man keen on ‘facts’ over feelings. Mrs Bain was a quieter woman who tended to defer to her husband in the discussion, but who also had views of her own which came out more in the second interview. Both members of the couple attended both interviews and, in the second interview particularly, displayed a relaxed relationship in which they consulted and informed each other as to when things happened and how. This coincided with the part of the interview process which asked people to talk about the past, that is, their own childhood and their early marriage.

Mr and Mrs Bain seemed a very traditional couple with Mrs Bain in charge of food and meals. They have two adopted children and she gave up work shortly before the had the children (partly because they had moved house due to a job change of Mr Bain). She made it clear that her main occupation has always been her husband and children to the level of becoming involved with her children’s school to help out with teaching the children about shopping and cooking.
Coeliac Disease Group (Male)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Clarke</td>
<td>22</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brenda</td>
<td>Nil</td>
<td>n/a</td>
<td>35-44</td>
<td>pt VDU Operator</td>
</tr>
<tr>
<td>Steve</td>
<td>Coeliac Disease</td>
<td>1</td>
<td>45-54</td>
<td>Commercial Manager</td>
</tr>
</tbody>
</table>

Mr Clarke was diagnosed with Coeliac disease just a year earlier and through a biopsy to test for an ulcer which it was thought he might have. He did not have all of the classic symptoms or for many years, just serious indigestion and bloating. Mr and Mrs Clarke operated a very traditional division of domestic tasks, and Mrs Clarke saw as her role, not just undertaking the provision of appropriate food to her family, but also making sure that her husband followed his special diet. She made sure that he was aware of what he should be doing, and also tried to create the environment which would make it easy for him to do so, without giving the condition or the diet a high profile. She seemed to achieve this by being very knowledgeable about the diet, making sure the right kind of food was always available for him, limiting the amount of inappropriate food that he was exposed to, and being aware of his likes and dislikes.

Mrs Clarke’s description of her husband suggested someone who was used to being catered for and did not feel he had to take responsibility for his condition, to the level that at times he had threatened to give the diet up, was kept to it through the strategies she used to make it easy for him to do so. There was an interesting contrast between how Mrs Clarke organised her husband’s diet, and her comments about her 13 year old daughter who had been diagnosed with irritable bowel syndrome. Mrs Clarke spoke of how she felt that her daughter had become very good at dealing with her own condition in terms of diet control, in a way which implied that she felt her daughter was, at 13, quite capable of doing so.
Coeliac Disease Group (Male)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conley</td>
<td>36</td>
<td>2 (none)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gill</td>
<td>Nil</td>
<td>n/a</td>
<td>55-64</td>
<td>Self Empl. Secretary</td>
</tr>
<tr>
<td>Roy</td>
<td>Coeliac Disease</td>
<td>2</td>
<td>55-64</td>
<td>Self Empl. Gardener</td>
</tr>
</tbody>
</table>

Mr Conley had been diagnosed with Coeliac disease two years earlier after a long period of ill health which got progressively worse and which, for a brief period before diagnosis, they believed could have been a terminal condition. His improvement within a short period of following the diet was very noticeable and commented upon even by the people he worked for (as a gardener), some of whom sent recipes for his wife to try.

Mrs and Mr Conley seemed to operate a very traditional division of domestic tasks, even though they were both in full time employment (Mrs=two part time jobs). The role of looking after the family was one that Mrs Conley saw as hers, at one point in the interview saying that all she ever wanted to do was get married and have children. The women in the family seem to have had a tradition of rallying round to help each other out at times, like her mother and mother in law helping out with the children when she and her sister ran a business together, and her daughter looking for recipes for her mother to use for her father. Mrs Conley had become very familiar with the requirements of her husband’s diet, as well as what his likes and dislikes were. Sticking to the diet and not breaking the rules was very important to both members of the couple.

Mrs Conley was interviewed alone for both of the interviews. She was a quiet but expressive woman who became very lively when talking about things that concerned her or that she was enthusiastic about. Her descriptions of her husband seemed of a quiet man of few words who did not like to make a fuss, but who was used to being looked after. She described her mother in law as someone who indulged her son and who ‘taught’ her daughter in law what her new husband would need in terms of food and meals, when they were first married.
Mr and Mrs Flow attended both interviews together. They had lived in the same house for almost all of their married life. They had three children who were adult and no longer living at home, but they mentioned visits from grandchildren and helping them to learn social mores at the meal table. The couple seemed to have operated a traditional division of domestic tasks for most of their married lives, with Mrs Flow organising her employment around care of their children, and also helping her mother, who lived nearby, when she became incapacitated by arthritis. Family meals were only complete at the weekends because Mr Flow's work involved very long hours. However, since his retirement, not only had they been able to eat together regularly, but Mr Flow had been able to take over most of the cooking, something he said he had always wanted to do, and Mrs Flow had never particularly enjoyed.

Mr and Mrs Flow seemed to be a gentle contented couple who enjoyed each others company. Mr Flow took the lead in the interview but they also consulted each other and supplemented information for each other. Their retirements seems to have freed them to take responsibility for aspects of the home that they really want to do (Mr=Cooking; Mrs=Gardening). Nevertheless the family diet, which includes one for coronary heart disease as well as Coeliac disease, seemed to be seen as a project that they treated as a joint venture, both in terms of learning about the content and dealing with the organisation.
Coeliac Disease Group (Male)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
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<tbody>
<tr>
<td>Jolson</td>
<td>38</td>
<td>2 (none)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diana</td>
<td>Nil</td>
<td>n/a</td>
<td>55-64</td>
<td>Probation Officer/ Warden</td>
</tr>
<tr>
<td>John</td>
<td>Coeliac Disease</td>
<td>3</td>
<td>55-64</td>
<td>Systems Engineer</td>
</tr>
</tbody>
</table>

Interviews took place with Mrs Jolson only for both of the interviews. The overall impression was of Mrs Jolson’s anger about her husband and his illness, which was diagnosed just three years earlier, but had manifested symptoms for many years. Mrs Jolson explained that her husband had not acknowledged that there was something wrong until the symptoms became extreme and she persuaded him to consult the GP. At one point, because of a doctors insensitive way of expressing himself he began to believe that he had a terminal illness, which hit him very badly. Since he had been diagnosed correctly, although the symptoms had improved noticeably, he did not discuss the condition or acknowledge the effect it had had on him. Mrs Jolson was convinced that living with the illness had influenced his personality and been a major cause of his reserve and poor communication skills. It was almost that he was the illness, rather than had the illness. The course of their marriage, according to Mrs Jolson, seemed almost to have followed the path of the illness, that is, deteriorated over time, but had not improved with the symptoms, since the diet was introduced. This poor relationship has been exacerbated by an accident that Mr Jolson had within the previous six months when he fell from a ladder and was severely concussed. He had only returned to work part time since that event.

Mr and Mrs Jolson had operated a traditional division of domestic tasks, with Mrs Jolson taking total responsibility for food and meals, and her husband restricting himself to outdoor matters, taking no interest in becoming involved in food matters. This has included her husband’s special diet. She commented that she had to check every thing that he ate because she could not trust him to make sure that his food was gluten free. She, in contrast, had tried to find out as much as she could about the diet and its consequences. She was convinced that it was the reason they were unable to have children. The adopted two children who are now adult and live away from home. She suggested that she had tried to protect her children from knowing about the difficulties that she and her husband had been having over the years, but she also hinted that there had been a point at which they almost separated. She drew parallels with the differences that she had detected in her own family (‘touch feely’) compared to her husband’s family (who she saw as much colder) and her own marriage.

Mrs Jolson was a very fluent woman, who, whilst clearly very frustrated and angry about the situation she found herself in, also admitted that taking part in the interviews had given her an opportunity to talk about the situation and to attempt to understand how she felt.
Mrs Nayme was interviewed alone for both interviews. She was a very fluent, energetic, forthright woman who clearly found the intrusion of this new diet very frustrating and resented the effect it had had on her personally. She and her husband seem to have operated a traditional division of domestic tasks for most of their married life, even though she now was in paid work on a full time basis. Mrs Nayme acted as advocate for her husband over his diet, making sure food was available for him at home and also speaking on his behalf in public, even though she admitted that he did not like attention to be brought to his situation. Mr Nayme did not seem to have had to pay attention to diet generally or in relation to his special diet, as his wife made sure she knew all that was needed to be known, and she reported that when he was a young person, his mother delighted in taking responsibility for food on his behalf.

Mr and Mrs Nayme’s children were adult and had formally left home but had currently returned, one with a partner. This precipitated a suggestion that she had made that the family should conduct a rota of meal preparation to replace the responsibility resting always with her. She described the difficulty of getting them to follow this despite agreeing to it originally, and that it only lasted for a matter of months. She admitted her own role in this in that she tended to want to take over or help because she found it easier than they do.
Mr and Mrs Poynt had two children, one of five and one of two. The five year old had just started school, but the two year old was in the house during the interviews and was very demanding of her mother’s attention. Even in the second interview when her husband was also there, they did not seem to be able to find a way to distract the child. A third interview date was arranged in the hope that this problem might be overcome, but the success was limited. Thus concentration and continuity was limited in these interviews. Nevertheless Mrs Poynt managed to convey much of her views, mainly because she was very fluent despite the interruptions and also because she clearly felt very strongly about her role and responsibilities.

Mrs Poynt was a very lively, energetic woman who was very forthright in her descriptions of the difficulties she had had with her husband’s health. He had been unwell for some time and was pressed to consult the doctor by his wife who was determined to find out what was wrong. She had dealt with her own diabetes (which her mother also had) for many years and expressed an interest in medical matters generally. She clearly saw the family’s health as her responsibility and worked hard to make sure that her husband’s diet was catered for both at home and when eating out. She gave a vivid description of acting as advocate for her husband in restaurants, and having problems in getting the co-operation she felt they needed. She found this frustrating but also seemed to gain a great deal of satisfaction out of the challenge. She had a strong sense of the importance of the family and saw the origins in her own family (‘a normal Greek family’), especially her mother who had been known to regularly cater for many people at mealtimes.

Mr Poynt, in contrast, was a rather shy reserved man who seemed happy to leave these decisions to his wife. He did not have much to say even with prompts, and did not feel the diet was a problem.
Mr and Mrs Unwin had spent all of their married lives working together as caterers in Britain and abroad (New Zealand). They were both in their seventies. Mr Unwin was diagnosed with Coeliac disease just four years earlier after some years of discomfort, but had noticed a number of unexpected changes such as the absence of a form of eczema. He also had had two heart attacks twenty years earlier, but had no treatment and no further problems.

Despite that fact that they had worked together as caterers for many years, in the home they had a very clear division of domestic tasks, with the kitchen firmly Mrs Unwin’s territory, which they both agreed about. They seemed to have settled into the diet very well, although admitted it was a little disconcerting to be with. Their main concern was the dwindling shops that they had access to in the small town they live in and without transport. They actively monitored each other’s health and explained each other difficulties to me.

Mr and Mrs Unwin attended both interviews together, and were a quiet, gentle couple who seemed very much in tune with each other. Mr Unwin was more talkative to begin with, but Mrs Unwin, who seemed rather reserved to begin with, in fact joined in more as time passed, especially in the second interview.
Appendix 6.
Vignettes of participants
Coronary heart disease
(female)
Coronary Heart Disease Group (Female)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Batley</td>
<td>31</td>
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<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
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<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stella</td>
<td>Heart attack</td>
<td>1</td>
<td>59</td>
<td>Retired (General Manager)</td>
</tr>
<tr>
<td>Peter</td>
<td>Nil</td>
<td>N/A</td>
<td>61</td>
<td>Retired (Civil Servant)</td>
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</tbody>
</table>

Mrs Batley had a heart attack shortly after returning from a holiday abroad and after some discomfort during the journey home. She had not experienced heart problems before that, but recognised (in retrospect) that she was at high risk, because of hereditary and other factors. The treatment had been medication, and lifestyle advice. She commented on the difficulty in trying to lower her weight as a by-product of her medication, which caused some distress. She retired from full-time work as a consequence of her illness and her husband had retired since then.

Mrs Batley seemed a gentle, calm woman with a dry sense of humour. She found some of the aspects of her illness distressing, see above, but also stressed the need to create some form of balance between ‘doing the right thing’ and ‘leading a reasonable life’. She and her husband had followed a traditional division of domestic tasks, until she became ill, when her husband had taken over the food tasks, to a level that she had found it necessary to negotiate the way forward. She was unwilling to give up her place in the kitchen, but expressed a willingness to divide up the tasks. The family meal had not become a fundamental part of family life mainly because her husband’s shift work prevented this.

Mrs Batley was interviewed alone in both interviews.
Coronary Heart Disease Group (Female)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canter</td>
<td>36</td>
<td>2 (none)</td>
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</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Conditions (CHD treatment)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elizabeth</td>
<td>Heart attack (surgery)</td>
<td>5</td>
<td>55-64</td>
<td>Retired (pt Nurse)</td>
</tr>
<tr>
<td>Colin</td>
<td>Nil</td>
<td>N/A</td>
<td>45-54</td>
<td>Surveyor/Architect</td>
</tr>
</tbody>
</table>

Mrs Canter was now retired mainly due to her illhealth, but had taken part time work for most of her marriage, saying that her responsibility was to cater for her family (this was despite a view of herself as being ambitious and competitive). Mrs Canter gave a lengthy and vivid description of the lead up to her heart attack, with disappointment in what she felt was the inadequacy of her GP. It was clearly a very traumatic experience, from which, five years on, she did not feel she had fully recovered.

Mrs Canter had a great deal to say about her illness experience and about her beliefs about how families should be organised. She had very strong views about the family and what it should offer, casting back to a childhood on a farm in a large family. She had very traditional views about the domestic division of tasks and expressed surprise about that fact that her children had not followed in her footsteps.
Coronary Heart Disease Group (Female)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colman</td>
<td>46</td>
<td>4 (none)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clare</td>
<td>Unstable Angina</td>
<td>4</td>
<td>55-64</td>
<td>Retired (Librarian)</td>
</tr>
<tr>
<td></td>
<td>Thyroid/digestive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>prob</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Menopause symptoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Craig</td>
<td>Nil</td>
<td>N/A</td>
<td>55-64</td>
<td>Engineer</td>
</tr>
</tbody>
</table>

Mrs Colman had retired as a librarian, mainly due to illness and, although she attempted to return to some part time work after her illness was diagnosed, was persuaded by her husband not to do so. She had had a number of serious attacks since the original diagnosis four years previously, and the most serious was 18 months earlier. She and her husband brought up their grandchild after her daughter in law died not long after the child was born (She spoke of her husband as ‘always wanting a daughter’). In between the first and second interview her grand daughter (who was in her teens) had returned to stay with them after problems with her stepmother. This had caused some difficulties in the family.

Mrs Colman seemed a quiet but positive woman with a good sense of humour, but had little to say about her illness experience without prompting. She and her husband seem to have operated a fairly traditional division of domestic tasks, although she later revealed a greater involvement by him in recent years. She seemed to have organised her paid work around her family demands, although, to some extent, she had been able to dictate many aspects of domestic life, such as when meal times took place. She spoke of leaving the family to sort themselves out, but at the same time was clearl the person mainly responsible for making sure that things in the home got done.
Mr and Mrs Hulse were both in their early seventies and retired. Mrs Hulse had her heart attack whilst they were on one of their extended holidays in Spain. She had immediate treatment in the Spanish hospital and was then offered 'fast track' heart bypass surgery when they returned to Britain. They both described the events (heart attack and surgery) in a very matter of fact manner, and praising the medical treatment in both countries.

They have no children, and seem to spend quite long periods of time apart (no explanation of why). Mr Hulse spoke of realising that it was going to be important for him to learn cooking skills should he need them. He mentioned friends helpless in the kitchen after losing their wives. He also spoke of developing his own way of doing things in the kitchen and having to get used to sharing when his wife returned. Mrs Hulse mentioned having to re-establish herself when she returned, but they both agreed that this did not take very long and gave not hint of this being problematic. Mrs Hulse seemed to have been responsible for food and meal tasks until relatively recently, but also offered contradictory statements, at one moment suggesting that she had been the person deciding what they would eat, and at others that she had had little or no choice.

Both Mr and Mrs Hulse came across as being calm independent people who, nevertheless had become used to each other’s ways and preferences. There seemed to be a strong view from both that individuals should be responsible for themselves as a general principle, but at the same time, particularly Mrs Hulse revealed a level of tension between the need to stress her own needs, and the desire not to draw attention to herself.

Mr and Mrs Hulse both took part in the first interview, but only Mrs Hulse took part in the second interview.

* A new procedure which involved a shorter period of time in hospital and visits from specialist nurses in the home for a period of time after being discharged. Those who agreed to take part received surgery almost immediately as part of an experimental procedure plan.
Mrs March had been married for just under two years when her husband died from a sudden heart attack. Her son was just a few months old and she brought him up alone. She moved to live with her sister in their parents/family home five years earlier. She had a minor heart attack twelve years earlier when she was living alone, but the diagnosis was less clear. Her recent heart attack was more serious and clearly diagnosed. She describes her heart trouble, gall bladder trouble and recent a serious viral infection as difficult and worrying but not devastating, the latter two being seen as the more problematic. She described herself as having been very fit and health eating through her life and attributes this as a protection against illness. She had a strong sense of personal responsibility and self diagnoses and treats. (she confessed following a homeopathic treatment without telling her GP who she felt might disapprove)

Mrs March came across as a very forthright woman used to looking after herself. Nevertheless, despite losing her husband at a very early age, and receiving very little support from her parents in law (with whom she had been living when her husband died), she expressed a strong sense of the importance of family for care and support. Although she moved to Lincolnshire not long after becoming a widow, her son was sent to spend time with her parents, particularly his grandfather. She expressed very traditional ideas about gender roles in families, despite evidence of contradictions in her own brief marriage and the choices made by her son in his marriage.
Coronary Heart Disease Group (Female)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
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</thead>
<tbody>
<tr>
<td>Rice</td>
<td>12</td>
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<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mary</td>
<td>Heart attack</td>
<td>18 months</td>
<td>65+</td>
<td>Retired (Teacher)</td>
</tr>
<tr>
<td></td>
<td>Dairy allergy</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>John</td>
<td>Nil (but see notes)</td>
<td>N/A</td>
<td>65+</td>
<td>Retired (Physicist)</td>
</tr>
</tbody>
</table>

This was a first marriage for Mrs Rich, but a second for Mr Rice, whose first wife died after an illness which he retired from work to nurse her through. Mrs Rice was still in full time work as a school teacher when they married, which demanded a great deal of her time.. Mr Rice took responsible for the domestic tasks and had retained them despite her retirement, apart from a few tasks she had managed to take over. There was some indication that Mr Rice had not been ‘allowed’ to take on cooking tasks in his first marriage until his wife became ill. Cooking seems to be important for Mrs Rice who mentioned on more than one occasion her view that food was an indicator of caring and a site for contention. There was some indication that before she was married and before her mother died, these were functions she performed for her mother and her brother who lived not far away.

Mrs Rice also expressed some concern about her husband’s actual choice of food, which was heavily weighted to a red meat content, which she would not have chosen herself, and felt her husband should reduce, because she felt he was strongly at risk for heart disease himself. These are health issues that Mr Rice did not seem to include in his food responsibilities, and which Mrs Rice found frustrating.

Mrs Rice was a very fluent thoughtful woman who was one of the few participants who speculated about the symbolic meaning that food can have for relationships. The first interview was conducted with just Mrs Rice, in which she seemed to be more forthright about her feelings over their eating arrangements. The second interview was held with both members of the couple, during which she seemed more concerned about representing her husband well and helping him express himself. Mr Rice seemed less fluent than his wife responding to prompts with practical descriptions and little in the way of feelings.
Appendix 6.
Vignettes of participants
Coronary heart disease
(male)
Mrs Abel described the difficulty of dealing with her husband when he was ill, partly because physically she was unable to help him move around the house, and partly because of difficulties in providing food recommended by the CHD diet (because of access to shops and because of her husband’s food preferences). It was the practical aspects that she stressed.

Mr and Mrs Abel were married quite late in life and had both held similar full time employment until Mrs Abel responded to reorganisation in the work place to move to part time and then retire completely. Mr Abel had returned to work after his illness, but at the time of the interview on a part time basis. It would seem that once married they fell into a very traditional way of organising the home, with Mrs Abel taking over all of the domestic tasks. She also did all of the shopping even though she no longer drove their car. Her husband occasionally collected heavy items in the car if requested. This was a major cause of her frustration, but tended to be about the lack of access to shops and poor bus services, rather than alternative ways of using the family car. She did not seem to expect her husband to do the shopping regularly or to take her shopping by car.

Mrs Abel seemed a rather cautious reticent woman who had particular issues that she wanted to talk about - access to shops, poor public transport, whether to the shops or to the hospital to visit her husband; being physically able to look after her husband. These were all expressed at a practical level and not a feelings level. I invited Mr Abel to join us for the second interview, and expected him to be quite forthright, as a consequence of his manner over the telephone during the original contact. In fact he proved to be very reticent answering questions in a very monosyllabic manner. He may have been concerned about the tape, but did not object when asked if he minded being taped, perhaps because his wife intervened to say that ‘of course he would not mind’.
Mr Burrell had retired before his heart attack, and had had some risk factors for a number of years (high cholesterol) which lead them both to pay attention to his diet. Mrs Burrell had suffered from Crohns disease (an illness which affects the digestive system, causes considerable pain and has no permanent cure and no really effective treatment) for twenty five years.

Mrs Burrell had always been a housewife and cared for the four children from her husband’s first marriage. It seemed to have been Mrs Burrell’s role to monitor the family’s health and ensure that they attended the GP for regular checks. Mr Burrell boasted of his wife’s cooking successes in competitions and for family get togethers, which she enjoyed doing even when she was unable to eat much of what she prepared. They both made links with family traditions inherited from their parents, describing large family Christmas celebrations, but they also note changes in the ways their children organised their own family lives.

Mr and Mrs Burrell both attended both interviews. They are both quiet reserved people who express a great deal of concern about each others health and illness experience, and answered on behalf of each other or supplemented what each other said. They seem to anticipate and co-operate with each others needs, but at the same time operated a traditional division of domestic tasks. Cooking was seen as Mrs Burrell’s domain, whilst tasks such as wood work was that of Mr Burrell, although there were recent indications of changes since Mr Burrell’s illness, through his wife’s concern about him ‘doing too much’.
Mr and Mrs Calman had been married for eleven years and it was Mrs Calman's second marriage. She had three children from her first marriage, one of whom still lived with them, but was adult and independent. Both in their early fifties, they were also both in full time employment. Mr Calman had returned to his work after recovering from heart surgery. Mrs Calman reported her husband as having had adverse symptoms two years earlier, which she was sure had been heart trouble but which her husband only believed when confirmed by the heart specialist after tests. He had been seen at work and at home as a fit and healthy and so not at risk in an way, despite evidence of risk factors (smoking, high cholesterol). The shock of the attack and surgery had made him more willing to follow his wife's suggestions (for food changes etc).

Mrs Calman had already seen the home and domestic tasks as her responsibility to deal with without help. She admitted that, now adults, her children had commented that they would have liked more guidance in this as children. She reported that her current husband had no interest in cooking and preferred not to be involved.

Mrs Calman was a very fluent woman who, by her own admission, could be very forthright. She described her husband as a reserved man who did not express himself well and needed interpretation, which she undertook. She had communicated with their GP on his behalf to explain in more detail, in order to ensure an accurate diagnosis. She took the initiative for her husband's health, from meal content to making doctors appointments.

Mrs Calman was interviewed alone on both occasions.
Mr Cotton retired as a consequence of his employers dissatisfaction with his absence resulting from his illness. It was clearly something that he felt he had been forced into and would not have chosen. His retirement triggered a need for his wife and he to rethink the direction of their household arrangements. They made the decision that Mrs Cotton would develop her work as the manager of a shop and Mr Cotton would take over the domestic tasks.

Mr and Mrs Cotton had operated a fairly traditional division of domestic roles from when the birth of their children, despite Mrs Cotton's successful career progression prior to this. Mrs Cotton did not return to (pt) work until her children were in their teens and she consulted them about this beforehand. Nevertheless they both professed to be very happy with the new arrangements and seemed very supportive of each other. There was, however, some evidence that Mr Cotton was ambivalent about his new role. He spoke very enthusiastically about his cooking experiments, as well as his involvement with his grand children, but he also described keeping the TV on in the house for company, even when he was not looking at it, and spoke of wanting to keep 'busy, busy, busy'.

The first interview was held with Mr Cotton alone, and the second with both members of the couple, at my request. Mr Cotton was a very talkative man, who went off on tangents, and then would apologise for doing so. He described his family in a very loving way, and clearly drew a great deal of support from them, particularly as a consequence of his illness experience. Mrs Cotton was a friendly woman, who seemed a lot calmer and more relaxed that her husband, but also very supportive of him. During their joint interview they answered for each other, or checked with each other about the accuracy of their individual responses.
Mr and Mrs Greig were both in their early seventies and retired. Mr Greig had had a history of heart problems which had been treated with medication, but had not caused a change in his employment as a welder, despite the physical demands this created. However, his retirement was triggered by his heart trouble which cropped up again a year before his official retirement was due, at which he was persuaded to apply for sickness status for that final year, to avoid having to look for another job. He clearly was still a little embarrassed by this, and was proud of the fact that he had had only changed jobs twice in his life, remaining in three jobs for long periods of time, loyalty being an important factor. Mrs Greig’s employment had always been part time and organised around the children and the caring. She spent some considerable time caring for her mother who had become increasingly demented and eventually had to be hospitalised.

Mr and Mrs Greig seem to have operated a clearly defined division of domestic tasks, with Mrs Greig very clear about the inappropriateness of men having to do domestic tasks, although Mr Greig felt that he could take over the cooking if necessary. Once they were both retired Mr Greig had begun to share the house cleaning, but was still prevented to undertake any cooking. He spoke very highly of his wife’s cooking abilities.

Mrs and Mrs Greig were interviewed together on both occasions. The seemed a quiet, shy couple who enjoyed each others company with no friction at all. Mr Greig tended to take the lead in the interview, with Mrs Greig less talkative, but, in fact, more adamant than her husband about the appropriateness of gender roles.
Mr and Mrs Howard were in their late forties, and Mr Howard, at 47, was the youngest participant in the CHD group, and at the lower end of the age range for CHD generally. He described two brief events a week apart, which he could not really describe as 'heart attacks', but enough to make him decide to consult his GP. He was very shocked to find, after tests, that he was recommended heart bypass surgery. He considered himself very fit, partly through his job as a welder, but also because of his sporting and exercise activities. However, in retrospect, he recognised risk factors (smoking and heredity). He was still recovering from the surgery and was only just beginning to seek work, which would have to be different in nature from the heavy work he had been used to, and he anticipated problems, finding work of a compatible income. Mrs Howard seemed to have suffered a history of illhealth, indicated by casual comments picked up in the transcripts, but which were not treated with significance by the participants during the interviews.

Mr and Mrs Howard seem to be one of the few couples who have had a relatively non-traditional arrangement over domestic tasks, but it was not clear how accurate this was from the jokey way in which they described their domestic arrangements. There was some indication that the kind of sharing they undertook had become more ad hoc as a consequence of Mr Howard being at home for six months. They had two sons who no longer officially lived at home, but seemed to come to stay on a regular basis, and also were able to expect their mother to continue to do their washing for them, which they brought home regularly.

Mr and Mrs Howard were both chatty and teased each other throughout both interviews. Mr Howard tended to take the lead in the interview, with Mrs Howard sharing descriptions or challenging some of her husband’s comments. They seemed most relaxed when talking about their youth in the North of England and their affection for the region, which they saw as generating poor eating habits but good relationships.
Mr and Mrs Legston had two adopted children who no longer lived at home. They had lived in the same house for the whole of their married lives. Mr Legston had had heart problems for a number of years, but had had a recognisable heart attack just 18 months earlier, which had been treated with medication and lifestyle advice. Mr Legston was retired, but Mrs Legston has continued her part time work as a care assistant as something that she enjoyed doing. They had recently been recruited to help out with their grandson as a result of their daughters recent divorce.

Mrs Legston was interviewed alone for both interviews, although I met Mr Legston briefly as I arrived and he went off to look after his grandson. Both seem very quiet reserved people and Mrs Legston did not talk in detail about how she felt about her situation. They seemed to have developed a mix of traditional and shared ways of organising the home. For example, before they had children, when they were both in full time employment, whoever came home first prepared the meals. The flexibility had also been reflected in arrangements with their children. However, the overall organisation remained with Mrs Legston. She expressed a strong sense of responsibility for her husband’s diet, which she seemed to see as her responsibility.
Mr and Mrs Marston were both retired and formally pensioners, but Mr Marston originally ceased work due to redundancy and Mrs Marston continued to do some cleaning work. She was, however, about to give up this work in order to help out with the care of her grandchildren, when her daughter began paid work herself. Mr Marston had a minor heart attack 18 months earlier which was treated with medication.

Mr and Mrs Marston were interviewed together on both occasions. They seemed a quiet reserved couple who did not say a great deal, even with prompting. Mr Marston seemed concerned but resigned about his heart condition, his wife described him as 'a worrier'. They had four children, none of whom lived at home, but most lived close by. They had close links with their children and with Mrs Marston's family in Ireland, whom they visited regularly. Food seemed to play an important part in this latter family connection, and was blamed as part of the cause of Mr Marston’s heart attack, which occurred shortly after their return from a visit. However this was not the case with their own children, with whom they rarely ate. Mr Marston had deferred to his wife in cooking tasks through their marriage, but was accepting of his wife’s comment that he would have to fend for himself a bit when she started to look after their grandchildren, although this still seemed likely to be supervised by Mrs Marston. She said that she enjoyed cooking, but was also quite happy for others to undertake this - not that this seemed to have happened very often.
Coronary Heart Disease Group (Male)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morton</td>
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</tr>
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<table>
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<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vic</td>
<td>Heart attack (surgery)</td>
<td>18 months</td>
<td>65+</td>
<td>Retired (Chartered Accountant)</td>
</tr>
<tr>
<td>Marie</td>
<td>Nil</td>
<td>N/A</td>
<td>55-64</td>
<td>Assistant to club secretary</td>
</tr>
</tbody>
</table>

Mr Morton retired before his heart surgery, but had continued to do accountancy work for specific people on a casual basis. He and his wife had conducted a very traditional organisation of the home and family, mainly through the preference of Mr Morton, who insisted that he did not want his children to be latch key children and that mothers should stay at home with the children. He linked this with his own childhood where he saw his mother caring for the children, suggesting that she had never ‘worked’, although he did reveal that she acted as a receptionist for his doctor father. Mr and Mrs Morton had four children, all adult and, with one still living at home.

These interviews were quite difficult, in that there was some tension evident during the first interview with both Mr and Mrs Morton. Mrs Morton seemed a tense woman who was not at all relaxed and her contribution to the first interview was limited. It was particularly noticeable by an eventual outburst in which she complained about the fact that she had always been responsible for food in the home, even currently with her adult working daughter still at home and her husband retired. In between the two interviews Mr Morton informed me that his wife had left him, so the second interview was just with him. Mr Morton seemed a relaxed welcoming man who, even in the second interview seemed relatively unfazed by the dramatic turn of events. He commented on discovering M&S pre-prepared meals because he had never fancied cooking himself.
Mr and Mrs Royle were both formally retired although Mrs Royle, at the time of the interviews, worked part-time at a doctor’s surgery. Mr Royle had had a series of minor heart attacks over the previous 12 years, treatment for which had been limited to medication. He also developed diabetes (controlled by diet) five years earlier, at approximately the same time as his retirement. He felt that the latter had been more problematic for him than the heart trouble. Mrs and Mrs Royle agreed that they had always shared the household tasks equally and Mr Royle was very proud of the extent to which he was actively involved (even with the hoovering!), although there was some indication that Mrs Royle had, in fact, had to do more than her husband when she was caring for their children and he was out to work. They did not see this as interfering with a general principle of sharing operated throughout their marriage.

The couple conveyed a strong sense of the importance of family, stressing their choices to make sure that their children could join them when they socialised. The drew from their own childhood, again stressing traditions of families doing things together.

Mr and Mrs Royle attended both of the interviews, and both seem very positive strong personalities, with strong opinions. Mr Royle tended to take the lead in the interview, but they also consulted each other over responses to questions as well. Mr Royle conveyed a strong sense of the need to take personal responsibility for dealing with things like illness, but he also stressed the need for ‘balance’ and enjoying life, especially food which they both felt was an important part.
Mr Scruton was formally retired but had worked part time for the same firm that he worked for before, doing minor work. He had returned there since his illness. Mr and Mrs Scruton had operated a very traditional division of domestic tasks, with Mrs Scruton firmly in charge of food tasks, as well as her husband’s health which she saw as her role. She felt that her own early experience of being a ‘hole in the heart baby requiring early surgery and constant attention to her own health had informed her in her role of ensuring her husband’s and children’s health. Mr Scruton seemed very happy to leave her in charge of these kinds of tasks. Interestingly, despite both professing to be happy with their arrangements, Mrs Scruton explained that she had made sure that her two sons learned how to cook at a very early age, something she felt was important for men to do as well as women. Neither of them expressed surprise over their sons involvement in the kitchen in their own marriages.

Both members of the couple convey a view that attention to the dietary advice the have been given, and that was available generally, was very important. Nevertheless, they also expressed a view that a sense of balance was important and that indulgence was acceptable within reason. There was some sense that what happened outside the house needed less restriction than inside the house.

Mr and Mrs Scruton were both fairly forthright people who had plenty to say. Mr Scruton tended to take the lead, describing events in great detail.. Mrs Scruton was a quieter person, who would occasionally interrupt him to keep him on what she seemed to feel was ‘on track’, and added her views, usually over those areas that she felt authority, such as meal organisation and content.
## Coronary Heart Disease Group (Male)

<table>
<thead>
<tr>
<th>Family Name</th>
<th>Years Married/Together</th>
<th>Number of Children (at home)</th>
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<tr>
<td>Tayte</td>
<td>46</td>
<td>2 (None)</td>
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<table>
<thead>
<tr>
<th>First Name</th>
<th>Medical Condition(s)</th>
<th>Years since Diagnosis</th>
<th>Age Range</th>
<th>Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audrey</td>
<td>Hiatus Hernia, Diverticulosis, Stomach virus</td>
<td>some years, 6 years</td>
<td>65+</td>
<td>Housewife/retired (pt Secretary)</td>
</tr>
<tr>
<td>Tommy</td>
<td>Heart attack (medication), Gallstones</td>
<td>6 years, 18 months</td>
<td>65+</td>
<td>Retired (Managing Director)</td>
</tr>
</tbody>
</table>

Mrs Tayte had had a long history of health problems, including three hernia operations, which took up a considerable part of the first interview. Although the focus of the interview was supposed to be her husband’s heart problems, not only did she convey the view that her own conditions were more serious, but she also questioned the accuracy of the diagnosis of her husband’s heart disease. This was left unresolved between the two of them, but was an undercurrent through the two interviews.

Mr Tayte’s employment seemed to have been very demanding, particularly in terms of time, which had left Mrs Tayte to take responsibility for the home and family. This was something she seemed to approve of in principle, explaining that she gave up a job that she loved because she felt it was much more important to be around for the children. She nevertheless conveyed the view that it was quite a burden that she managed alone. She was clearly very proud of her abilities within the home, especially cooking, and she expressed strong disapproval of her daughter-in-law for not intervening to ensure her son’s weight loss. She was very knowledgeable about food and nutrition, and there was evidence of some tension between enjoying food and ensuring her own and the family’s nutritional health. A sense of balancing the ‘good’ with the ‘bad’ seemed important.

Mrs Tayte was a very forthright woman who had a great deal to say and often went off on tangents. Her husband, who hovered around rather than attended the first interview, only joined the second interview for the final few minutes. He was a much quieter person who seemed to want to be precise, but not to argue. Mrs Tayte often dismissed what he had to say, nevertheless there were moments when he managed to stand his ground.
Mr Watten had had a series of heart ‘events’, mainly chest pain diagnosed as angina, over the previous ten years, his first heart attack four years earlier and ‘fast track’ heart by-pass surgery 18 months earlier after a second heart attack. Mrs Watten was diagnosed with diabetes five years earlier after feeling very ill for about six months.

Mr and Mrs Watten seemed to have operated a very traditional division of domestic tasks with Mrs Watten totally responsible for food and meals and Mr Watten expressing a lack of interest in becoming involved, and noting that if he had to cater for himself he would become a ‘microwave merchant’. However it was revealed that there were a few tasks that were ‘his’, it seemed partly because he enjoyed them and partly because they were OK for a man to do (that needed a strong arm, such as mashing potatoes!). Mrs Watten was very matter of fact about her role and did not betray any frustration about this.

Mr Watten and Mrs Watten attended both interviews and Mr Watten seemed to expect to do most of the talking and so dominated the interviews. Mrs Watten was a much quieter person who, even when questions were directed at her, was cautious in replying and was often interrupted by her husband. Nevertheless there were a few matters over which she was quite firm, such as saying that she expected her husband to conform to her diet as a diabetic. Mr Watten seemed ambivalent about his condition, suggesting at one moment that he was in control of it and at others expressing some anxiety about it. However, they both described the diet as ‘theirs’ rather than ‘hers’ or ‘his’.