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The everyday food practices of community-dwelling Lesbian, Gay, Bisexual, and Transgender (LGBT) older adults



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A B S T R A C T

Malnutrition during old age is a significant public health issue. Prevailing behavioral and structural senior malnutrition interventions have had marginal success, largely failing to reflect the realities of people's daily lives. This novel study employed Social Practice Theory (SPT) to explore the food practices of an under-researched, yet highly vulnerable, segment of the older adult population—Lesbian, Gay, Bisexual, and Transgender (LGBT) seniors. Four focus groups were conducted with 31 older adult clients and volunteers at a national LGBT social service and advocacy organization. Findings revealed that food practices—far from being mere expressions of individuals' choices or immutable habits—are entities composed of meanings, materials, and competences that are structured as they are performed repeatedly in a social context. Gaining insight into how and why diverse older adults perform food practices in light of obstacles common to aging has important implications for senior nutrition program and policy development.

Background

Everyday food practices, from shopping to heating up leftovers, have large effects on health and wellbeing, yet they are so mundane that researchers, social service organizations, and policymakers often overlook them. By exploring the food practices of an under-researched segment of the older adult population, Lesbian, Gay, Bisexual, and Transgender (LGBT) seniors, this paper illustrates the value of a social practice framework to program design and policy interventions to promote health.

Malnourishment and LGBT older adults

The United States (US) is undergoing a dramatic demographic shift. Currently, more than 46 million Americans, or 14.5% of the population, are 65 and older (United States (US) Administration on Aging, 2016). By 2060, the number of older Americans (i.e., those 65 and older) is projected to more than double to 98 million, with more individuals in the “oldest old” cohort (age 85 and older) than ever before (US Administration on Aging, 2014). Among the older adult population, more than 2.4 million age 50 and older are LGBT, a number expected to double by 2030 (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emllet, 2015; US Administration on Aging, 2014). Due to unreliable counts of individuals who identify as such, the numbers of LGBT older adults

may be even larger (Knauer, 2011; Ramirez Barranti & Cohen, 2000; US Administration on Aging, 2016).

Malnutrition among older adults is a significant public health concern (Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011). Approximately 9% of the nearly 45 million non-institutionalized older Americans suffer from malnutrition, with 45% of older adults at risk of malnutrition due to physical, social, economic, and medical factors (Elia, Zellipour, & Stratton, 2005; Fulkerson, Larson, Horning, & Neumark-Sztainer, 2014; Furman, 2006; Guigoz, 2006; Hall & Brown, 2005; Harris-Kojetin, Sengupta, Park-Lee, & Valverde, 2013; Visvanathan & Chapman, 2009). Malnutrition during old age is correlated with numerous health problems (Amarya, Singh, & Sabharwal, 2015; Chandra, 2002; Stratton, Green, & Elia, 2003).

Myriad factors make LGBT older adults especially vulnerable to malnutrition. While many LGBT older adults receive support and care from “families of choice” (e.g., friends and extended family) and LGBT organizations, they are twice as likely as heterosexual seniors to live alone, and three to four times less likely to have children to provide care and companionship, with more than half reporting insufficient companionship and isolation (Grossman, D'Augelli, & Hershberger, 2000; Harley & Teaster, 2015; Knauer, 2011). Living alone with few social ties can reduce enjoyment of food preparation, leading to skipped

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meals, eating less healthy food, and thus poorer nutrition (Romero-Ortuno et al., 2011).

Additionally, LGBT seniors have poorer health outcomes than heterosexual seniors, including higher rates of diet-related chronic disease and disability, and psychological distress, anxiety, and depression — conditions that adversely affect nutrition (Center for American Progress, 2009; Knauer, 2011; Wallace, Cochran, Durazo, & Ford, 2011). Relatedly, approximately 9% of LGBT seniors live with HIV disease, which compounds underlying health problems and makes nutrition critical (Knauer, 2011).

LGBT older adults also face barriers to medical care and social services not experienced by heterosexual older adults, including overt homo- and trans-phobia by health care and social service providers (Czaja et al., 2015; Orel & Fruhauf, 2015). Some LGBT seniors who fear discrimination avoid medical care and conceal their sexual and gender identity from health and social service providers (Choi & Meyer, 2016; Wallace et al., 2011). Further, LGBT older adults are 20% less likely than heterosexual seniors to access government services and may feel excluded from, and not partake in, institutional food programs run by organizations insensitive to LGBT clients (Choi & Meyer, 2016; Services & Advocacy for GLBT Elders (SAGE) New York City and LGBT Movement Advancement Project (MAP), 2010).

Financial instability among LGBT seniors is another barrier to sound nutrition. While economic insecurity affects many older adults, LGBT seniors experience greater vulnerabilities than heterosexuals due to historically discriminatory policies, such as job discrimination and the inability to marry, which have resulted in lost government benefits and diminished opportunities to build wealth (Choi & Meyer, 2016).

Nutritional interventions, including congregate and meal delivery programs, support the nutritional needs of older adults, including LGBT seniors (Jones, Duffy, Coull, & Wilkinson, 2009; Nieuwenhuizen, Weenen, Rigby, & Hetherington, 2010). However, they have significant limitations: unreliable funding; inaccessible locations and meal times; meal standardization with highly processed ingredients, and lack of sensitivity to LGBT clientele (Choi & Meyer, 2016; Feeding America, 2014; Wacker & Roberto, 2013). Additionally, most weekly meals consumed by older adults are prepared at home (34% prepare all weekly meals at home and 63% eat fewer than eleven meals prepared outside of the home weekly, excluding home- and congregate-meal programs). There is thus a need to investigate seniors' at-home food preparation and related practices (US Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), 2017).

A social practice framework

Many public health interventions geared to the nutritional needs of older adults are behavior change strategies based on theories that presuppose that individuals make choices by considering the costs and benefits of options within a “portfolio” of values, attitudes, norms, interests and desires (Cohn, 2014; Hindess, 2016). The underlying assumption is that individuals are rational, autonomous decision-makers able to change through their own volition. Shifting population behavior thus involves strategies such as education, marketing, or economic incentives to facilitate desired behaviors (Hindess, 2016).

Behavior change strategies have been only modestly successful at the scale necessary to sustain improvements in population health (Brownell et al., 2010; Cohn, 2014; Coleman, 2010; Michie, Johnston, Francis, Hardeman, & Eccles, 2008). A central critique is that they place inordinate responsibility on individuals and their rationally chosen actions, suggesting that even ingrained habits can give way to an individual's conscious adoption of alternatives (Dawson & Grill, 2012; Hindess, 2016). In emphasizing choice, such approaches underestimate the effects of infrastructures, conventions, beliefs, mental models, and differential resources that constitute and constrain behaviors (Hindess, 2016). Even socio-ecological models that include social, cultural, and material factors treat these as independent variables influencing

behavior, focusing on the individual as the change agent (Potvin, Gendron, Bilodeau, & Chabot, 2005).

Social Practice Theory (SPT) is an alternative because it shifts the unit of analysis from the *individual* to the *practices* themselves (Shove, Pantzar, & Watson, 2012). Social practices are simply everyday actions that are reproduced and reinforced, or modified and transformed, as individuals perform them (often habitually) within a social context (Warde, 2005). Although practices are often conflated with behaviors, they are both *performances* (i.e., behaviors) and *entities* that exist whether performed at any moment in any place. For example, cooking is a behavior, but the practice of cooking is an entity that has existed throughout civilization, evolving over time and across cultures. Cooking as an entity persists even if its performance declines or disappears in a place or time.

Practices as entities are composed of three elements: 1) meanings, the interpretations that people attribute to a practice; 2) materials, the resources, objects, and infrastructures that enable a practice to be performed; and 3) competences, or skills and know-how (Blue, Shove, Carmona, & Kelly, 2016). Practices are *social* because interactions determine and reinforce how the elements that comprise practices are selected and integrated, and social norms determine which practices are considered ordinary and appropriate (Blue et al., 2016). The repeated performance of a normalized practice stabilizes material infrastructure, meanings, and know-how, entrenching the practice. Different practices compete for time, space, and resources, and certain infrastructure and conventions lock social practices into trajectories.

Practices change and evolve through alterations to their constituent elements, over time and from context to context (Shove et al., 2012). For example, the meaning of cooking may shift from a culturally significant gathering to a necessity for survival, and may be conceptualized in one context as heating frozen dinner and in another as spending hours over the stove. The material resources for cooking may include money, ingredients, or appliances. Cooking know-how varies and changes over time due to material changes (e.g., new technologies), social changes (e.g., lost intergenerational skills transfer) and policies (e.g., the elimination of home economics courses). Thus, changing a practice involves systematic intervention that alters materials, skills, and cultural conventions in combination to encourage new performances. New practices can also substitute for old practices if they are more advantageous.

A social practice is rarely performed in isolation from other practices (Schatzki, 2002). Rather, practices are bundled with others performed in combination and even simultaneously. Purchasing food, for example, is bundled with traveling to the grocer, cooking, eating, and dishwashing. A change in one practice often changes the other bundled practices.

Sociologists have applied SPT to issues like resource consumption and sustainability, but public health scholars have only recently adopted a social practice framework (Bourdieu, 2010; Delormier, Frohlich, & Potvin, 2009; Frohlich, Corin, & Potvin, 2001; Giddens, 1986; Strengers, 2015). For example, Blue et al. (2016) used SPT to explore changes to the practice of smoking to better understand practice-based public health interventions. Cohen and Ilieva (2015) explored how city policies change food buying practices. The wider application of SPT to public health can reveal new opportunities to shift everyday practices central to health (US Department of Health and Human Services, CDC, 2017).

Data and methods

Four focus groups were conducted with older LGBT adults to uncover and learn about the elements (meanings, materials, and competences) that constitute their at-home food practices. The study took place at Services & Advocacy for GLBT Elders (SAGE), a national organization that provides health and social services, including nutrition support and policy advocacy (Anon, n.d.).

Convenience sampling was used to recruit participants from SAGE's clients and volunteers. We sought community-dwelling older adults with English proficiency who procure, prepare, and eat meals at home regularly, as well as volunteers and caregivers involved in the food practices of SAGE clients. Participant recruitment involved flyer distribution and SAGE staff communication (Ritchie & Lewis, 2014). We did not collect demographic information from the focus group participants, but as indicated in Table 1, of the 2294 participants of SAGE Center Midtown, most are male, white, gay-identifying, and in their 60s.

We conducted focus groups to generate data shaped by group interaction about the intricacies of everyday food practices that are integral to eating at home (Ritchie & Lewis, 2014). The focus groups were composed of: 1) SAGE clients who have never been caregivers, 2) SAGE clients who are or were primary caregivers, and 3) "Friendly Visitors," volunteers who visit SAGE clients weekly. Two groups included clients who had never been caregivers, and one focus group each was conducted with the other participant groups.

The focus groups were guided by an open-ended protocol to elicit information about the participants' food practices, both their own and of those with whom they shared meal preparation (see Appendix A). Questions probed factors inhibiting and enabling at-home food preparation and eating, including: the meanings attributed to shopping, cooking, and eating; material and physical constraints and opportunities; and competences related to meal preparation.

The focus groups were conducted in July 2016 at SAGE Center Midtown, a full-time LGBT senior center, and were moderated by the authors. Each group consisted of eight to twelve individuals totaling 31 participants, lasted approximately 75 minutes, were conducted in English, and were audio recorded. Each participant received a \$20 stipend. Participants were assigned unique codes during data analysis to ensure confidentiality. The methods were approved by the appropriate institutional review board.

The researchers reviewed and transcribed the focus group audio files. We analyzed the data by organizing the transcripts using qualitative data analysis software. Although the use of a priori parent codes during data analysis may limit the opportunity to identify unanticipated themes in the data, we used such codes derived from social practice theory to highlight comments related to practices, meanings, material dimensions, and competences, bundled practices, and specific behaviors, strategies, meanings, relationships and interactions, constraints, and consequences of food practices. We used hierarchical coding (Ritchie & Lewis, 2014), with top-level ("parent") codes distinguishing types of food (and related) practices (e.g., shopping, cooking, eating), "child" codes used to identify specific activities (e.g., ordering, heating, dishwashing), and "grandchild" codes to identify practice elements (e.g., meanings, materials, competences). The content and context of comments were assessed, with both researchers reviewing the codebook prior to finalization to minimize bias and enhance reliability. After the codebook was finalized, the researchers identified crosscutting themes among the codes and trends within the data.

Findings

Since we selected focus group participants who prepared and ate most of their meals at home, they all engaged in practices that are fundamental to independent living. Despite many commonalities among these practices, the elements varied considerably and thus participants performed food practices differently. In some cases, participants reported that practice elements changed over their lives, reshaping how they performed individual practices.

Meanings

SAGE clients and Friendly Visitors ascribed various meanings to

Table 1
Selected demographic characteristics of SAGE Center Midtown participants.
Source: SAGE Center Midtown. "SAGE Center Midtown, 2016".

Characteristic	Percent of participants
Age range	
60s	50%
70s	35%
80s	12%
90s	2%
Gender identification	
Female	30%
Male	67%
Sexual orientation	
Gay	53%
Lesbian	15%
Heterosexual	10%
Bisexual	7%
Race/ethnicity	
White	69%
Black/African American	10%
Latino/a/Hispanic	9%

food practices. Many focus group participants viewed food preparation at home as a simple, thrifty, efficient, or healthy way to feed themselves, describing the meaning as maintaining independence and control over their daily lives. Yet, food practices held more emotional and abstract meanings for some, who used cooking to establish and maintain connections to others or to reminisce.

Food practices as independence

Many focus group participants performed food practices that maximized ease, convenience, and affordability, enabling them to sustain themselves independently. These included shopping close to home or strategies to simplify meal planning, preparation, and cleanup. For some, the meaning of food preparation shifted from social engagement (i.e., cooking with partners and family) to a pragmatic emphasis on simplicity, particularly for those who had lost a partner or whose appetites had changed due to aging. As one SAGE client explained, preparing food at home provided "a sense of competence, that I'm [using] the room and the equipment to prepare my meals, that I can shop and put everything in the fridge. I feel very comfortable. And I know that I'm taking good care of myself."

For others, the need or desire to save money and minimize effort meant that meal planning and cooking were largely about efficiency. Several SAGE clients described efforts to prepare food more efficiently by making enough for leftovers or using shortcuts: "I plan meals for the week. I usually try to make a little bit more at dinner so I can have it for lunch the next day. Which makes them more economical... and... healthier." Another client described repurposing leftovers to save money: "I cook one day for maybe two days. ...I use a crockpot all the time. You can make a chicken in the crockpot, and with that, you can also make chicken broth at the same time. So... you can have sliced chicken or chicken with gravy another day... even... chicken salad. You try to be thrifty, 'cause everything's so expensive."

Several SAGE clients relied on frozen foods for ease and security because they could stockpile ready-made food. One Friendly Visitor had a friend-at-home¹ who, because of being largely homebound, purchased enough *Lean Cuisine* frozen dinners during a single shopping trip to last a month. Frozen dinners in another household enabled a client to continue eating at home despite the declining health of his partner, who had been the sole cook. A Friendly Visitor explained this couple's transition to predominantly purchasing and eating frozen meals: "...George* used to be the cook in the family, and then it kind of switched

¹ Within SAGE's Friendly Visiting program, SAGE clients who are paired with Friendly Visitors are referred to as "friends-at-home."

when... he fell... And then Robert* started. So, their meals took a big hit at that point. They switched to... frozen dinners..."

For some clients, the meaning of home food preparation as independence was compromised when health-related issues required switching from scratch cooking to alternatives like take-out. In describing how her friend-at-home had begun ordering take-out more often and cooking less, one Friendly Visitor commented, "I can tell... when she's tired, she's started to order in more, and that's a distinct change from even six months ago. And she always laughs it off, 'oh, you know, it's so hot today' or something... It's hard for her, and [cooking is] not something she wants to give up."

Another SAGE client explained that his partner in a previous relationship cooked, and eating at home consisted of "formal meals" that regularly included guests. In his current relationship, however, neither partner cooks, so "cooking" has a new meaning: "...We cook in the microwave things we bring home from a restaurant."

Other focus group participants described shopping as healthy physical activity that facilitated independence. One SAGE client noted: "Grocery shopping becomes an exercise program."

Food practices as social connection

Another common meaning attached to food practices was social connectedness. However, many focus group participants prepared and ate most of their meals alone, had limited or no social or familial networks, and indicated that they felt disconnected from others and lonely while cooking or eating alone. One SAGE client described eating at home as "kind of lonely," adding that she does not have anyone for whom to cook. Another client said he keeps the radio and television on while preparing and eating food at home so that it feels like "somebody is talking to him." In this way, social connectedness, or lack thereof, influenced individuals' performance of food practices.

The performance of food preparation varied in process or style depending on whether the meaning was socializing or mere nourishment. When describing meal preparation and eating, a SAGE client explained: "If there's someone I'm sharing a meal with, I feel I can fix something we'll both like. But, if I'm fixing for myself, I may not be as extravagant... So, some of my meals are a little bit more reduced to... simple stuff. Whereas [if I am sharing] I'll make the effort... because I have... a social element involved."

For a SAGE client who no longer had a partner with whom to cook and eat, his food practices shifted from cooking at home to eating out or taking in prepared food: "...It's a social thing. ...[W]hen I had a partner, he was into cooking, so... it was something we did together. Now that very often I'm by myself... I'm not going to knock myself out just for me. I'll just run out and get something."

Some Friendly Visitors noted that the social element of eating at home was so integral to the meaning that in the absence of someone to share meals their friends-at-home simply did not eat at home. In discussing her SAGE client's at-home eating practices and preferences, one Friendly Visitor commented: "What I've noticed with my friend-at-home is that I don't think [he] will eat if he's alone at home. He's not totally homebound, but it's hard for him to get out... He's much more liable to eat with others, and I think he knows that; we talk about it actually."

The theme of socialization through food also emerged during discussions of food preparation, which for some signified the possibility of hosting and entertaining others, with the practice representing a social connection and independence. A Friendly Visitor discussed how the meaning of cooking held by her friend-at-home has always focused on hosting and entertaining, with desire for independence becoming more pronounced as age-related functional decline occurred:

"My friend-at-home was... a consummate host most of her life, so she cooks 'cause that was big part of her life and it's how she was raised. She enjoyed eating out back in the day, but she's always cooked. So... for her at this point... she's trying to practice [cooking] with her eyes closed 'cause she hopes to somehow be able to continue some of that, even as her eyesight deteriorates... And she has a couple cocktails every night as well, she's really

into the cocktail hour. She's always got one ready for me too. It's sort of part of the deal. That's the thing, it's the hosting is how she has... worked around feeling like she's not receiving charity from me. She must host me, that's a big part of it. That's why she continues to cook."

For the SAGE clients who are primary caregivers for a loved one, the meaning of preparing adequate meals at home was described as a substantial responsibility that involves making "something decent" requiring "extra effort." One SAGE client who cares for his brother who has schizophrenia explained: "If you're caring for somebody... you're aware that you're cooking for somebody else and so you put the extra effort into it. I wonder how we would all do if we were preparing alone in our apartment... I think it might be a totally different story."

Further supporting the idea that caregivers feel compelled to provide nutritionally sound and tasty food to their loved ones, another SAGE client-caregiver, who cares for her partner who has dementia, noted: "I also feel obligated to try to feed someone as well as myself. ... [A]s you get older, you don't have the energy, and that's when you need food the most."

Some SAGE clients described the meaning of shopping as a source of social interactions. One client noted:

"I enjoy two things when I go to the supermarket. First, I like making friends with all the workers. When I walk in, they all say hi to me... And the other thing is meeting people. I'll pick up two items and I'll say, 'oh you think I'm buying that.' Or, 'I can use it.' And we end up a five-minute talk by someone I never met before... And you have a nice conversation, so it's more like a socialization at the same time."

Food practices as nostalgia

For many SAGE clients, cooking was associated with fond memories of parents and other loved ones, as well as with their lives growing up. One client discussed her interest in writing a cookbook, reflecting a merging of cooking and writing practices to share cooking knowledge acquired from her upbringing and earlier life experiences. Another described cooking as nostalgic, a source of competence, and a way to share her knowledge with a new, younger partner:

"Much of my cooking comes from my mother, what she chose and how she chose to cook it. And so, I also feel some sense of nostalgia when I'm fixing much of the dishes that she would fix. But also, I have a sense and a feeling of competence because I'm very comfortable in my kitchen. And just a sideline, I have a new partner, and she's 20 years younger than I. And her mother kept her out of the kitchen, and so she stands in the doorway and watches me. And at first it was a little off-putting, but now I understand she's learning how to cook from me. So now, I have another positive feeling about cooking."

Other focus group participants mentioned the nostalgic aspects of cooking. One noted: "...when I'm cooking, I remember those days when I used to cook for the family all the time." Another explained that when she includes Polish items in her meals that her mother had made at home during her childhood, she gets "a little nostalgic."

Food as creative and relaxing

Participants talked about the sense of pleasure they get from cooking, with one client stating: "making your own food is... sort of a creative process." Others found cooking therapeutic. In discussing the meaning of the cleanup after a meal, one SAGE client commented: "I actually find the cleaning more therapeutic than cooking. Probably because there are fewer variables involved and it's kind of a chain I can do without a lot of thought. Whereas there's usually a lot more thought in choosing and preparing foods." Another added: "I find [cooking] very relaxing. 'Cause you can concentrate on what you're doing. I enjoy what I cook." Yet another client compared the relaxation of food preparation and eating at home to the stress of eating elsewhere: "You're not rushed when you're eating [at home], there's no time [pressures], you can take as long as you want. When you go to somebody's house or a restaurant, it takes so long."

Material elements

Focus group participants discussed the role of material elements in facilitating, impeding, or shaping their food procurement and preparation practices. Materials ranged from the availability of food retailers, to kitchens and appliances, to financial resources.

Food store availability

SAGE clients' food shopping was shaped by the perceived attributes of available food retail establishments: location, price, and value. Some frequented discount stores because of modest budgets, while others shopped at neighborhood grocers to ease getting to and from stores. For some clients, certain stores were places to socialize with staff and customers.

Proximity was important for nearly all focus group participants, determining where and how they shopped. One client explained, *"I shop nearby because I find it never works for me being in the bus, going uptown, dragging bags along the way. For [a] few dollars more... I'd rather do it around in the neighborhood."* For others, quality and cost were more important. One client described traveling to other neighborhoods for good value, variety, and atmosphere: *"Where I have my apartment... it's a food desert. They have a thousand restaurants, but a grocery store they don't have... So, I go to Trader Joe's... [in Manhattan]... and on Court Street [in Brooklyn]. And it is a little schlep, but it's worth it financially, variety wise, atmosphere wise."*

Another SAGE client discussed how her enjoyment of the selection at a specialty food outlet motivated her to shop there despite the crowds: *"Chelsea Market has gotten so busy it's just annoying. But, I try to time it because I love the produce they have there and the fish store and all of that is really a nice treat."* Food preference and desire for variety and quality also influenced some clients' decisions to shop at local farmer's markets. As one client commented, *"I shop at... the summer produce markets that are local... for a lot of stuff. And I always go to them when I want my apples in the fall. I mean, I'll just put my backpack on and load it up with all those apples... You get the variety you can't get from any of the [super]markets."*

A SAGE client who shopped at a local dollar store that sold low-cost food offered his advice on how to identify quality food items to purchase: *"You have to be careful... because if you buy off-brand stuff there, a lot of garbage. But if you buy on-brand stuff, you get very good pricing and quality."*

Most SAGE clients did some food shopping weekly, yet several experienced difficulties, largely from health issues and material constraints, such as the distance of grocers, or apartment buildings without elevators. One Friendly Visitor said: *"A lot of the issue is around mobility with people not being able to get out of their homes to purchase what they need."* A client explained why living in a "walkup" apartment building made it difficult to shop for food: *"The worst part of shopping is bringing bags home and carrying it up the stairs. I live on the fourth floor, so I get tired. I might have to take two or three trips to get it all up the stairs."*

Others described physical challenges to at-home food preparation, including difficulty lifting heavy pots of water when preparing pasta, standing in the kitchen to prepare food, and hard-to-reach cupboards. As one SAGE client stated: *"I've found that some of the cookware... is heavy... because my strength isn't what it used to be."*

Frozen foods to ease preparation

Many SAGE clients discussed using frozen foods to facilitate food preparation. For those with functional impairments, heating up frozen foods was described as much easier than cooking from scratch. In discussing her friend-at-home's regular consumption of frozen *Lean Cuisine* meals, one Friendly Visitor noted: *"In terms of preparing things, you put it in a microwave and press go. She's able to do that herself."*

Frozen foods were also popular due to their cost effectiveness, with one SAGE client noting: *"One thing that I've been doing lately because I think it's more economical is buying frozen vegetables, because I used to buy*

a head of broccoli, and you're eating the damn thing all week. So this way, you can just buy a pound of broccoli frozen and use it when you need it."

Some clients, especially those who spent a lot of time at home, discussed the appeal of preparing frozen foods during the summertime to avoid using the oven, which would heat up their small apartments. In describing his use of frozen foods, one client commented: *"I recently discovered... Trader Joe's, which has... really good frozen entrees and things. I incorporate those, and on really hot days, I just pop it into the microwave... So, that's the option I use in the summer... Even if you have air conditioning, you're stuck in the apartment."*

Apart from purchasing frozen foods at the grocery, one SAGE client discussed how she prepared frozen herbs to eliminate waste and ease cooking: *"I hate to go out and buy the peppers and the cilantro and this and that and cut them up. No, I don't do that. I put it through the food processor. Then, I take a tray to make ice and I put a few cubes in the freezer... When I'm going to cook, all I have to do is pick out one, two, three... and that for me is wonderful because it lasts me six months to a year."*

A SAGE client who is a primary caregiver for his brother who has schizophrenia discussed having started cooking when his brother moved in with him several years prior. For this client, his desire to make his brother healthy meals despite his lack of time and cooking skills led to relying on frozen vegetables pre-packaged with sauces. He noted: *"I'm more like a short order cook... [I]f I can't do it in 20 minutes, it's not going to get done. So, I have salmon or... something that's healthy and then Jolly Green Giant prepared vegetables with the sauce in the package, and I'm fine with that."*

Tools to facilitate food practices

The focus group participants discussed tools they used to facilitate food practices, often leading to variations in food shopping or cooking practices. For example, in discussing food procurement strategies used by her friend-at-home, who is primarily homebound and has a very limited social network, one Friendly Visitor discussed how she had downloaded *Seamless*, an online platform for ordering take-out from restaurants, on her friend-at-home's iPad to make it easier for her to order meals. After learning how to use it, her friend-at-home found ordering-in appealing.

Another Friendly Visitor purchased a *George Foreman Grill* to enable his friend-at-home to cook more easily. The Friendly Visitor chose the grill based on concerns about the limitations of the apartment and the competence his friend-at-home had to use an electric griddle: *"I was thinking about getting her a microwave, but two problems: this prewar apartment with no outlets where you can plug the microwave in, and, I was really concerned she'd put something metal in the microwave and start a fire. She had a grill before... so she was comfortable with that, so I thought 'let's get her a better one.'"*

Microwaves were mentioned as critical material elements that enabled SAGE clients to prepare food at home, especially because of the wide reliance on frozen foods. Microwaves were described as easy and efficient, and an alternative to using an oven or stove. As one SAGE client noted: *"I never use my stove. And I'm very lucky, the building I live in has free electricity... I have a one-room apartment... I'm not going to put anything in the oven that's going to heat up the entire room, winter or summer. So, I use my microwave and my toaster oven."*

In addition to using tools to prepare food, other participants discussed material elements that make at-home food practices easier, such as specific types of cookware to accommodate diminished abilities. As mentioned above, one SAGE client used a slow cooker to make multiple meals at once. In discussing the perceived benefits of using glass Pyrex dishes, another noted: *"You put a little water [in the dish], and you don't have to be scrubbing. Because right now, I'm dealing with arthritis, and scrubbing is out of the question."*

A smoothie machine enabled a different SAGE client to eat more vegetables: *"By... investing in one of those machines to make smoothies, finally for the first time, I'm chugging down veggies."* Another client discussed simplifying food preparation to avoid appliances or special

equipment, explaining, “Everything is very simple. If I can't manage with my two hands, it's not done. You know, people have blenders and they have all those different machines that do things... God gave me two hands, thank God I can still use them. And that's what they're for.”

Reflecting the bundled nature of practices, one SAGE client talked about how he tunes into the news by watching the television or listening to the radio while cooking, commenting, “If I can [cook] when I'm also watching the news on television or on the radio, hearing it, that makes me feel I'm not giving away time I don't want to.”

Space and equipment

Many participants noted that they have lived in the same apartment for many years. For several, the material dimensions of their apartments, including kitchen size, functionality, and availability of cooking appliances constrained their ability to prepare and eat food at home as they desired. One SAGE client explained: “Our appliances are all ‘aging-out’ also, and when you're a rent controlled or stabilized tenant, you hesitate [to ask for replacements]. You have clutter... [and] hesitate to ask [the building management] for a new stove and a new refrigerator, so it really... limits the amount you can [cook] if you're using old appliances with limited storage.”

While space limitations restricted the at-home food preparation practices of some SAGE clients, others mentioned how they have adapted to their spaces and have adopted minimalist practices. In describing a typical interaction with her friend-at-home regarding cleaning up after eating, one Friendly Visitor commented, “She has maybe two glasses. I've offered to wash and she says, ‘no no no, I can get that.’ She might have one or two plates. It's a very small apartment. There's not a lot of storage, there's not counter space. I've looked around, like ‘where are the utensils?’ ‘where are the plates?’ She'll have two glasses next to the sink.”

Grocery and meal delivery services

Some participants relied on grocery and home-based meal delivery services to obtain food each week. These ranged from online retailers, such as FreshDirect, to local grocery stores, nearby restaurants, or home meal delivery programs such as ‘Meals on Wheels’ and ‘God's Love We Deliver’. The types and frequency of services used by SAGE clients varied widely based on different factors, including degree of functional and financial limitations, knowledge or know-how to use such services, and perceptions of the benefits or necessity of doing so. Further, satisfaction with these services and food quality varied based on the service type, with most participants unfavorably viewing home-delivered meals. One Friendly Visitor noted: “My friend-at-home... has [Meals on Wheels] all stored in her freezer, and she doesn't like them. She says they're gross, and she tried to call and cancel, but they said, ‘oh you qualify.’ So, she... just throws them away.”

Others discussed limitations of meal delivery programs besides poor food quality, including inflexible delivery protocols and practices, such as being required to be home for a delivery. One Friendly Visitor described the limits of delivery services: “The problem she runs into is getting things delivered 'cause she's in a walk up. She's like, ‘no one will bring my stuff up to me.’ Sometimes her neighbors will bring it up. She wants to be as independent as possible. So, she doesn't want to rely on someone else to bring her stuff up.”

For some, having food delivered was a way to avoid traveling to and from grocers, yet some clients disliked that home delivery prevented them from selecting their own items. As one Friendly Visitor explained: “She gets everything delivered at this point, which I think is really convenient for her given that she can't really do it on her own anymore. The only problem is that she feels like she... no longer can select the freshest [items]. They send her what they send her. If it's not what she wants, it's going to have to do.”

Competences

Various dimensions of competence were discussed, including functional competence (physical or cognitive ability to shop and cook), cooking skills, know-how to search for the best deals or quality food, an understanding of healthy eating, and knowledge of food-related programs and services. The mix of competences influenced the types of food preparation practices the SAGE clients engaged in. Several clients mentioned how they receive assistance with food shopping and meal preparation from Friendly Visitors, hired professionals, or family and friends. One Friendly Visitor explained that her friend-at-home often asks her house cleaner to purchase groceries for her: “She has a cleaning lady who comes I think every other week, and she'll also do some odd jobs. My friend-at-home will give her a little shopping list and [she will] pick up some things [for her].”

Other help involved doctoring up meals. One Friendly Visitor noted that the home attendant caring for her SAGE friend-at-home aided him in enhancing the flavor of dinners he received from ‘Meals on Wheels’: “[The home attendant] taught him how to doctor-up his Meals on Wheels. He'd throw them out because he didn't like them, and she taught him how to add seasoning or some fresh things... [H]e said it really helped make them more palatable.”

Know-how and physical capabilities were shared between a SAGE client and his Friendly Visitor, enabling them to co-cook dinner. The client had a lifetime of cooking knowledge but was physically unable to cook a full meal, and instead explained step-by-step how to prepare dinner to his Friendly Visitor, who then carried out his instructions. The Friendly Visitor explained: “[My SAGE friend-at-home will] narrate how to cook a meal to me, and I'll do it while he sits and watches. Which is useful for me, it's education. I'll make something for the two of us that he tells me how to make what he's planned in advance and has his health care attendant get the materials for.”

Several focus group participants described their competences in shopping and cooking that enabled them to save money, buy food that was more suitable to their food practices, and prepare food in ways that made eating feasible or more convenient. One client explained: “On Thursday, I look at the [supermarket] brochures that come to the building and I clip out the ones that appeal to me in terms of price and things I like. I put them in order and select a day when it's not too hot... [and] when the lines are not going to be too long. And I do my shopping in a very organized way, and I feel so smart because I save money and I have not made unnecessary trips to the store and I'm done for the week.” Another SAGE client detailed how he plans meals based on what is on sale at the local grocers, and the frequency with which items go back on sale, stocking up just enough products like yogurt so that he can keep buying them only when they are discounted. Others noted schedules for cooking that enabled them to cook ahead and have enough food to last for several meals.

SAGE clients had competences that enabled them to address various physical challenges through changes in the way they performed different practices. One switched to smaller pans when lifting became more burdensome; another avoids lifting a pot full of pasta and water to the sink by cooking the pasta until all the water has boiled out.

Interactions among participants

The focus group format facilitated wide-ranging, animated interactions that influenced the findings in three ways: 1) enabling participants to conceptualize a broad definition of food practices; 2) encouraging discussion of sensitive issues; and 3) identifying nuanced variations in practices. For example, among the Friendly Visitors, comments about mobility constraints and physical limitations led the participants to discuss a wide range of practices (e.g., ordering take-out, directing a Friendly Visitor to execute a recipe) that might not have emerged as forms of shopping and cooking without the interactive discussion. By disclosing that her stove no longer worked, a participant prompted a

larger discussion of material constraints (e.g., small apartments, frailty) and practice innovations (e.g., microwave cooking; lighter kitchenware) that might not have otherwise been revealed. As one participant responded to an open-ended question (e.g., what does cooking mean to you?), others in the focus group would offer varied responses that elaborated on the initial answer, providing similar and contrasting examples, leading to a wide range of findings (e.g., nostalgia, companionship, independence).

The focus group interactions also illustrated variations from group to group. Participants in the Client-Caregiver focus group, for example, discussed how caring for another person influenced their food practices, with several members expressing how they felt a sense of responsibility to prepare nutritious meals. Participants in other focus groups also desired well-balanced meals, but they were more interested in their own health and did not feel the same duty or obligation. Further, it was evident from the Friendly Visitor focus group that their friends-at-home were frailer and in poorer health than clients in the other two focus groups, relying more on others to perform food practices. However, expressed desire for ease, convenience, and affordability in food procurement and preparation were universal across the groups.

Discussion

The focus group findings illustrate that food practices—far from being merely the expression of individuals' choices or immutable habits—are entities composed of meanings, material elements, and competences that are structured as they are performed repeatedly in a social context. While practices can become normalized as they are performed, they can also change over time and across contexts as their elements shift. This study highlighted the various ways that food practices can stabilize, mutate, rapidly shift, or cease altogether as practice meanings, materials, and competences are reconstituted as life circumstances change. It also suggests opportunities to change the elements of food practices to enhance the health and wellbeing of older adults.

Changing food practice elements

The meanings associated with food preparation practices varied significantly from SAGE client to client and shifted as their lives changed, with consequences for how the practices were performed. For one client, shopping was associated with socializing and entailed frequenting food retailers to strike up conversations. Another client, a friend-at-home, equated cooking with entertaining and maintaining control over the social interaction, with weekly visits revolving around hosting with a cocktail and meal. For other SAGE clients, shopping and cooking were viewed as laborious and off-putting tasks to be performed as expeditiously as possible.

Material elements also played a critically important role in shaping SAGE clients' food practices. Readily available and affordable frozen foods, coupled with the phenomenon of 'cooking' in the microwave, enabled SAGE clients to continue eating at home. For some, worn and malfunctioning stoves in their rent-controlled apartments led them to use alternative cooking materials (e.g., a crockpot, electric griddle). Other material elements, like the lack of an elevator or difficult-to-navigate stairs, required SAGE clients to alter shopping practices, including greater reliance on food delivery and surrogate shoppers. Further, the material elements involved in performing food practices were also the clients' bodies themselves. For example, one client's decision to use only her hands, not appliances, to prepare food illuminates how one's body can be appropriated as a material element to facilitate food preparation, while underscoring the intimate association between material elements, meanings (e.g., self-sufficiency), and cooking competence (e.g., know-how to prepare food by hand).

SAGE clients had varying degrees of food competences. Some were expert chefs, while others had limited cooking skills; yet, competences

had changed for all. For some, cooking competences vanished with the loss of a partner who could cook, altering their performance and perception of at-home eating. For others, diminished functional competences altered their abilities to perform food practices as in the past. Yet, many compensated by using know-how to reconfigure practice elements. Some clients re-conceptualized the meaning and means of at-home eating, employing materials to ease cooking and cleaning, such as equipment (e.g., microwave) and products (e.g., frozen entrees). One client with cooking expertise but physical impairment continued to "cook" at home by combining his know-how with his Friendly Visitor's physical abilities, narrating cooking steps to the volunteer, who lacked cooking skills but followed instructions to cook dinner. Another used skills once used to cook from scratch to improve the taste of Meals-on-Wheels entrees, combining competences and material elements to facilitate eating at home. Other clients passed along their food know-how to others by writing a cookbook or teaching, efforts that reinforce the links between food practices and social connectedness.

Practice dynamics

Understanding the dynamics of food practices is key to supporting and changing them. Practices are social and thus are influenced by the practices of others. Practices are also interconnected and therefore become stabilized or change because of the practices to which they are bundled. Material elements may either enable practices to change or lock people into particular practices.

The focus groups revealed that food practices were influenced by social interactions even among SAGE clients who lived alone or were unable to travel outside their homes frequently. The meanings, competences, and even materials constituting food practices were socially constructed and acquired across clients' lives, but they were also influenced by clients' current social contexts. Friendly Visitors, for example, often helped to give new or expanded meaning to eating (or drinking) together with their friends-at-home, supported clients' existing competences, and aided in transforming the material landscape to enable them to eat at home. Other SAGE clients engaged in food practices as they performed them in stores, at the SAGE Center, or with friends and family. Changes in food practices in the wider society, such as the increased acceptability of prepared meals or the common NYC practice of ordering takeout normalized the shift to such food practices among SAGE clients.

Practice elements are not discrete, but rather interact with and influence each other. For example, clients' perceived usefulness of certain materials was closely related to competence in using those materials. In addition, the meanings associated with material elements (e.g., electric griddle as fostering independence), coupled with competence in using the materials (e.g., know-how to use the griddle) made cooking at home feasible for some. Further, as competences changed with functional decline, certain material elements became more significant (e.g., location of grocers, living in a walk-up building, limited financial resources), altering the meaning of food practices and sometimes spurring a practice reconfiguration, thereby enabling clients to continue performing everyday food practices but in new ways. Further, food practice elements were co-dependent. For example, cooking invoked multiple meanings (e.g., fond familial associations, relaxation) that were informed by and subsequently shaped cooking competence. Similarly, the meanings ascribed to practices like cleaning up after a meal and procuring and preparing food also influenced the types of materials (e.g., microwaves) used to cook at home.

Interconnected practice performances shape those practices, stabilizing, transforming, or halting them. For instance, making the shift from cooking dinner at home to ordering in take-out meals may involve a halt in the practice of shopping, cooking, and cleanup that is difficult to reverse. Further, findings illustrate that for SAGE clients, food practices shape other everyday practices, which in turn affect food practices. For example, travel modes affected food shopping and

decisions about cooking and eating, and housekeeping practices influenced the types of dishes, cookware, and appliances, as well as cooking methods, that clients used at home.

Material changes also enable practice changes. The popularity of the microwave among SAGE clients illustrates how this device has normalized certain practices, perpetuating their uptake and maintenance over time, as practices like scratch cooking are displaced. Microwaves (or toaster ovens, electric griddles, or juicers) necessitate certain shopping and preparation practices (e.g., relying on ingredients that do not require cooking) that over time normalize new types of meals and practices (e.g., reheating, which may not have traditionally been considered “cooking”).

Practice innovation

Practices also change through performance innovation. SAGE clients used innovative strategies to engage in food practices and make them satisfying and healthy. For some, this meant re-conceptualizing the meaning of a practice: shopping as a social outing or exercise; cooking as independence or companionship; washing dishes as calming. Innovations also involved the use of material elements like appliances and cooking equipment, new types of grocers and food delivery apps, or other individuals as physical extensions of a client's own limited body. Some discussed choosing dishware to make cleanup easier or modifying cooking techniques to accommodate diminished strength. Others doctored up Meals-on-Wheels or cooked multiple meals at once to ease food preparation.

Findings illustrate how even small innovations can have large effects on everyday food practices. For example, freezing herbs to ease food preparation and avoid waste, using iPad apps for ordering, or cooking by choreographing a Friendly Visitor, were strategies to facilitate eating. By drawing out different competences and material elements, these practice innovations significantly affected clients' everyday food practices. Clients also innovated by bundling food and related practices to accommodate preferences, aging-related changes, or altered financial and social circumstances. For example, one client merged the practices of cooking and listening to the radio to make food preparation less lonely, expanding the meaning of cooking to include satisfying a socio-emotional need. Another client combined shopping with exercise.

The physical and mental competences to perform practices differently, or to apply new equipment, techniques, or strategies to these practices, enabled SAGE clients to innovate. These practice innovations enabled them to continue eating at home, even though practice meanings, material dimensions, and competences significantly changed.

Implications for service design and policy

Equating food with its nutritional value, as is often the case in studies of older adult nutritional health, misses aspects of food that are significant to the lives of older adults, even those for whom cooking is not considered important. Thus, interventions should account for the dynamics of everyday food practices rather than addressing merely one-dimensional variables of nutrient quality and intake through commonly adopted interventions, such as cooking education, food subsidies, or congregate meals.

Uncovering the values, attitudes, knowledge, capabilities, and material elements within a social practice framework offers insights into how and why older adults perform everyday food practices in light of obstacles common to aging. These insights can yield innovative, practice-oriented policies that promote healthy food shopping, preparation, cooking, and eating patterns that fit the realities of older adults' daily lives and support sound nutrition. Additionally, enabling seniors to prepare nutritious meals at home has important clinical implications. The interconnected daily practices required for home food preparation

provide psychosocial, physical, and emotional benefits, from mobility and physical activity to social interaction and independence (Hughes, Bennett, & Hetherington, 2004; Keller et al., 2006). Moreover, facilitating healthy food practices can prevent malnutrition and its associated negative health outcomes (Amarya et al., 2015; Callen & Wells, 2003).

Despite the differences noted above between LGBT older adults and heterosexual elderly (e.g., experiences of discrimination, fewer children), our focus group findings suggest that LGBT older adult food practices are not likely to be different than the experiences of older adults in general. Thus, the lessons from this research could be applied to program and policy design for a wider spectrum of older adults. To ensure that practice-based interventions are responsive to and reflect the needs and preferences of diverse older populations, seniors, including but not exclusively those who are LGBT, must be active participants in research and the policy process.

Limitations and future research

The study presents a novel approach to examining older adult food practices, with lessons for program and policy design, yet it has several limitations. Our convenience sample of SAGE clients and Friendly Visitors is not representative of the older adult LGBT population, particularly those who are isolated and not connected to a social service organization, or those too frail to participate in a senior center. Additionally, our findings are specific to clients who attended SAGE Center Midtown in Manhattan and may not reflect the experiences of clients attending other SAGE centers across NYC or those of LGBT older adults in non-urban areas. Future studies should include individuals from other communities, and subpopulations of older LGBT adults who differ by gender, race/ethnicity, income, living arrangements, health status, and geography (e.g., urban versus rural settings) to assess whether and how food practices vary across these populations. It would also be useful to collect quantitative data on elements that affect food practices, such as health status and health care utilization, and to analyze this data in conjunction with qualitative data to explore relations between food practices and health trends.

Appendix A. Sample questions for focus groups with SAGE clients

Questions

1. Let's do a quick round of introductions. Please tell the group your name and how long and in what capacity you have been involved with SAGE.
2. **Where** do you eat the majority of your meals?
3. **Why** do you choose to eat your meals where you do?
4. [Probes: *convenience, habit, comfort, safety, financial reasons, socialization opportunities, health issues, health preferences*]
5. When you think of eating at home, **what** comes to mind?
6. What sorts of **feelings or emotions** come up for you when you think about preparing meals at home?
7. What are some things you **like and dislike about shopping, preparing, and eating meals at home?**
8. What are some **strategies** you use **to make preparing meals at home easier?**
9. [Probes: *help from family, friends, or paid caregivers, appliances/equipment, social service supports, financial or other support from public sources*].
10. What are some **obstacles** you face in preparing meals at home?
11. [Probes: *financial resources, assistance, time, abilities, physical or cognitive limits, space*].
12. What **would you need** to prepare **more of your meals** at home?
13. [Probes: *financial resources, assistance, time, abilities, space*]
14. Does being gay, lesbian, or transgender impact your shopping and meal preparation practices, and if so, in what ways?
15. Is there **anything else** we haven't discussed yet that you think is

important for us to know about your meal preparation practices?
16. Do you have any questions for us?

Thank you for taking the time to talk with us today. It was extremely helpful to hear from you.

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