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ORIGINAL RESEARCH

Lived experiences of self-care among older, home-dwelling individuals identified to be at risk of undernutrition

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Introduction: In a society where most older people live in their own homes, it may be expected of older individuals to exercise their potential to take care of themselves in daily life. Nutrition is a central aspect of self-care, and groups of older, home-dwelling people are at risk of undernutrition.
Aim: The aim of this study was to describe the lived experiences of self-care and features that influence health and self-care among older, home-dwelling individuals identified to be at risk of undernutrition.
Methods: Qualitative interviews were performed with eleven home-dwelling individuals who had been identified as being at risk of undernutrition. The interviews were recorded, transcribed verbatim, and analyzed with a descriptive phenomenological method.
Findings: Self-care as a lived experience among older, home-dwelling individuals identified to be at risk of undernutrition is about being aware of food choices and making decisions about taking healthy steps or not. In the presence of health problems, the appetite often decreases. Being able to take care of oneself in daily life is important, as is receiving help when needing it. Working at being physically and socially active and engaged may stimulate the appetite. Having company at meals is important and missed when living alone. Being present and taking each day by day, as well as considering oneself in the light of past time and previous experiences and looking ahead, is central, even when having fears for the future and the end of life.
Conclusion: Health care professionals should be aware of these findings in order to support self-care in older people, and they should pay attention to the social aspects at meals.
Keywords: aged, health promotion, phenomenology, qualitative interviews

Introduction

In a society where most older people live in their own homes,[1] it may be expected of older individuals to take care of themselves in daily life. Self-care can be described as the practice of activities that people initiate and perform on their own behalf to maintain health and well-being,[2] and it includes, among other things, food-related activities.[3] Sydner[4] accentuates the importance of considering nutrition in a holistic perspective that includes the person's choices and active performance as well as external conditions, and underlines that eating and meals may include meaningful functions to people.

Studies confirm that the risk of undernutrition in the elderly is multifactorial.[5–7] Tomstad et al[8] reported that being at risk of undernutrition among older, home-dwelling people was strongly related to living alone, being inactive, perceived helplessness, and receiving help to master daily life. Older people at nutritional risk have also

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been found to have reduced self-care ability,[8,9] which can be considered as having reduced potential for performing self-care activities. Self-care ability depends on a person's internal and external recourses. However, the reasons for doing productive operations of self-care, both norms and desires, may have special importance with regard to realizing such activities.[10]

Previous studies[11,12] have shown that older, co-living, home-dwelling women valued nutritional self-care activities, including shopping and preparing food, and the meaning of the meal as a positive resource in the daily life of the family. Gustafsson et al[12] reported that single older women, however, had lost the meaning in preparing meals and eating, and Kullberg et al[13] showed that single-living, older men with somatic diseases looked upon preparing food as a necessity and might be vulnerable regarding their nutritional self-care. Men who lived in a partnership reported pleasure in sharing meals with another person, and they received nutritional support from their partners.[13]

The symbolic meaning of meals, however, may differ across persons and groups, as may their motives and attitudes regarding food choices.[14] Sydner[4] argues that in supporting sufficient nutritional care in older people, the outcome may be dependent on the person's special situation, history, and context.

Understanding the complexity of being older and at risk of undernutrition is important for health professionals. This complexity may be considered as a phenomenon that includes both variations and similarities among persons' lived experiences.[15]

Therefore, the aim of this study was to describe the lived experiences of self-care and the features that influence health and self-care among older, home-dwelling individuals identified to be at risk of undernutrition.

Method

Design

The study was based on a phenomenological research approach, and narratives of lived experiences of self-care were analyzed by a descriptive phenomenological research method designed by Giorgi.[15]

Study group

The informants in this study were home-dwelling older persons (≥65 years) who had participated in a self-reported survey study in southern Norway performed in the year of 2009.[8] This survey study consisted of a randomized sample of 158 older persons who were screened with the nutritional screening instrument, the Nutritional Form For the Elderly (NUFFE). The items in NUFFE include dietary history, dietary assessment and assessment of obtaining food products, company at meals, activity, and medicine use.[16,17] The inclusion criteria in the present interview study were age ≥ 65 years and identified to be at risk of undernutrition. A number of about ten informants were assessed to be sufficient.

There were 32 persons (20.3%) at risk of undernutrition, identified with a NUFFE score ≥ 6,[8] who were potential informants. The recruitment process was implemented successively until a sufficient number was obtained. An information letter about the study, with a request for participation, was distributed. A reminder was sent to those who did not answer. The process was completed when eleven of 27 invited persons gave written consent to participate. These persons were contacted by the first author by telephone to arrange the time and place for the interview. Eight women and three men between 69 and 93 years of age were interviewed by the same researcher between the autumn of 2010 and the spring of 2011. The characteristics of the informants are displayed in Table 1.

The interviews

The informants were interviewed in their homes or at the campus of the local university, depending on their own preferences. A phenomenological approach focuses on the individual's lived experiences, and this methodological ideal underlined the importance of letting the informants tell their experiences openly and freely.[15] The interviewer presented two opening questions and asked the informants to narrate one situation where they had experienced taking care of their own health and well-being regarding food intake and meals and one situation where they had experienced not doing this. Follow-up questions were raised when it was necessary.

Table 1 Characteristics of the informants in the study

Informants	Sex	Age	Civil status
A	Female	81	Living alone
B	Female	80	Living alone
C	Female	87	Living alone
D	Male	75	Living alone
E	Male	93	Living with a spouse
F	Female	72	Living alone
G	Male	69	Living alone
H	Female	79	Living with a spouse
I	Female	78	Living with a spouse
J	Female	75	Living alone
K	Female	71	Living with a spouse

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The interviews were recorded and lasted 47 minutes on average and were transcribed verbatim.

Data analysis

The interview text was analyzed by means of the steps described by Giorgi.[15] Step 1 ("Read for sense of the whole") included reading the whole transcribed text of each interview to get a sense of the entire text. In step 2 ("Determination of meaning units"), the text was reread and broken into parts of meaning units. In step 3 ("Transformation of informant's natural attitude expressions into the language of health science"), each meaning unit was expressed in accordance with the language of health science, without losing the informant's narrated life world in the text. Then the meaning units in each interview were systematized according to content and common features from the interviews were summarized in a general structure. The general structure and the features that support this structure are presented in the findings.

Ethics

The study was approved by the Regional Committee for Medical Research Ethics in southern Norway (REK Sør-Øst D, registration S-09075d, 2009/933) and by the Norwegian Social Science Data Services (project number 21031). The research was designed and performed in accordance with the Declaration of Helsinki[18] and common principles regarding clinical research[19] were followed. The information letter about the study that was sent by mail to possible participants explained the selection conditions. The informants had the opportunity to unconditionally withdraw from the study and the confidentiality of information was assured.

Findings

General structure of self-care

Self-care as a lived experience among older, home-dwelling individuals identified to be at risk of undernutrition is about being aware of food choices and making decisions about taking healthy steps or not. In the presence of health problems, the appetite often decreases. Being able to take care of oneself in daily life is important, as is receiving help when needing it. Working at being physically and socially active and engaged may stimulate the appetite. Having company at meals is important and is missed when living alone. Being present and taking each day by day, as well as considering oneself in the light of past time and previous experiences and looking ahead, is central, even when having fears for the future and the end of life.

Features that may have influenced health and self-care among older, home-dwelling individuals who had been identified to be at risk of undernutrition

Being aware of food choices

The informants revealed an attitude toward their food intakes that showed that they were aware of their food choices. For several of the informants, it was important that their food intake was healthy and included varied food, such as fish, meat, potatoes, vegetables, fruit, eggs, and bread. Others preferred food they liked or food that could be prepared easily and that could be assessed as nutritionally sufficient. Sometimes they chose food they enjoyed, even if they thought they should not or had been advised to choose differently because of their health. One of the informants said that dinner was not the preferred meal but that living with a spouse who enjoyed this meal influenced the choice to eat dinner every day.

The informants told that their appetite was usually good. Several of them thought they were eating too much and wanted to reduce their food intake to lose weight. They were also aware of having the same quantity of food for the different meals. Being slim was described as helping with physically mobility.

Having daily regular meals was valued by the informants and usually incorporated routines. Eating dinner every day was mostly considered important and preparing large portions for several days was sometimes preferred. Some informants occasionally gave less priority to having dinner in favor of a more simple meal. The informants mostly preferred homemade food. They prepared their own meals because they enjoyed it. They could then control their food intake or have meals according to their taste. For some, preparing meals was as an activity they "had" to do and could manage or was an incorporated habit in their daily life. One male informant said that the meals were mainly prepared by his wife as an established arrangement.

Going food shopping was valued. Several of the informants regularly needed assistance from other family members, neighbors, or taxi drivers regarding transportation. This was mostly described as a satisfactory arrangement, but demanded planning purchases that would last for several days. For some informants, food shopping was something one managed without assistance. When living with a spouse, it was possible to cooperate when buying food and was an activity the couple performed together or could be shared between them because of health problems.

Health problems and decreased appetite

All the informants had health problems of varied kinds and intensity, and several of them had experienced acute medical events. Mostly, their health situation demanded awareness and adaptation in their daily life, and they needed medical treatment and professional health care support periodically or permanently.

Health problems and experiences of mental strain sometimes caused bad days that influenced the appetite negatively. Decreased appetite and weight loss during illness was a situation that could be changed with the help of correct treatment. Another experience was that becoming more aware of food intake and of reducing the sense of stress after a serious medical event. One informant said that her physician had recommended weight control and given useful nutritional advice. There were also experiences of missing adequate medical support when having health problems that impaired food intake. However, professional nutritional recommendations and advice were also devalued in favor of personal experiences.

Valuing self-care and receiving help when needed

Being able to take care of oneself in daily life and performing self-care activities were mostly described as important to work to achieve. Being helpless and dependent was undesirable. There were, however, occasionally experiences of helplessness and dependency, and receiving family support and help was sometimes necessary. For informants who usually lived alone, living permanently with other family members in order to get help could be described as not wanted. Receipt of help from family regarding daily activities was also described as a support to avoid until it became necessary. The family was experienced as a security, and not having close contacts with the family brought a sense of insecurity.

One informant preferred to be alone and did not care about eating when having bad days. Others said that it was important to receive adequate professional support and information when having nutritional problems. An informant said that she took great care to ensure sufficient fluid intake when being seriously ill, and she was also looked after by her family.

Some needed regular home nursing to support health care activities in daily life, but taking care of one's own food intake and meals could be experienced as taking care of oneself.

Being engaged in the family was important for pleasure and a sense of belonging. But this also brought reasons for worries, sorrows, bad or good memories, as well as thoughts about the future and the responsiblity for giving help, for example, being a parent is a lifelong responsibility.

Receiving regular help regarding housekeeping, for instance with cleaning, was described as necessary or not immediately necessary. Financial concern was not a worry and gave certain possibilities, like buying the food one wanted.

Valuing activity, social connections and engagement, and working for it

To be physically active was viewed as important in order to maintain health, and this was described as taking a walk outside, if possible, depending on one's personal health or the environment (for instance, presence of slippery roads). A meal could be appreciated after the walks. One informant told about a training activity she enjoyed, which also included sharing a meal with the other participants. To be physically active was also described as a goal that was hard to realize, and some of the informants said they sat too much.

Decreased mobility influenced the performance of physical activities, and assistive devices could be needed to enable mobility inside the house or outside. House work was also experienced as a physical activity to maintain but was now more tiring. Due to being more physically tired or more sensitive to stress, there were things that could be hard to carry out, for example, baking cakes.

The informants valued social activity and missed such activities when loosing contact with friends or when their social life decreased. Meeting friends and cheering one another up and sharing meals were experienced as important. Health problems limited social activities, and some of the informants had friends who were in the same situation, or they had lost friends who had died. To be socially active was stimulating and brought valued company at meals and was also experienced as stimulating for the appetite. Eating good tasting meals in a restaurant, with a spouse or other family members, were nice experiences, too. A sense of not being socially capable limited such activities.

The move from one's longstanding home was a situation that caused less contact with old friends and neighbors. But there was also described a wish to be closer to one's social network and nearer the local food shops. Knowing neighbors and their living places well were positive experiences that brought opportunities for meeting people and for social connection. One of the informants said that she enjoyed being invited for coffee by her neighbors, but this did not happen very often. Having older neighbors and decreased mobility were described as socially unsatisfactory.

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Handiwork, listening to the radio, reading books, or writing were appreciated and also missed when health problems limited these activities. One of the informants narrated that she had impaired hand function and her sight had decreased and she did not manage to do needlework or read as much as she wanted. The evenings were therefore sometimes experienced as boringly long, so she would "chain-eat". Another informant said that she enjoyed sitting in her armchair, and eating a slice of bread and drinking a cup of coffee, with her knitting nearby. Participating in social clubs and having special duties to perform was also described as an important activity, as well as being engaged in voluntary or formal work for other people. To get up early in the morning, eat breakfast, and use the day to help other people was a good experience, and to give pleasure to other persons stimulated the appetite.

Company at meals

Several of the informants who lived alone missed having company at meals. After losing a spouse, it was difficult to enjoy eating alone or the food tasted less good; meals with their partners had been a pleasure to them. One informant prepared her meals more simply because she did not enjoy cooking just for herself. Eating alone was also described as a necessary habit for single-living people, although company at meals was mostly preferred. Watching TV or listening to the radio while eating could be a replacement for social contact. For some of the informants, loneliness was a challenge in daily life or a worry for the future.

Being in the company of other family members at meals was appreciated when these opportunities were present. Living with a spouse included not only company, but also well-prepared meals that tasted good.

Looking ahead, being present, and remembering the past

When looking ahead, several of the informants feared becoming helpless and losing cognitive functions, something that was described as the worst state of living. Others said that maintaining their health was important, and some of the participants said that they preferred to "die with their shoes on." Thinking about the future could also be described as bringing a feeling of anxiety about health and possible diseases, or it could be dealing with failing joy of life. Having "something to look forward to" was described as important. Looking ahead could also be described as knowing that life has an end and that this has to be accepted. Being "present" was described as taking each day by day. Some preferred that every day was predictable, and some described this as boring. Being engaged in daily activities, self-care, and also helping other people were described as important. Feeling well, finding life interesting, and being satisfied with the situation overall were described as experiences of being present. Description of the past contained important experiences regarding the meeting of present demands (such as nutritional self-care) in a positive or negative way. Several of the informants also told about a previously active life, with responsibilities of housekeeping and participation in working life. The past also represented memories to look back on.

Discussion

The aim of the present study was to describe lived experiences of self-care and features that may influence health and self-care among older, home-dwelling individuals identified to be at risk of undernutrition. Mostly, the older persons who were interviewed found it difficult to respond directly to the opening questions and to describe concrete situations that they had experienced where they had managed to take care of their health and well-being regarding food intake and meals, or not. However, by allowing the informants to narrate freely and by guiding them carefully, the stories of lived experiences about the actual theme were told.

The obtained general structure of those individuals' self-care reveals a complex picture, and the features that may have influenced these persons' lived experiences of self-care included both variations and similarities that are important for health care professionals to understand.

In the health literature, self-care has been described as the practice of activities that people initiate and do on their own behalf to maintain and improve health and well-being.[2] The traditional view underlines that self-care activities are rational and goal directed and that realizing such activities depends on the person's internal and external resources.[2,20] Consequently, basic daily health maintenance behaviors, such as sufficient food intake and performance of useful food habits, include taking an assertive and active position in health care decision-making and health education.[2,20] Being aware of food choices and making decisions about investing in healthy food-related habits and activities, or not, is an aspect of the obtained general structure of self-care that may reflect that idea of self-care. However, within a phenomenological approach, nutritional self-care activities may not be considered as a series of physical events in accordance with a series of rational and conscious thoughts.[20] Rather, they may be seen as a way of "being-in-the-world" and directed to the situation of the human subject,[20,21] and related to

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the meaning that actualizes such activities, which includes both an objective aspect and a subjective aspect (such as the person's thoughts, feelings and intentions).[20,22] This approach may make sense of both the similar and varied descriptions of the participants concerning food choices and habits in their everyday lives, and also to their choices when they knew these were not healthy in some situations.

The informants did not describe sufficient food intake as a challenge in their daily lives. Further on, several of them described that they were eating too much or wanted to lose weight. Orem[2] points out several basic conditioning factors that may influence a person's self-care, for instance cultural elements, and underlines that such factors may be internalized by individuals and influence their value systems and self-concepts. The phenomenological concept being-in-the-world[21] describes the human subject's strong and mutual relationship with the world and the environment, situated in a context. A restrictive attitude to the quantity of food intake may reflect a cultural ideal of the body image. In a study among older women,[12] the participants expressed a fear of becoming fat or they wanted to lose weight, and those women were bothered with their body image. The present study also showed that being slim could be perceived as being healthy, as having the proper food intake, and as making it easier to be mobile. However, the ideal of being slim may not correspond to being healthy in old age.[12] Being a moderate degree overweight is associated with lower mortality rates among older people.[23,24] None of the participants mentioned such perspectives in the present study.

Being at risk of undernutrition was not a main part of the informants' narratives when talking about their food intake. It should be noted that there was an interval of time between the nutritional screening of the informants and the interviews, and there might be a possibility that their nutritional status had changed. Furthermore, the items of NUFFE are based on a wide selection of risk factors,[16,17] and the instrument is probably able to identify an early stage of risk.

However, there may also be the possibility that informants presented a preferred self-image in the interviews.[25] This can mean that a person knows one thing but wants to convince the other person to believe the opposite. A dislike of reporting about eating has been found in a previous food survey among older women.[26] In the present study, taking care of one's food intake and meals was also presented as taking care of oneself.

Another interesting perspective is that people sometimes may "lie to themselves" in a kind of self-deception.[27,28] Sartre described this as "bad faith." This is not an intended lie to oneself, but involves the individual's capacity to hide the truth from him/herself and is based on the setting of a low standard of evidence, made possible in the context of a feeling of anxiety.[27,28] When looking ahead, the informants revealed worries regarding their health and self-care. However, being present in one's own situation, taking things day by day, may involve examining the evidence of one's situation critically, or not. The narratives may also reflect anxiety about a vulnerable state of living regarding self-care. Looking back to the past may also be seen in that perspective.

Several of the informants needed assistance with regard to food shopping: for instance, assistance with transportation. This was not mainly described in the light of "dependence", but rather, was described as "sufficient arrangements of help" by neighbors, family, or other resources, and this may have strengthened the informants' sense of autonomy and self-care. This is an interesting finding. Another study[29] reported that older persons who relied on others to shop might perceive themselves as more autonomous than older persons who did not rely on others. They might also be more vulnerable regarding a social network.

Having health problems was described as an essential challenge periodically or continuously that also sometimes influenced the informants' appetite or food intake negatively. A relationship between impaired perceived health and risk of undernutrition has been reported in other studies among older, home-dwelling people.[5,30] Having contact with the health care system and receiving professional support and help when needing it was mostly considered as a safety. However, such contact was also mistrusted when the advice, for example regarding food intake and nutrition, and support were considered to be unuseful. A positive orientation to health and self-care may be based on a trust of health care professionals when support is needed.[29] Another study among older, home-dwelling persons also showed that having good relations with health care professionals and appropriate treatment was perceived as significant for good health.[31] In the present study, there was also an experience that decreased appetite and weight loss that occurred with illness could be changed with the help of appropriate medical treatment.

The informants in the present study valued the ability to take care of themselves in daily life and to perform self-care activities. Some of the participants described that they needed home nursing for support with health care in their daily lives, but mastering challenging situations was described as positive. Although dependency was undesirable, the family was described as important regarding possible support and help, and the older persons could also

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support their families. This aspect of reciprocity may lead to an understanding of dependency in later life that is based on reciprocal responsibilities and mutual relationships, for example within the family.[32] This can be considered in light of the fundamental view of human beings as dependent on each other.[33] A relational view of human beings removes the contradiction between dependence and independence. Having the ability to ask for and receive help from other people may be considered as a natural dependence[33] and not a contradiction to self-care.

When looking ahead, however, being helpless and dependent was described as a frightening situation. Older people's attitudes to advanced age may be influenced and fortified by society's images and attitudes toward this part of life. It is claimed that a culture that depreciates older people will probably have a negative impact on people who are aging.[34] Thinking about the future and possible changes regarding health was described as causing feelings of anxiety. Delmar et al[33] argued that anxiety about becoming dependent and more helpless has its roots in an individually oriented view of the human being that values independence and which may dominate a liberal society. Fighting to maintain the zest for life was also described in the present study. Previous studies have reported that optimistic expectations of aging are significant to good health in the future.[35,36] Furthermore, studies have also showed a relationship between being at risk of undernutrition and depression among older persons.[30,37] Tomstad et al[8] reported a strong relationship between perceived helplessness and risk of undernutrition among older, home-dwelling persons.

Health problems limited the informants' physical and social activities. At the same time, they valued such activities for their health and well-being, and being active, both socially and physically, could stimulate the appetite. A consciousness of the benefit of activities for maintaining health and well-being in later life has also been reported in other studies.[31,38] Along with health problems and limited mobility, external factors, like slippery roads, could also influence the performance of such activities negatively. One factor also, was that several friends might be in similar situations or were dead. Another study among older, home-dwelling persons found an increasing social isolation as a consequence of, among other factors, impaired mobility and friends passing away.[39] Moreover, Tomstad et al[8] reported a strong relationship between living alone and nutritional risk, and a similar relationship was found between being inactive and being at risk of undernutrition. Another study[40] showed that having social contacts can protect against being at risk of undernutrition.

One finding in the present study was that a consciousness of being engaged with or helping other people could influence well-being and appetite positively. Furthermore, another study among older, home-dwelling persons[31] similarly showed that being engaged with other people was a source of well-being. Orem[2] argued that when "bringing in the person," there may be several basic conditional factors that interact with the informants' self-care, health, and well-being. The psychological, interpersonal, physical, and social sides of health are not separated in individuals.[2] However, a phenomenological approach focuses on the person's description of a situation as a whole and the meaning of lived experiences.[41] In spite of having health problems, valuing activity and social connection and engagement, and working towards these, were central features of self-care, as a lived experience among these informants.

The present study revealed challenges to health and well-being regarding eating, after the loss of one's spouse or when living alone in older age. Another study among older women showed similar findings.[12] The current study showed that company at meals was valued and missed when absent and that a sense of loneliness was common to several of the informants. These aspects may be a challenge to nutritional health care in a society where living at home in old age as long as possible is the preferred policy. It may be claimed that a salutogenetic perspective has true relevance for health care.[42,43] A main focus in that perspective are the factors that move persons toward health.[43] The findings in our study indicated that the social aspects of meals are important to health and well-being. Consequently, this should be important to both health authorities and health professionals.

In the present study, the basis for validity was obtained by performing a phenomenological reduction that searched for essences in the text.[44] This process assumes a bracketing of one's own preunderstanding in order to be open to the text and to describe the participants' narratives and not interpret them.[15] However, it could be argued that the authors had knowledge that may have influenced the analysis. The findings may be considered reliable in light of the fact that the same meanings were consistently identified in the narratives.[44] It seems possible that the findings could be transferred to other similar groups of older people in the western world.

Conclusion

The lived experiences in the study group revealed that being aware of food choices and decisions of food-related self-care activities may not only be based on rational thoughts, but also on one's own preferences.

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Receiving help from health professionals or family when needed is important, but such dependency may also be based on reciprocal responsibilities and mutual relationships within the family.

Health problems can decrease the appetite, and getting appropriate health care support and medical treatment can be necessary to support sufficient food intake. Self-care that focuses on social and physical activities and engagements is of importance to enhance health and well-being, and can stimulate the appetite. Different groups of health care professionals within a geriatric team should be aware of these findings in order to support self-care in older people, and should pay attention to the social aspects of meals.

Author contributions

Study design: STT, GAE, OS. Data collection: STT. Data analysis: STT, US, OS. Manuscript was drafted by STT. Manuscript critically revised: STT, US, GAE, OS. Approved final manuscript: STT, US, GAE, OS.

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Disclosure

The authors report no conflicts of interests in relation to this work.

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