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What do the terms wellness and wellbeing mean in dietary practice: an exploratory qualitative study examining women's perceptions

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What do the terms wellness and wellbeing mean in dietary practice: an exploratory qualitative study examining women's perceptions

Abstract

Background Wellness and wellbeing are terms associated with health within dietetic discourse. More broadly, these terms are found in social discourse as represented in food and nutrition consumer communications. With the increasing requirement for evidence-based healthcare, there is an imperative to understand whether these terms are meaningful to individuals typically targeted for nutrition interventions and whether there are any implications for dietetic education. Methods To explore the understanding of these terms, eight semi-structured focus groups were conducted with 32 female participants (age range 23-79 years) who were actively engaged in managing their health. Overall understanding of the terms, factors that impacted perceptions and any relationships with food behaviour were investigated with the groups. Group discussions were transcribed verbatim and each transcript was examined by two researchers. Inductive analysis linking codes into main thematic categories was conducted using the constant comparison approach across the full data set. Results Wellness and wellbeing were identified as meaningful terms associated with health. A theoretical framework of wellness and wellbeing reflecting these meanings was developed linking four dominant thematic areas. These were Desired outcomes (most sought after result); Taking control (self management strategies); Internal influences (various personal inner factors influencing behaviours); and External influences (plethora of peripheral factors influencing behaviours). Conclusions Wellness and wellbeing are terms that are relevant and aspirational for individuals typically targeted for nutrition intervention. A theoretical framework of dominant areas of influence on notions of wellness and wellbeing was identified. This theoretical framework is worthy of further research to determine usefulness and effectiveness in dietetic practice settings.

Disciplines

Medicine and Health Sciences | Social and Behavioral Sciences

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What do the terms wellness and wellbeing mean in dietary practice: an exploratory qualitative study examining women's perceptions

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Introduction

Wellness and wellbeing are terms associated with health within nutrition and dietetic discourse. The terms can be found within a variety of professional settings such as nutrition peer reviewed literature, nutrition policy documents, and materials developed for use within dietetic practice (CSIRO 2006; Godfrey 2010; Kennedy et al. 2011). More broadly these terms are also found in social discourse on food and nutrition within consumer literature (Kickbusch and Payne 2003; Goodman-Fielder 2013; Sanitarium 2013). Within both contexts these terms are generally linked with less well defined quality of life outcomes as incentives for individuals to consider changing food behaviours (Stadler et al. 2010; Stuijbergen et al. 2010). However despite the ubiquitous use of these terms there is limited research (Bacon et al. 2002; Bowles et al. 2006; Boelsma et al. 2010) and an apparent inconsistency with measurement of quality of life or wellness and wellbeing outcomes in the context of nutrition interventions. This means there is scant evidence available to ascertain if improvements in wellness and wellbeing are relevant or achievable as end-points to consider as evidence-based outcomes for dietary practice.

The evidence-based approach to practice in dietetics utilises clinically relevant scientific evidence underpinned by patient-centred practice to manage health conditions successfully (Splett and Myers 2001; Smith 2003). Indeed effective management of lifestyle related health conditions such as ischaemic heart disease and diabetes which plague populations globally has attracted international interest (World Health Organisation 2009; World Health Organisation 2011). However, the rationale for evidence-based effective practice may be different for the various stakeholders involved in the health nexus. For instance governments are very interested in the most cost effective way to

manage health conditions (Smith 2003). The incentive for seeking cost savings for governments for lifestyle related health conditions link to the allocations they represent in the health expenditures for many countries (Organisation for Economic Co-operation and Development 2009; Australian Institute of Health and Welfare 2010).

Not surprisingly lifestyle related health conditions also tend to dominate dietitians' case loads working in the community in western countries (Cant 2010). Dietitians are focussed on achieving successful clinical outcomes with patients, but patients themselves may have different rationales for managing their health condition. For instance they may be more interested in contextual outcomes that focus more on their individual and family lives. Understanding the motive/s that drive patients to want to manage their health condition is fundamental to patient-centred practice and is required to enable the articulation of meaningful personal goals (Rosal et al. 2001). Ensuring goals are set that link patients' needs with definable outcomes agreeable to practitioners are more likely to enable aspired changes in behaviour to occur.

Behaviour change models do provide dietitians with a useful way to look at the theoretical underpinning of behaviour change in practice (Spahn et al. 2010). For instance the Stages of Change model has been utilised with varying amounts of success in practice but is one model that enables dietitians to be able to predict which strategy might be most successful for a particular individual (Rosal et al. 2001). This can be achieved through identifying which one of the five stages of change patients may be currently situated within - from Precontemplation to Maintenance - and then implementing a relevant strategy based on their specific needs (Prochaska and Velicer 1997). Whilst these models are very useful, in practice the current social constructs about health need also be acknowledged (Ball et al. 2010; Guillaumie et al. 2010; Norman et al. 2010). In line with this perspective the National Institute for Health and Clinical Excellence (NICE) behaviour guidance specifically acknowledges 'different patterns of behaviour are deeply embedded in people's social and material circumstances and their cultural context'(NICE 2007). Furthermore the literature also

suggests that consumers are moving into a new era of health management looking for self determination in managing their own health future (Mattila et al. 2010). Mainstreaming of alternative therapies within health frameworks (Schuster et al. 2004; Sointu 2006; Nahin et al. 2010; Otto et al. 2010) and the development and marketing of food products to manage specific health issues or support general wellbeing (Nestlé ; Berry 2004; McMahon et al. 2010) provides suggestive evidence that there is social change around how individuals and society view food and health management.

Calls for a change to the traditional focus on pathology management in healthcare to identifying other factors that might enhance health and link with broader societal changes, is not new (Ickovics and Park 1998). However research into how social constructs of wellness and wellbeing might influence food behaviours is limited. The aims of this study were to examine if the terms wellness and wellbeing were meaningful to groups of individuals normally targeted for nutrition interventions and to identify if there were any perceived relationships between food choice behaviours and these terms.

Materials and methods

Study context and participant profiles

Food and diet have been previously acknowledged as being highly gendered (Monaghan 2007) with women being 'predominantly responsible for procurement, preparation, and serving of food' (Madden and Chamberlian 2010). Hence to attract individuals to the study who might typically seek or be provided with dietary advice and enact changes in food behaviours purposive sampling for female participants was used through two methods. The first method sampled every second female person from a data base of participants from previous dietary trials who had expressed a willingness to be included in further studies. A further recruitment was made through advertisement at two community health centres. These centres included a regional Diabetes Centre and a commercial

exercise and fitness centre that ensured the invitation flyers were made available to clients in the reception areas. These community based centres were opportunistically chosen as there was a professional relationship with the research group and they were willing to allow their client's to be invited to attend focus groups. The clients of these centres were assumed to represent individuals with a specific interest in food choice for managing a health condition, or managing their health in a more generic way. English-speaking women were thus recruited to participate in one of eight groups typically targeted for nutrition education or intervention. The groups were: healthy adults (F.G. 2 and F.G. 4), healthy overweight adults (F.G. 1 and F.G. 3), adults with diabetes (F.G. 5), and three groups of adults who had committed to an exercise program of varying periods (duration < 1 year (F.G.8), 1-3 years (F.G.7), and > 3 years (F.G.6)).

Study design and procedures

A qualitative approach utilising focus groups was identified as the appropriate methodology (Patton 2002) as this was an exploratory study to identify how the terms were understood by relevant target populations. Participants were allocated into a specific group representing their self-nominated current health or exercise status. The purpose of having a number of different groups was to gather exploratory data from a spectrum of individuals normally targeted for nutrition intervention. Basic descriptive demographic details were collected from the participants including age, occupation, marital status, and if children were living in the home environment. Focus groups were held in meeting rooms on the University campus and lasted between 60-90 minutes. They were conducted by an experienced moderator [AM], and an additional researcher acted as an observer [JS or KW]. All participants were given a \$50 voucher as reimbursement for their time at the completion of the focus group. Approval for this study was given by the University of Wollongong Human Research Ethics Committee (No 06/304).

Focus group question guide

The moderator followed a semi-structured question guide (Table 1) and inclusive format as recommended by Krueger (Krueger 1994). The moderator also utilised presentation slides to provide visual stimulation for group discussion about wellness and wellbeing. The images reflected the findings from a review of literature on recognised influences on wellness and wellbeing (McMahon et al. 2010). Examples of images were sunsets, beaches, flowers, family, children, animals, sporting themes, religious symbols, food and coloured patterns. The opening statement from the moderator was used to clarify the purpose of the study and reinforce that all opinions were valued before the question guide was followed. Participants were asked to express their feelings when presented with the images. Each session was brought to a close by the moderator offering a summarising statement of the discussion for the group members to comment upon. The moderator ensured all participants had the opportunity to voice their opinions equally.

Data analysis

All focus group sessions were transcribed verbatim from the digital recordings by the observers. Typed transcriptions were reviewed against the digital recording to confirm accuracy. The research data coding and analysis was guided by the Qualitative Theory Grounded Approach (QTGA) to ensure the final themes were embedded in the data (Strauss and Corbin 1990). The primary coder [AM] identified and developed coding descriptors and a mind map of possible relationships after several readings and immersions in the transcribed data (Saldana 2009). A combination of coding identification and thematic analysis was also carried out separately on each focus group by two researchers and discussed to ensure credibility in the coding process (Rice and Ezzy 1999; Walton et al. 2006). All focus group data were coded and any deviant cases explored. The QSR Vivo 7.0 qualitative analysis software (QSR International Pty Ltd, Doncaster, Victoria, Australia) was used to review coded data for discussion prior to consensus being reached on themes and subcategories. The final inductive analysis linked codes which had common elements into main thematic categories using the constant comparison approach across the full data set. Exemplary quotes were identified

and agreed by consensus to represent each theme expressed in the data. A final schematic reflecting the findings was developed and verified with one of the observers and fellow coder [JS] (Saldana 2009).

Results

Thirty two women (aged 23 – 79 years) participated in the focus groups (see Figure 1). They came from a broad range of occupations and life-stages, (Table 2). An additional seven women interested in participating were unable to attend. The women who could not attend included one from the healthy weight group, one from healthy overweight group, two from the group for people with diabetes, one each from the exercising < 1 year, 1-3 and > 3 years groups respectively. However the seven additional participants provided commentary in telephone or face-to-face interviews. The comments were reviewed and noted to include the same themes identified in focus group data, but are not reported here due to the difference in the collection method used.

Thematic Findings

The focus group participants were enthusiastic and recognised the terms wellness and wellbeing as being meaningful linked terms. The final analysis revealed four dominant thematic areas influencing perceptions of wellness and wellbeing: *Desired outcomes* (most sought after result); *Taking Control* (self management strategies employed to mitigate or enhance influences); *Internal Influences* (various personal inner factors that influenced behaviours) and *External Influences* (plethora of peripheral factors that influenced behaviours). Figure 2 summarises the spectrum and the interrelationships between the various identified themes.

The participants from all groups differentiated between the two terms but some also commented that there was not always a clear distinction between them, and that they could often be interchanged. For instance:

“they both come under one umbrella, I don’t know there is a difference between the two terms, not for me anyway” F.G. 7

However, wellness for most participants was more closely aligned to health to a *Personal State of Being* linked closely with ‘*Internal Influences*’ such as ‘*Beliefs/mental outlook*’.

“Wellness is more about can you get out of bed and can you climb the stairs you know that sort of thing” F.G.1

Wellbeing was distinguished from wellness as encompassing broader dimensions linking *Internal* and *External Influences* to *Desired Outcomes* and overall *Satisfaction with Life*.

“Wellbeing is psychological, and (um) achievement and how your family is, and all those sort of concepts” F.G.8

The Wellbeing proposition of *Satisfaction with life* was aligned with achieving meaningful personal *Desired Outcomes* attributed to realising various self management strategies under the theme *Taking Control*. *Food and Physical Activity* was identified as a critical self-management strategy employed to achieve *Social acceptability (Desired Outcome)* but was recognised as being impacted by *Internal Influences* and *External Influences*. For instance:

“(I) have done P.E. courses and health and fitness courses...it just makes you more aware of [um] your eating habits in front of students and that you have to model good eating habits” F.G. 3

The participant was articulating the interplay between her own *knowledge and skills (Internal Influences)* and the responsibilities she felt towards her students’ *Social support - significant others (External Influences)* that made her feel more accountable for the food choices she made in their presence.

Though no new themes were identified after interviews with group 5 it is important to note that different emphases on *Desired Outcomes* were apparent for different groups and life-stages. For instance, a number of participants who had committed to long term exercise regimes (> 3 years)

identified work/life balance as being of critical importance to their wellbeing and that when they were unable to participate in *physical activity* they felt a 'lack' of *Energy (Desired Outcome)*. In contrast participants with diabetes viewed their management of their condition as having the most potent impact on their wellbeing.

"I can measure my sugar, I can do some exercise, or there is another set of parameters I can measure to measure my wellbeing...may not be exactly the same as I feel... I might feel quite well, but when I start to measure things I see 'uh oh' the sugar's up" F.G. 5

This quote also illustrates how perceptions of wellbeing can be altered quite quickly when an individual's *Desired Outcomes* have not been met. The 'lack' of *Social acceptability - accomplishment* for this participant in being able to manage her health condition immediately affected her perceived wellbeing. This change was acknowledged to be unexpected and out of step with her perceptions prior to measuring an objective biomarker.

Subthemes

External Influences

Participants identified a diverse range of factors that they felt often required thoughtful management to temper the impact on their own wellbeing and wellness which were collectively recognised as *External Influences*. For instance:

"My job is a very stressful job. It's not a nice job and I find that if I am doing exercising it's a way of getting my stress out without taking it out on others" F.G.8

Hence this participant linked her management of the stress imposed from her *work (External Influences)* with her *physical activity (Taking Control)* through to her *Capacity (Desired Outcome)*.

There was also a general recognition of the need for *Community connection*, which was linked to *Desired outcomes – Social acceptability* via adoption of *lifestyle choices* relevant to wellbeing and *Satisfaction with Life*.

"I get a lot of pleasure out of that, knowing that some poor freezing child over there (in South America) has got a few beanies to work or a jumper or something" F.G.6

Other *External Influences* also identified by participants included *Social responsibility: discourse (food, health, marketing and alternative therapies)* and *Professional support*. These were seen as both positive and negative influences. For instance certain *discourses* as well as specific *professional support* were viewed with cynicism or embraced depending on the belief about the trustworthiness of the source.

"I think we are lucky now, with all the support we have (access to), with the dietitians..that are available to us. I think it is wonderful" F.G.2

In this instance the participant recognised and valued the interactions with the *professional support* they were able to access.

Internal Influences

Across all the groups there was recognition that there was a set of *Internal Influences* reflecting personal factors that affected an individual's wellness from *Beliefs/Mental outlook* through to *Knowledge and skills*. These *Internal Influences* also impacted their ability to respond to the external environment. For instance:

"I think I have been on every diet...my father took me to a doctor when I, look I was not even a teenager thinking I had a thyroid problem or something like that, that's how all of my life I've lived with this fat thing and I'm fat. And I'm even coming up 62 and I still feel fat, up here (pointing to her head)"F.G.2

This participant acknowledged her *Identity* as a 'fat person' was so ingrained and lifelong that despite her efforts with changing her *lifestyle choices - food (Taking Control)* she felt she could not change her *Identity* even if she achieved her *Desired Outcome (Social acceptability)*. Participants also recognised that *ambivalence (Mental outlook)* was a factor influencing whether or not they

would take on particular strategies more permanently like incorporating physical activity or eating well. For example:

“The problem was you could only get that sort of stuff (natural foods) from limited sources and eventually, you know, you go back to buying all the processed stuff...even(though)...that (eating natural foods) really did help us all feel so much better” F.G.1

Taking Control

There was general identification of a range of strategies that participants employed or would like to utilise more effectively to control the *Internal* and *External Influences* that they were dealing with on a daily basis to achieve their *Desired Outcomes*. These strategies were identified under *Coping mechanisms*, with a particular emphasis on *Food and Physical Activity* as being useful and effective *lifestyle choices*. *Food (Coping mechanism)* was particularly layered with meaning as it was linked to positive and negative benefits including satisfying hedonistic needs and meeting social expectations depending on the food or patterns of food chosen. For instance indulgence foods such as chocolate were used as mood enhancers but also linked to post-consumption guilt and negativity if over-consumed. There was also an appreciation that *Food choice* strategies may change over time or circumstance. For instance:

“if we are to have children (we decided), we need to change a few things, so we did change, we completely went away from all white flour, went to wholemeal flour, we did all the right things”

F.G.2

This participant acknowledged that once the life changing decision was made with her partner about trying to conceive children then their *Belief/mental outlook -Ambivalence (Internal Influence)* to engage with recommended *lifestyle choices (Coping mechanism)* also altered.

One key *Coping mechanism (Taking Control)* reported across all groups was ensuring sufficient *compartmentalising - time for self* to help protect the individual from the various *Influences*, and enable the individual to support their feelings of wellbeing. For example:

“(I) suffered from depression and thought you know, if I do all these things (eating well and exercising) without taxing myself, like giving myself a bit of space(away from work and others), I feel much better” F.G. 3

In this quote the participant was identifying her ability to temper her *Mental outlook (Internal Influences)* and the pressures from her *Work (External Influences)* through ensuring she had sufficient *Time for self*. This also had a flow on affect of enabling her to engage in aspired *food and physical activity* behaviours.

Desired Outcomes

Diversity in the specific *Desired Outcomes* for individuals in achieving wellbeing through *Satisfaction with Life* was evident across the groups. Some participants thrived on *Social acceptability*, others in developing *Capacity* or gaining *Energy* while others identified *Happiness* or *Peace* as key endpoints.

“If you are well, if you feel good and you’re feeling fit and healthy, you feel happy. Personally, that’s what I think it is about”F.G.8

There was also discussion and acceptance that *Desired Outcomes* were not static in terms of meaningfulness for individuals. Life-stage and its associated priorities were recognised to affect the emphasis that might be placed on each valued *Desired Outcome*.

“It’s just a different stage in our lives...I don’t miss the stress (work life) but you have different stressors in your life (when you retire) but, (um) I feel that I am more in control of those – providing everyone is happy”F.G.2

This participant conceded that *Internal and External Influences* not only varied throughout life but so did the perceived relevance of those *Influences* in terms of impact and her ability to cope. *Happiness* was also identified as becoming a more prominent *Desired Outcome*, particularly in a more non-specific way for her *Significant others*.

Discussion

To our knowledge this study is the first to analyse perceptions about the terms wellness and wellbeing among individuals typically targeted for nutrition intervention. Similarly to the results from other authors working on defining wellness and wellbeing in the modern context (Cummins et al. 2003; Duckworth et al. 2005), our participants articulated that these are meaningful terms which encompass a spectrum of dimensions. There was an interaction between *External Influences* which they often felt they had limited control over, and *Internal Influences* incorporating both emotional and rational aspects that impacted their ability to implement behaviours to achieve a *Desired Outcome*. Achieving their *Desired Outcome* was an articulated marker for an individual's wellbeing. The emphasis on which outcomes were more important to them varied between groups and often reflected the life-stages of the participants. For instance older participants in the groups openly discussed differences in their perspectives of achieving wellbeing as being related to having *Peace* and *Capacity* as opposed to their children, or even themselves at early stages in their life, when *Social acceptability* and *Energy* were more aspirational. This variation in meaning for individuals and over time is concordant with Healey-Ogden and Austin's (2011) research in exposing how individuals express their notion of wellbeing. Their work identified wellbeing is a 'lived experience' and reflects the individual's personal life journey acknowledging that these perspectives also change over time (Healey-Ogden and Austin 2011).

Patient-centred practice embedded in evidence-based practice guidelines within the dietetic profession around the world acknowledges the need to engage with the patient's individual perspectives on the rationale for enacting change (Franz et al. 2003; Dietitians Association of Australia 2005; Dietitians of Canada 2011). A key tenant of these guidelines is that the dietitian core competency skill set includes being able to aid behaviour change and individualise nutrition care plans through negotiated dialogue with the patient in various practice settings (Horacek et al. 2007; The British Dietetic Association 2008; Dietitians Association of Australia 2009). Having a clear understanding about what are the key *Desired Outcomes* for an individual at any point in time, and

enabling them to respond effectively to challenges that impede their progress, is critical for patient-centred practice to be effective. Hence recognition of the aspired *Desired Outcome* for the individual could also be considered as part of the patient-centred care plan developed with practitioners. Understanding and strengthening patients' skills, knowledge and confidence to implement behaviour choices – *Taking Control* to address or support the *Internal* and *External Influences* on perceptions of wellness and wellbeing - is also likely to be most helpful for developing an acceptable nutrition care plan with the patient.

Ashcroft (2011) has described how understanding and engaging with dominant and sometimes disparate paradigms of health is critical for strengthening social workers practice. Similarly dietitians have been encouraged to engage in patient-centred care, which by its nature requires an acceptance and commitment to accepting other's viewpoints about the rationale for behaviour change (Holli et al. 2009). Assisting individuals to articulate their own notion of a satisfying life and their individual indicators for successful outcomes may be a useful starting point to link goals to relevant behaviour change strategies. This is likely to be more motivating and enable improved adherence and long term success. Furthermore identification of an individual specific set of influences both internal and external may provide an opportunity to develop or enhance more relevant self-management skills to ensure this occurs. Future research to explore the effectiveness of this framework within the challenging dietetic practice environment is planned.

Limitations

This was an exploratory study and more rigorous testing of the findings in particular nutrition settings with in-depth across groups and cultural and ethnic settings would be required. The assumptions about the participants representativeness of groups typically targeted for nutrition interventions was not random or challenged in the recruitment nor the group self selection process

and is a recognised weakness. The small token of appreciation given to participants at the end of their focus group participation to recognise their time may have influenced the women's willingness to participate and should be considered as a limitation. However it is worthy to note that the participants had self-nominated to be included in the study and are representative of individuals who express interest in being engaged with nutrition research activities, or were actively involved with managing a health condition, or were actively engaged in positive lifestyle behaviours. Thus they are likely to be similar to individuals who would voluntarily seek dietary advice and may provide insight into the framework that may be relevant for these individuals.

Conclusion

Wellness and wellbeing are meaningful terms for individuals typically targeted for nutrition intervention that are aspirational and linked to achieving notions of life satisfaction. Their achievement is recognised to be influenced by a broad number of behaviours including appropriate food and physical activity. Broadening the dialogue between practitioners and patients to acknowledge these individual constructed desired notions of life satisfaction could assist in the identification of self-management strategies which are more meaningful and motivational for the individual patient. This may enable successful outcomes from the perspective of both practitioner and patient to be achieved. Exploring and supporting this framework of wellness and wellbeing within an intervention setting as well as across larger groups incorporating both genders as well as diverse cultural backgrounds is worthy of further research.

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