



## Development and Use of the Organizational Framework For Exploring Nutrition Narratives

Catherine Morley, PhD, P.Dt.

School of Nutrition and Dietetics, Acadia University

### Abstract

*A hermeneutic phenomenology was undertaken to explore eating and feeding experiences with 11 women living with changed health status and who had household feeding responsibilities. Thematic analysis yielded two distinct narratives; those in the Life-the-Same (LS) group (n=3; participants whose lives were relatively the same after a period of adjustment to their condition), and the Life Altered (LA) group (n=8) (those whose lives were completely altered as a result of their condition). Participants in the LS group had adjusted to new diet, exercise, and medication routines, achieved physiologic goals, and had similar eating and feeding routines as before their diagnoses. Participants in the LA group experienced profound changes in ingesting and digesting food, and eliminating waste, in their physical appearance and enjoyment of eating, and they rarely left home. Anticipated physiologic effects of dietary change were not achieved due to the natural course of their medical conditions. Family and friends took on feeding duties when the regular 'feeder' was acutely ill, however, participants in the LA resumed these roles as soon as they were able (even though they were unwell) owing to the strength of role identification.*

*The Organizational Framework for Exploring Nutrition Narratives (OFFENN) emerged from the analysis of the interview transcripts; it is comprised of four domains (Personal; Household; Beyond Household; and Unthoughts), and four filters (Events/Facts; Values/Beliefs; Actions; Emotions and Reflections). The framework offers a means to explore clients' narratives and to invite conversations about eating and feeding; it is not meant to be prescriptive of dietary guidance, and has application in dietetics education (in preparing students for their counselling roles and in informing research).*

### Introduction

*"I've been thinking. You tell me what to eat, I'll do it, and God will reward me and take away my tumour... if that doesn't work out, at least I'll go to Heaven when I die".*

*"I guess I have been eating out of control as a signal to, you know (casting eyes upward)... to indicate that I am not ready to go yet and to give me more time".*

These statements approximate many that I witnessed from people receiving therapy when I worked as a dietitian at a cancer clinic. As I was trained to only address physiological aspects of eating, I was confused

by these comments; that there might be psychological, spiritual, social, or other issues imbedded in requests for nutrition information was unsettling. One day, after several clients had expressed appreciation for my work with their families, I said to a social work colleague, "None of my advice has been able to help them get better, so why would anyone want to thank me?" My colleague's response compounded my confusion: "Maybe you are so stuck in a box called *nutrition equals good health*, that you can't even hear when a person is expressing gratitude for you being human at a time and place when they needed it". At the time, this response angered and further confused me because it was becoming more apparent that I did not have insights into what I was

doing, why what I was doing might be helpful, and how I might approach my work with greater awareness.

The primary assumption guiding my practice in the early years was that people would implement the advice I provided, surprising indeed, considering my inattention as to whether they had a home or kitchen, could access food, whether they lived with others, the relationships of those who lived together, household feeding relationships/arrangements, and so on. Was the home situation such that the advice I offered was remotely suitable? Had it been appropriate to the beliefs, ideals, and preferences of the person and their family? What had the person believed about what/how they should eat? What might be the effects of dietary change on family function and feeding traditions? Was nutrition even a relevant issue for this person and their family? None of these questions occurred to me then. Questioning these assumptions was the backdrop against which I conducted my doctoral research. It seemed I was helping some people (given their expressions of gratitude) but I did not know how. I reasoned that if I learned about values and meanings associated with eating and feeding, and how these shifted, if at all, with changed health status<sup>1</sup>, I would be more aware of how to use these insights in how I offered nutrition counselling.

## Synopsis of the Literature

Given the universality of eating for all people, there was little literature found on the meaning of eating - with or without illness. Perhaps this is because eating is so commonplace that it is considered unworthy of study or uninteresting (Smith, 1987; Thompson, 1993) or because its complexity is so overwhelming that it is difficult to know where to begin. In the absence of literature on eating and feeding with changed health status, writings from four topic areas (eating behaviour; the illness experience; body/self relationships; and feeding the family) informed the study.

**Eating behaviour.** The six main views in the literature about eating behaviour were:

- i) Biomedical/physiologic: related to prescribing and expecting compliance with dietary instructions or guides for optimal physical health and function as established by an 'expert';

- ii) Behavioural: related to measuring or understanding attitudes, beliefs, and values about food and eating, and relationships between beliefs and behaviour;
- iii) Sociological: exploring the social nature of eating, the symbolic nature of food and eating behaviours including offering/accepting food and drink (e.g., Visser, 1989);
- iv) Philosophical/spiritual: eating as an expression of self or desires/hopes for oneself (Fischler, 1988; Lupton, 1994);
- v) Gastronomic: food preparation and eating as pleasurable, sensual experiences;
- vi) Ecologic/political: eating choices connected to awareness of environmental and political issues involved in food production, distribution, and availability.

The premise consistent in these perspectives is that food preparation and eating behaviour are "largely rational cognitive choices made freely by individuals" (Lupton, 1996, p. 665), thus negating the complex, often "unthought" (Lupton, 1996, p. 665) social-psychological mesh related to eating beliefs and behaviours. Lupton's view echoed my experiences working with people experiencing serious illness – although their search for nutrition information was often framed as explorations related to physiological aspects of eating, their nutritional narratives revealed complex, often contradictory thoughts and beliefs about food, and spurred my interest in learning about possible meanings of eating and feeding that differed from those that dominated the dietetics literature.

**The illness experience.** In the food and eating literature, the focus was/is on healthy people and their eating habits, not related to the experiences of people living with illness. While physiology-oriented guidelines for dietary management abound(ed), the experience of and meanings of food and eating in illness were not addressed. Popular books and magazines about what to eat when one has or is trying to feed someone living with a chronic medical condition such as diabetes, heart disease, cancer, etc. are, for the most part, compilations of dietary advice and recipes. Experiential accounts that incorporate the meanings of eating and food do not appear to exist. Illness narratives, in contrast, are intensely personal, insightful, introspective, and impassioned descriptions. Rather than, or in addition to, discussing logistics of self care and condition management, these narratives (e.g., Frank, 1991; McFarland, 1993; Hanak

---

<sup>1</sup> 'Changed health status' refers to any change in a person's health; it is not disease or condition specific, may be for any duration (short term or acute; long term or chronic, or end of life), and be of any degree of seriousness.

and Scott, 1993) refer to symbolic and interpreted meanings of daily events, activities, and conversations, often conveyed as opportunities to learn about oneself, and profound changes in sense of self and meanings in life. Rusk (in Hanak and Scott, 1993) likened this transformation to the need for the firing process for pottery to become useful and beautiful:

*In the firing process, some pieces are broken, but those that survive the heat are transformed from the clay into porcelain and are objects of art, and so it is with people. Those who, through medical skill, opportunity, work and courage, survive their illness or overcome their handicap and take their places back in the world have a depth of spirit that you and I can hardly measure. They haven't wasted their pain.*

An example is Arthur Frank's (1991) narrative of the fundamental alterations in his view of life and sense of self of his experiences surviving heart attack and cancer. He discussed the symbolic nature of medications, medical procedures, the language used to communicate messages about medical status and therapies, communication with family and friends, and the messages received contemplating everyday possessions and routines. McFarland (1993) described how the destroyed sense of self, the need to recreate self, and to recognize what matters in one's life weaves throughout making meaning.

Bolen (1996), a clinical psychiatrist, explored fundamental changes when experiencing illness in one's view of self and self-in-relation to others, the world, and existence.

*Whenever or however the line from health to illness is crossed, we enter this realm of soul. Illness is both soul-shaking and soul-evoking for the patient and for all others for whom the patient matters. We lose an innocence, we know vulnerability, we are no longer who we were before this event, and we will never be the same. We are in uncharted terrain, and there is no turning back. Illness is a profound soul event, and yet this is virtually ignored and unaddressed. Instead, everything seems to be focused on the part of the body that is sick, damaged, failing or out of control (Bolen, 1996, p. 14).*

*A life-threatening illness calls to the soul, taps into spiritual resources, and can be an initiation into the soul realm for the patient and anyone else who is touched by the mystery that accompanies the possibility of death (Bolen, 1996, p. 15).*

I was "touched by the mystery" (p. 15) in my work with individuals living with cancer and wondered how to learn from their experiences of eating to inform my counselling work.

**Body and self.** The self in relation to the body is an important consideration in exploring beliefs about food intake. The contribution of food to the creation of self differs whether one views the body as the self, or the self as more than the body (Moltman-Wendel, 1994). Fischler's (1988) notion of food identity, how a person achieves a balance between the biological need to eat and cultural influences, poses the possibility that one attempts to direct one's future through *incorporation* or the putting into oneself what one wants to become. In *Food, the Body and the Self*, Lupton (1996) described that the way a person thinks of themselves, and what they consider important in life and for themselves is expressed in food selection and eating behaviour. The message presented in some writings reinforced concepts of control through food choice and eating behaviour and included eating consciously to change one's *self* (in contrast to one's body function), to become a better person or fixed in some way, and to find spiritual peace (Cousens, 1997).

Licavoli (1995) and Kiy (1998) wrote about integrating client perspectives about why they eat as they do into nutrition counselling approaches, stressing the importance of trying to understand the many influences on clients' eating behaviour. Unfortunately, these writers retained the commonly-held view that changes in eating behaviour are **the** desirable and only outcome of nutrition counselling/education, and did not discuss how one might approach the challenge of understanding what motivates eating behaviour, nor other supportive outcomes of nutrition counselling. These were considerations I thought were critical to explore in this study.

**Feeding the family.** Women generally have the primary role in a family for feeding self and others (Schwartz, 1983; DeVault, 1993; Harnack, Story, Martinson, Neumark-Sztainer & Stang, 1998). DeVault (1993) described feeding the family as follows:

*Households are quite varied, homes for motley groups of actual individuals with their particular quirks and idiosyncracies. Both inclination and necessity produce variation in daily activities within and among households. But the work of "feeding the family" tends to collect these unruly individuals and tame their*

*centrifugal moves, cajoling them into some version of the activity that constitutes family. Because this work of social construction is largely invisible, such efforts simultaneously produce the illusion that this form of life is a "natural" one (DeVault, 1993 p. 91).*

This description is how I believe meals are for many families, despite the viewpoint posited by many cookbook and food writers that careful planning and methodical cooking efforts are typical, universal, and desirable. Women also hold primary responsibility for caregiving in illness (Robinson, 1994), even when they are the person living with the illness (Jesus, 1997). The combination of findings from these two areas of research raised questions about feeding responsibilities for women who live with changed health status.

**Summary.** Eating is a commonplace, everyday, universal experience that must continue even when one's health status changes. There is a biological imperative to eat. While there is substantive literature on medical nutrition, these writings honour physiological needs. Ongoing discoveries in nutritional science constantly result in prescriptive, often conflicting nutrition messages about what constitutes *good nutrition or healthy eating for a given medical condition, and this often produces dietary cacophony* (Fischler, 1993) and consumer confusion or about what, when, how, where, and why to eat. Confusion might lead to consultation with a nutrition expert that can further contribute to the cacophony. Consultation with an expert may inspire change in some people some of the time but is not likely to be the catalyst for dietary change. Some consumers may feel even more overwhelmed with nutrition advice that is inconsistent with their food identity, thoughts, and emotions about food and eating, and daily routines. Accounting for dietary change is complex and beyond the scope of this paper.

While dietetics might draw from the substantial food studies literature on cooking and eating practices, social rituals involving eating, and the symbolic aspects of food and sharing/offering food, there was very little available on how people experience eating, the meanings of eating, and how all of these may change with changed health status. The literature on the illness experience also lacked content about eating and feeding. This literature is replete with accounts of how chronic and/or life threatening illness often results in a search for meaning, profound changes in one's sense of self (Bolen, 1996), how one views one's self in relation to one's body

(Frank, 1991), reconsidering connections between one's mind, self and body (Moltman-Wendell, 1994), and the choices one has made in life and has still to make (Bolen, 1996) yet contained no entries on meanings of eating when living with illness. While changes in activities of daily living owing to illness were addressed (Robinson, 1994; Young-Mason, 1997), the logistics of feeding oneself or another when ill remains largely unexplored, as do meanings of eating with changed health status.

The literature about food and eating, when viewed as a composite, points to the complexity of eating and the challenge this presents in undertaking research in this area. Rather than acknowledging the complexity, many theories, notions, and models that address small, defined, and confined aspects of eating are presented as the only way to think about eating behaviour. This tendency to reduce the complex phenomena of eating and feeding into measures or indicators such as taste, convenience, and health concerns (e.g., Glanz, Basil, Maibach, Goldberg & Snyder, 1998) is similar to van Manen's observation about educational research: "Much of educational research tends to pulverize life into minute abstracted fragments and particles that are of little use to practitioners" (p. 7). Likewise, dietetic research aimed at gathering information about specific aspects of feeding or eating behaviour or physiological effects of dietary modifications, while contributing pieces of understanding about eating behaviour, detracts from opening up exploration of these complex phenomena, or even recognizing their complexity.

## Method

**Background to selecting the method.** The research method was informed by the writings of Van Manen (1998), Caputo (1987), Thompson (1993), and F.J. Smith (1987).

Hermeneutic phenomenology was selected as the research approach; this refers to uncovering meanings imbedded in everyday events and activities (van Manen, 1998). van Manen (1998) suggested that phenomenology "offers us the possibility of plausible insights that bring us in more direct contact with the world" (p. 9) and described phenomenological research as:

*...the study of lived experience, the explication of phenomena as they present themselves to consciousness, the study of essences, the description of the experiential meanings we live as we live them, the attentive practice of thoughtfulness, a search for what it is to be human, and a poetizing activity (p. 19).*

Caputo (1987) referred to hermeneutics as “an attempt to stick with the original difficulty of life” (p. 1) that endeavours “to resist the temptation to simplify things” (p. 1). Further, Caputo wrote that hermeneutics “always has to do with keeping the difficulty of life alive...” (p. 3). Caputo wrote of the challenge of exploring anything that exists in ‘the flux’ (that is, phenomenon that constantly change, and are unable to be paused to be studied), and to “build up unities of meaning and stable objects in and through the flow of time” (p. 5). Eating is one such activity. Eating has many similarities and differences from person to person and from one instance to the next in the same person. Caputo believed that the point of hermeneutic exploration was “to face up to the difference and difficulty which enter into what we think and do and hope for, not to grind them to a halt” (p. 5).

In the field of home economics, Thompson (1992) promoted exploration of everyday matters of household, family, and the discourse of domesticity with *hestian hermeneutics* (Hestia was goddess of the hearth and home in Greek mythology). Thompson (1992) encouraged attention to the symbolic systems involved with matters of kin and personal relations, child rearing, household resource management, personal and family health, and food, nutrition, meal preparation, and hospitality. Her view was that the language of commerce has shaped thinking in health and human services with emphasis on corporatism and ‘*the bottom line*’, and proposed shifting the focus to human relationships and the essence of life. Similarly, Smith (1987) also encouraged the study of everyday phenomena about which little was known, and wrote:

*“We must learn to live and listen in the darkness for the ‘unthought’ and not despair of the ‘unknown’, just because it is the unseen. We must learn even to ‘see’ in the dark, as we have learned to listen and feel in it. We must know how to listen for the sounds of the night, for even though we cannot actually see we can still move and feel. At night we need not see in order to live. And perhaps if we saw everything that lived and loved in the night, we might not want to live at all in the day” (p. 190).*

This study was a phenomenologic inquiry of the lived experiences of eating and feeding of women who had experienced changed health status and who had families to feed. I wanted to know about what it was about eating and feeding that we, as dietitians, and as a society, did not discuss (as evidenced by this topic not appearing in the dietetics literature and minimally in the illness

experience literature). Hermeneutic phenomenology seemed appropriate to the study because eating is a commonplace, universal, and everyday act reflecting personal beliefs, and involves making choices. What is known about eating was derived largely through empirical, positivist research methods, approaches that have not captured the complexity and nuances regarding eating behaviour and what eating means to people. Uncovering and describing the meanings imbedded in the acts of eating and feeding would contribute to making them visible or explicit to readers, and be of interest and use to dietetics practitioners, individuals living with illness, and their families.

**Getting to the research question.** The notions underpinning this study and sub-questions were, if:

- food selection, eating and feeding behaviour are expressions of one’s sense of self (Fischler, 1988; Lupton, 1996) and,
  - sense of self undergoes transformation with change in health status (Frank, 1991; Bolen, 1996),
- i) How, if at all, does changed health status influence food selection, and eating and feeding behaviour?
  - ii) How, if at all, does the nature of the health condition relate to the above?
  - iii) How do women living with changed health status and with feeding responsibilities for others sort through the dietary cacophony (Fischer, 1993) and the multiple demands for their time and attention to take action to eat?
  - iv) What are the implications of these findings for dietetic practice?

The research question was: What is the experience of eating for women with changed health status and feeding responsibilities for others?

### **Terms/notions.**

changed health status: one previously lived without and now lives with a medical condition

chronic medical condition: permanent, medically-diagnosed illness or disease that may be ‘managed’ or ‘controlled’ long term but is not curable

diet history: the process whereby a dietitian requests and receives information about another’s food intake and usual dietary habits

feeding responsibility: where a person has regular, ongoing responsibility for feeding others (e.g., family members, friends, neighbours, roommates, etc.) (DeVault, 1993)

food identity: an individual's balance of biologic and cultural needs for food and eating; a means of defining and expressing self, and predetermining one's destiny (Fischer, 1988)

life-altering condition: refers to medical conditions where symptoms amenable to dietary manipulation are experienced daily, and affect daily activities

life-threatening condition: refers to medical conditions likely to hasten death

nutritional narrative: beyond the diet history, includes learning about the meanings of food and eating, and familial and social responsibilities for feeding

**Personal ontology and epistemology.** Drawing on my experiences as a dietitian working in clinical settings, at the outset of this study, I believed that:

- offering food to a person living with illness and having the food accepted/consumed is an important focus of caring for loved ones during illness;
- what, how, when, and why one eats is a means of coping during illness;
- since women play a dominant role in caregiving in illness (Baines, Evans and Neysmith, 1991; Jesus, 1997), and women have a dominant role in feeding families (De Vault, 1993) women may also have a dominant role in feeding in illness, whether they are the person who is ill or the caregiver. ;
- Fischler's concept of food identity (1988) had relevance for the study of eating with changed health status;
- how someone thinks of food and eating will depend on the nature of the medical condition they live with, particularly the presence/absence and immediacy of symptoms that typically arise from not following a prescribed dietary regimen.
- gathering information through in-depth semi-structured interviews would yield the detailed insights I sought more than would written surveys or structured interviews.

**Description of the research approach.** A lived experience phenomenology (van Manen, 1998) to explore women's experiences of eating and feeding with changed health status was undertaken using a progressive interview design (Patton, 2001), that is, ideas arising in interviews could be used as points for discussion in subsequent interviews. The intent was to study food getting, preparation, service, and consumption at its most chaotic (when those who had the feeding role were experiencing illness) to search

for any commonalities among participants with the view that findings would inform approaches to future nutrition counselling efforts. The study was approved by the University of Calgary Research Ethics Board.

Eleven participants were recruited through referral from dietitian colleagues and word of mouth. Participants had experienced or were living with a variety of conditions including esophageal, nasopharyngeal, ovarian, or breast cancers; inflammatory bowel disease; hyperemesis of pregnancy; paraplegia; hypertension; and Type 2 diabetes. One participant was referred by a colleague to whom she had shared her search for the meaning of her family's experiences after her spouse and one of her children were diagnosed with cancer in the same month. Eight interviews were conducted in participants' homes, and three by telephone owing to distance.

The discussion points were: 1) describe your experience of eating at present; 2) describe how eating was before your health status changed; and 3) describe any emotions related to the difference, if any, between that you described for points 1 and 2.

## Analysis

### **Transcript review and content categorization.**

Transcripts were read three times. Using sentence-by-sentence review and interpretation approaches (van Manen, 1998), during the third review, detailed notes were made linking each entry with a page and line number. Review of the notes produced 41 themes. These were further grouped with the headings of *Personal, Household, and Beyond Household, Counselling/Communication Approaches, Nutritional Narrative Interpretation, and Other*. The first three headings included further subheadings of:

- i) factual accounts of feeding/eating related events;
- ii) beliefs related to feeding/eating events or activities;
- iii) actions taken;
- iv) emotions related to either the events, actions or beliefs.

Nine of 11 colleagues who had agreed to review and comment on the emerging themes provided feedback on the categorization. All agreed with the categorization, and contextualized their comments with examples from their counselling experiences.

Based on the similarity of categories emerging from assessment of all of the interviews, even with different personal circumstances and medical conditions, 11

interviews were considered a sufficient number as saturation appeared to have been obtained.

## Findings

Key observations emerging from the categorization were:

- All participants, without prompting, addressed the same types of issues in their narratives (Personal, Household, Beyond Household, and Other domains), and used the same filters (events or facts; values and beliefs; actions/behaviours; emotional reactions/reflections).

- There were two different types of narratives, distinctly different in length, detail, and complexity; those of people whose lives were completely changed as a result of their condition or effects of treatment (*Life Altered* (LA) group), and those whose lives were relatively the same following a period of adjustment to the changes in daily living resulting from their diagnosis/condition (referred to as *Life-the-Same* (LS) group).

The differences between the eating and feeding experiences of participants in the LA and LS groups are outlined in Table 1.

*Table 1: Comparison of eating/feeding experiences of participants in Life Altered and Life-the-Same groups*

	LA Group	LS Group
<b>Personal Domain</b> (re: mostly to eating)	<ul style="list-style-type: none"> <li>• Learned about physical symptoms that may be affected by diet and recommended diet modifications</li> <li>• Sorted through dietary information</li> <li>• May have modified diet according to beliefs about effects of diet on health or disease outcome (from wholehearted adoption to refusal)</li> <li>• Ongoing monitoring (daily, hourly, by the minute) of body functions ('body as barometer'); modified diet accordingly</li> <li>• Deteriorated appearance</li> <li>• Compared experiences (directly or vicariously) to others with similar conditions</li> <li>• Continually tested for normal; challenged function/tolerances</li> <li>• Learned control of the body, not always possible; balanced 'cost' of control with other costs (e.g., taste)</li> </ul> <p><b>Emotions</b></p> <ul style="list-style-type: none"> <li>• Ranged from pleased with limited ability to affect symptoms to anger about ongoing need to keep trying</li> <li>• Grieved loss of pleasure and spontaneity in eating</li> </ul> <p><b>Reflections</b></p> <ul style="list-style-type: none"> <li>• Wondered about meaning of illness and lessons to be learned</li> <li>• Queried role of eating in 'learning the lesson' and 'getting the message'</li> <li>• Recognized/appreciated personal strength(s)</li> <li>• Possibility of living years with condition seemed more difficult to contemplate than short term survival</li> </ul>	<ul style="list-style-type: none"> <li>• Determined whether diet might affect physical parameters</li> <li>• Learned about diet modifications</li> <li>• Changed diet</li> <li>• Monitored weight (weekly) or blood values (quarterly) to assess effects of diet change</li> <li>• Experienced desired changes; confirmed belief in ability to control one's body</li> </ul> <p><b>Emotions</b></p> <ul style="list-style-type: none"> <li>• Disliked diet/exercise regimes</li> <li>• Pleased with changes in appearance/fitness levels</li> </ul> <p><b>Reflections</b></p> <ul style="list-style-type: none"> <li>• None reported</li> </ul>

	<b>LA Group</b>	<b>LS Group</b>
<b>Household Domain</b> (re: feeding others)	<ul style="list-style-type: none"> <li>• Family/friends did cooking/shopping when person who had the feeding role was too ill; most participants resumed these roles as soon as physically able</li> <li>• Attempted to find a balance between family food/meal preferences and own needs/tolerances (in all but one informant)</li> <li>• Some tried preparing separate foods for family and self</li> <li>• Made efforts to maintain normal family feeding practices</li> </ul> <p><b>Emotions</b></p> <ul style="list-style-type: none"> <li>• Weary and dispirited with physical and emotional demands of maintaining household routine and monitoring physical status; determined to continue</li> <li>• Resented sense of obligation to feed others; unwilling to relinquish this role</li> </ul>	<ul style="list-style-type: none"> <li>• Shopping/cooking routine unchanged (family contributed)</li> <li>• Purchased lower fat foods; modified cooking methods</li> <li>• Household members ate feeder's diet</li> </ul> <p><b>Emotions</b></p> <ul style="list-style-type: none"> <li>• 'Hated' low fat diet and exercise; family disliked restrictions but maintained them</li> </ul>
<b>Beyond Household Domain</b>	<ul style="list-style-type: none"> <li>• Little or no eating outside of home (fear of symptoms; potential for embarrassment; limited food/menu choices)</li> <li>• Visiting required extensive preparations for meals; often abandoned (problematic for guest/host)</li> <li>• All social activities, vacationing, etc. curtailed</li> <li>• Stopped work or adapted to work from home</li> <li>• Entertaining at home stopped outright or catering was done by others</li> </ul> <p><b>Emotions</b></p> <ul style="list-style-type: none"> <li>• Grief and sadness with loss</li> </ul>	<ul style="list-style-type: none"> <li>• Continued to eat out</li> <li>• Continued to travel and visit</li> <li>• Work unchanged</li> <li>• Entertaining unchanged</li> </ul> <p><b>Emotions</b></p> <ul style="list-style-type: none"> <li>• None mentioned</li> </ul>

## Discussion

**Emergence of the Organizational Framework for Exploring Nutrition Narratives.** The *Organizational Framework for Exploring Nutrition Narratives* (OFFENN) (Figure 1) emerged from reflecting on the domains and filters during the analysis. The term *nutritional narrative* was selected rather than diet history to reflect the depth of information typically conveyed when a person is asked to recount what they eat on a daily basis (that is, contextual descriptions and rationale frequently accompany accounts of one's dietary intake). The OFFENN is comprised of three dynamic layers. Readers are asked to imagine the middle circle (three shades of blue) is a sphere divided into three shifting sections, the four circles (blue, yellow, green, red) as interconnected spheres bumping around within the larger sphere, and the outer layer (grey diamonds) as a large shell that contains the other layers. The large, middle sphere represents the domains of a person's life - *Personal, Household, and Beyond Household*. The inner conjoined spheres represent the filters through which one recounts eating and feeding experiences, and the outermost layer represents *Unthoughts and Other* influences on eating and feeding.

**Domains.** Influences on eating and feeding within the Personal domain relate solely to the individual, their views and beliefs on how eating choices affect their biology/physiology and appearance, and their gastronomic experiences of eating. The *Household* domain relates to the relationship the person in the feeding role has with each household member, and their efforts to "constitute family" through meals (per DeVault, 1993, p. 91). The *Beyond Household* domain refers to eating that takes place away from home, or when non-household members are present in the home for meals (such as when visiting, or for social events). *Unthoughts and Other Influences* include the entire background and makeup of an individual, as well as social, political, philosophical, psychological, and cultural influences on a person's life that influence their eating. A person may not be aware of these influences. The *Unthoughts and Other* domain has the greatest stability of the three (although not entirely stable) as many characteristics and circumstances (inherited and acquired) are unchangeable or slow to change. At the same time, the influences on eating and feeding are ever-increasing as memories of experience are constantly added to compose one's background.

### Personal Domain

*individual*

- Biological Function
- Appearance
- Gastronomics

### Household Domain

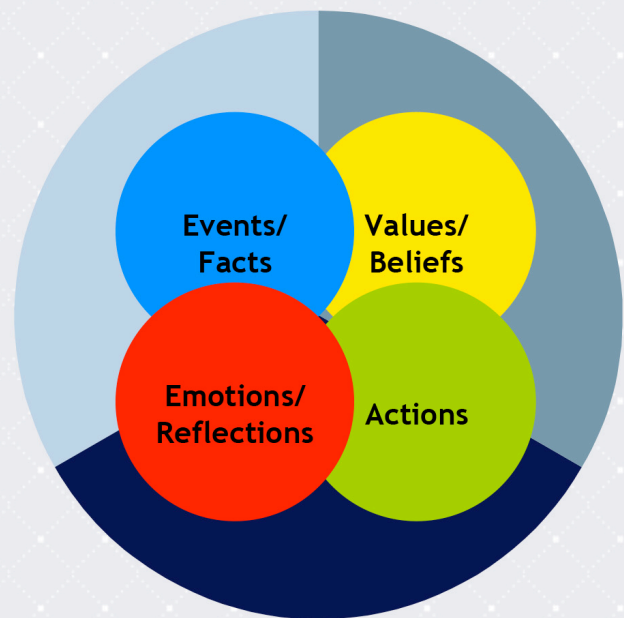
*individual in relation with household members*

- Relationship with each family member
- Creating family unity

### Beyond Household Domain

*individual outside of home*

- Activities/relationships outside home
- Entertaining at home



### ‘Unthoughts’ and Other Influences on Eating

Many individual and social characteristics and circumstances influence values, beliefs, actions, emotions, and reflections related to eating and feeding (about which a person may be largely unaware). These include identity, personality, history, economic status, sociocultural background, and political and philosophical perspectives, etc...

**Filters.** The four interconnected spheres represent the filters through which a person recounts their eating and feeding narrative. These are:

- *events or factual accounts* about what has happened or is happening such as diagnosis, treatments, side effects, food intake, etc.;
- *beliefs* about how to address problems or situations arising due to medical conditions, related treatments, etc., and *values* (including moral imperatives) about what one should do, or considers important given the circumstances;
- *actions* taken to learn to live with or to otherwise manage actual or anticipated symptoms or situations;
- *emotions/reflections* related to any of the above.

The connectedness of the spheres indicates that any aspect of an issue arising during a nutritional narrative may relate to a number of other aspects, just as they may arise as solitary concerns. This dynamism reflects the non-linear manner in which people recount nutritional narratives.

**Dynamics.** The dynamics of how one might use the OFFENN conceptual framework to explore a nutritional narrative reflects the complex, non-linear, and chaotic influences on eating and feeding and thinking about these activities. The proportions of the Domains (middle) sphere constantly shifts with personal circumstances

and one's decision or feelings about where to put one's energy. The four interconnected spheres tumble within the Domains sphere, 'bumping up' against any of the domains at a particular time in recounting one's narrative.

The possibilities for issues that may arise during a nutritional narrative are infinite. While there might be some predictability of the domain of concern and a filter a person might speak through depending on the phase of the illness experience, the specifics of a narrative cannot be predicted. For example, people newly-diagnosed with a medical condition often inquire about preventing or managing symptoms. One would expect their interests to be in the Personal domain (biological control) using the events and action filters. The specific nature of eating habits and questions/concerns based on eating and health education experiences would be unpredictable as these are highly individual. It may be that issues in the three domains may be insignificant relative to issues in the 'previously unthought' domain.

**Application in the OFFENN in practice.** The OFFENN is intended to offer insights into the multiplicity and interconnectedness of issues involved in eating and feeding, and to offer practitioners a means to sort through the issues expressed in nutrition narratives that might otherwise appear rambling, confused, or not

related to eating. While many aspects of the framework have been singled out and discussed separately in this report, none of them occur in isolation. The framework is not intended to have predictive or prescriptive value, or to generalize the experiences of study participants to all people living with illness. Rather, it is intended to offer a means for practitioners to sort through clients' experiences and narratives to provide the client-counsellor partnership a basis from which to collaborate on counselling priorities (Morley, 2016).

The OFFENN has been used in nutrition counselling practice, as the foundation for research studies, in facilitating learning for undergraduate and practicum students, and novice practitioners to acquire comfort in offering nutrition counselling, and as the inspiration for research-informed works including film and textile art pieces.

**The OFFENN compared to behaviour change models.** The OFFENN relates specifically to eating and feeding, not generic health behaviours. When using the OFFENN, it is recognized that there are many influences on eating and feeding, and many of these are unthought. Such complexity is not considered in behaviour change models (that tend to refer to adoption of behaviours relative to a biological goal). In contrast, the OFFENN may be used to explore influences on eating and feeding behaviour, and related thoughts and unthoughts, not to attempt to promote adoption of specific eating behaviours. In the OFFENN, eating to influence biology is only one influence on eating in the Personal Domain that might assist in exploring why someone eats what they do or holds certain beliefs and notions about eating. Other models (e.g., transtheoretical model or Stages of Change; Social Cognitive Theory, etc.) rely on rational-cognitive decision making as the basis for behaviour change whereas the OFFENN can be used to consider the myriad of influences on eating and feeding behaviour. The OFFENN was developed as a means to be inclusive of individual variation, embracing the 'chaotic and messy lives' (Miller, 1997) of people experiencing illness.

**Questions arising.** Given that the OFFENN was developed based on interviews with heterosexual women living in families and who had or were experiencing changed health status, questions have been raised about its utility for considering the eating/feeding issues of people with different life circumstances. The ontological stance throughout this project was that finding a way to sort through nutrition narratives

when people (research participants and others) were at their most chaotic would allow for consideration of less complex nutritional narratives. While this perspective still holds somewhat, the ontological shift was that all people live messy and chaotic lives (per DeVault, 1993) and thus, the OFFENN would have utility to explore the nutritional narratives of people with an infinite array of life circumstances. The OFFENN is suggested as a way to sort through a person's nutritional narrative to try to identify and reflect back to them their facilitating and constraining issues/concerns/beliefs (Wright, Watson & Bell, 1996) about eating and feeding so that collaborative, client-centred conversations (MacLellan, Morley, Traviss, Cividin, 2011; Morley, MacLellan, Traviss, Cividin, 2016) about their priorities can begin.

## Closing

Returning to the opening excerpts, when considered through the OFFENN, both used Beliefs/Values filters to express their narratives in the Personal domain. Both narrators conveyed belief in reward for what they considered as 'being good' (e.g., eating according to the dietitian's instructions; getting one's affairs in order), and that obtaining factual nutrition information and acting upon it would aid in their efforts to *be good*. Using the OFFENN to explore the narratives of which these excerpts were part provides those who witness these narratives opportunities to 'open up' possibilities to invite conversations about eating behaviours and the circumstances, beliefs, and emotions/reflections that inform their behaviours.

## References

- Baines, C., Evans, P., Neysmith, S. (1993). *Caring: Its impact on the lives of women*. In *Women's caring*. Baines, C., Evans, P., Neysmith, S. (Eds.). Toronto: McLelland and Stewart.
- Bolen, J. S. (1996). *Close to the bone: Life-threatening illness and the search for meaning*. New York: Touchstone.
- Caputo, J. D. (1987). *Radical hermeneutics: repetition, deconstruction, and the hermeneutic project*. Indianapolis, IN: Indiana University Press.
- Cousens, G. (1997). *Conscious eating* (4th ed.). Patagonia, AZ: Essence Vision Books.
- DeVault, M. (1993). *Feeding the family: the social organization of caring as gendered work*. Chicago, IL: University of Chicago Press.
- Fischler, C. (1988). Food, self and identity. *Social Science and Medicine*, 27(2), 275-292.
- Fischler, C. (1993). The uncontrollable body, or the modern alimentary complex. *Communications*, 56, 207-224.

- Frank, A. (1991). *At the will of the body*. New York, NY: Houghton Mifflin Co.
- Gadamer, H. (1998). *Truth and method* (2nd ed.). Continuum Publishing: New York, NY.
- Glanz, K., Basil, M., Maibach, E., Goldberg, J. Snyder, D. (1998). Why Americans eat what they do. *Journal of the American Dietetic Association*, 98(10), 1075-1081.
- Hanak, M., Scott, A. (1993). *Spinal cord injury: an illustrated guide for health care professionals*. New York: Springer Publishing.
- Harnack, L., Story, M., Martinson, B., Neumark-Sztainer, D., Stang, J. (1998). Guess who's cooking? The role of men in meal planning, shopping, and preparation in US families. *Journal of the American Dietetic Association*, 98(9), 995-1000.
- Hauchecorne, C. M. (1999). Writings on the experience of eating in illness in the *Journal of the American Dietetic Association*. 82nd Annual American Dietetic Association Meeting and Exhibition proceedings. Atlanta, GA.
- Jesus, J. G. (1997). When the housewife is missing. IV *Conferencia Internacional de enfermería familiar conference proceedings*. Valdivia, Chile.
- Kiy, A. M. (1998). Philosophy in nutrition therapy. *Topics in Clinical Nutrition*, 13(2), 51-62.
- Licavoli, L. (1995). Dietetics goes into therapy. *Journal of the American Dietetic Association*, 95(7), 751- 752.
- Lupton, D. (1996). *Food, the body and the self*. Thousand Oaks, CA: Sage.
- MacLellan D, Morley C, Traviss K, & Cividin T. (2011). Towards evidence-based client centred nutrition education guidelines: Dietitian and consumer survey results. *Canadian Journal of Dietetic Practice and Research*, 72(3), 115-120.
- McFarland, J. R. (1993). *Now that I have cancer I am whole*. Kansas City: Andrews and McMeel.
- Miller, S. (1997). Multiple paradigms for nursing - postmodern feminisms. In Thorne, S. and Hayes, V. (Eds.), *Nursing praxis - knowledge and action*. Thousand Oaks, CA: Sage Publications.
- Moltman-Wendel, E. (1994). *I am my body: New ways of embodiment*. London: SCM Press.
- Morley C. (2016). Feeding the family when the mother is sick. In *Mothers and Food*, Florence Pasche Guignard and Tanya Cassidy (Eds). Bradford ON: Demeter Press. PP 103-117 (chapter 7)
- Morley C, MacLellan D, Traviss K, Cividin T. (2016). Developing an evidence-based framework and practice points for collaborative, client-centered nutrition education (3CNE). *Canadian Journal for Dietetic Practice and Research*, 77, 1-6.
- Patton, M.Q. (2001). *Qualitative evaluation and research methods (3rd ed.)*. Sage: Thousand Oaks, CA.
- Robinson, C. (1994). *Women, families, chronic illness and nursing interventions: From burden to balance* (Doctoral dissertation). Retrieved from <http://hdl.handle.net/1880/48642> University of Calgary Institutional Repository.
- Schwartz, R. C. (1983). *More work for mother: the ironies of household technology from the open hearth to the microwave*. New York: Basic Books.
- Smith, D. E. (1987). *The everyday world as problematic: a feminist sociology*. Toronto, ON: University of Toronto Press.
- Smith, F. J. (1987). In-the-world and on-the-earth: a Heideggerian interpretation. In Frings, M. (Ed). *Heidegger and the quest for truth*. Chicago: Quadrangle Books.
- Thompson, P. (1992). *Bringing feminism home: home economics and the hestian connection*. Charlottetown, PEI: University of PEI Home Economics Publishing Collective.
- van Manen, M. (1998). *Researching lived experience: human science for an action sensitive pedagogy*. London, ON: Athlouse Press.
- Visser, M. (1989). *Much depends on dinner*. Toronto: HarperCollins Publishers.
- Young-Mason, J. (1997). *The patient's voice: Experiences of illness*. Philadelphia, PA: FA Davis and Co.

## Author Bio

Catherine is a professor in the School of Nutrition and Dietetics, Acadia University.

She holds a PhD in Community Rehabilitation and Disability Studies/Educational Research (Calgary), an MA in Adult Education (UBC), a BAsc in Human Nutrition (Guelph), and a certificate in Documentary Film and a diploma in Textile Arts (Capilano). She completed a dietetic internship at Vancouver General Hospital, and worked for many years in cancer care, then as a self-employed consultant in nutrition program development and evaluation prior to joining Acadia University in 2011. Her research centres on how the experience changes with changed health status including with aging. She has an interest in the use of participatory and arts-based research approaches and to extend the reach of research findings.