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"What I am supposed to eat?":
nutritional messaging in an inner-city
Integrative Medicine clinic

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Thesis

**“WHAT AM I SUPPOSED TO EAT?”: NUTRITIONAL MESSAGING
IN AN INNER-CITY INTEGRATIVE MEDICINE CLINIC**

by

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ABSTRACT

Public health experts have developed education campaigns based on nutritional messaging to alleviate illnesses related to unhealthy food consumption. This thesis examines cultural factors affecting the accessibility of such messaging, such as economic status, ethnicity, role in the family, access to transportation and markets, and familiarity with the topics of messaging. I explore how these variables affect learning and applying new nutrition knowledge in an individual’s daily life. The methods used were semi-structured interviews (n=10) and participant observations conducted in an Integrative Medicine clinic at an urban hospital.

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LIST OF ABBREVIATIONS

- BCHBoston City Hospital
- BMC..... Boston Medical Center
- BUMCH.....Boston University Medical Center Hospital
- CAMComplementary and Alternative Medicine
- IMGVisitsIntegrative Medicine Group Visits

CHAPTER I: ENTERING THE CLINIC

As I glance through notes from my weekly ethnographic observations at the Boston Medical Center's integrative medicine clinic, I find this small description from one of my first, which offers an introduction to the sights and sounds that awaited me throughout my time in the field: *I waited in the patient line to ask the receptionist where the Integrative Medicine Group Visits were being held today: the old waiting room or the small conference room. She kindly pointed me to the small conference room "way in the back of the clinic on the right." This was my fourth time in the clinic, so I moved quickly trying not to get in the way of nurses, physicians, and patients who were moving between rooms in the narrow hallway. I realized by that point everyone had a place to be and no time to waste.*

I entered the small, and only, conference room of the department. The room measured approximately ten by twenty feet with eighteen non-matching chairs crammed around the perimeter of the room. The wall with the door and the opposite wall had African tapestries on them. I was not surprised to see these artworks because the Family Medicine department had in past years gone to specific African villages to provide care and some medical residents still travelled there time to time. The other cream colored wall was covered mostly by a huge rectangular white board that had written on it "WELCOME TO INTEGRATIVE MEDICINE GROUP VISITS." The other two walls were huge glass windows that looked down onto a shorter building's roof. About a third of that roof has been used to start a garden.

I found my self-designated seat and began to fidget with sweaty palms. I think not having a chronic illness and not being a part of the group on a weekly basis added to my apprehensiveness to be sitting in on this intimate eight person group which included the doctor and meditation master. I let my thoughts wander to the garden below. I wonder if participants use that garden. Does anyone use farmer's markets? My thoughts were broken as participants began to come in.

Just beginning my master's thesis research in Medical Anthropology produced this whirlwind of details and notes. It all began when a physician at the Boston Medical Center asked me to complete research on some aspect of the Integrative Medicine Group Visits (hereafter listed as IMGVisits). The IMGVisits use a group medical visits approach combining integrative medicine, nutritional information, and biomedical healthcare into each session, and the physician wanted me to study what were the participants' perceptions of the IMGVisits? What information were the chronically ill participants finding valuable to remember and apply to their lives? What were the accessibility and challenges for the participants in using this information? I was very excited to be asked, but overwhelmed at the prospect of the tasks this would entail. I have a great interest in complementary and alternative medicines, yet this research would definitely provide me with many new and different questions I could examine.

Once I really considered the intent of the group I was asked to observe, I decided to focus primarily on the nutrition-messaging aspect of Boston Medical Center's IMGVisits. I knew there has not been much research done on these groups, in relation to that aspect. In addition, since my first Anthropology of Food course in undergraduate

school, I have been fascinated with food and its ties to health and culture. This project was the perfect opportunity to explore intersections of culture, food, and health, which have only recently begun to be explored. Understanding how cultural perceptions of health and nutrition give insight into how nutrition education, taught in a public health or biomedical setting, may or may not be appropriate for the populations trying to be reached. It also sheds light into how people carry multiple understandings of health and nutrition that influences the learning of new information.

During the planning stages of this study, the physician and integrative coordinator presented me with these questions: What are people getting from the nutritional messaging offered through IMGVisits? What part of these messages are they using? What is the accessibility; and barriers to, the messages? I knew participant-observation at the IMGVisits, along with interviews with participants would enable me to explore these questions. Yet, I wondered, what would be my framework for exploring these issues? I decided that Critical Medical Anthropology (CMA) and phenomenology would be the way to approach this research (Baer et al 1986, Desjarlais and Throop 2011). CMA, which seeks to uncover the causes of health disparities in relation to the larger societal structures (i.e. capitalism), how it's used provides a way to explore power differences that shape access and barriers to resources, including food choices, the relevance of health and nutrition information to people's lived experiences, and so on (Baer et al 1986). Because I knew the population receives care through the IMGVisits is largely poor or otherwise marginalized, I also suspected that CMA, as an approach to the political-economy of health and health care, would offer a lens through which to analyze the daily

life experiences of my participants, within social, political, historical, and economic contexts.

Phenomenology, as a complementary approach, provides a way to seek to understand the factors of an individual's experience that affect and interact with perceptions or experiences in the larger world, such as with the nutritional messages provided at group visits. It allows space for individual experiences to be examined and presented in relation to outside factors, and is shaped by the larger social, political, historical, and economic contexts CMA is based in. Additional concepts, such as Bourdieu's concept of habitus and Parsons's sick role, became important in emphasizing key points that arose throughout my data analysis.

During my research process, keeping up with a standard literature review as expected in graduate-level anthropological studies quickly felt unruly. There were, seemingly too many ways that researchers were exploring nutritional messaging; it was hard to narrow my focus to the most relevant literature to my research population's experiences. Public health literature focused on the education aspect of nutrition. What are ways to implement education to the public? Caraher and Coveney summed up this body of literature as focusing on the interventions to encourage health promotion, "rather than [to] tackle the structural factors" (595).

Anthropological literature examines numerous aspects of food and nutrition from early human diets to modern delocalization of food to cultural understandings of nutrition and food. For example, Beyers explores how Belgian and Italian cooking has been closely influenced by one another through decades of transference creating a "new ethnic

food”(2008:7). Katz and Voigt (1986) argue that beer was the grain product that established grain as a main food source for early agriculturalists. Padosky (2005) argues that food cannot always be a locating agent for a physical or geographical bodies or region or community. Highly diverse nations like the United States will have individual level food consumption diversity. I focus on articles that explored the structural influences on food perception, cultural understandings of nutrition, and how these connect to health, which is still a wealth of literature.

Each article I reviewed seemed to either address a barrier or an access point to food nutrition, or taught me something new about the relation of culture and food. Nonetheless, I was left with big questions: How does this all tie together? How does this all interconnect? There are so many moving facets in a person’s life. How do chronic illness, the small group setting, and shared experiences affect the learning of new nutrition knowledge? How do people manage to apply the nutrition knowledge to their lives outside of group visits? What I found, ultimately, was the existing literature only partly answered the preliminary questions of the IMGVisits facilitators, and the questions I developed. I saw that my findings had the potential to contribute to greater understandings of how the “flattening authority” model creates better communication and empowerment for participants to learn new nutrition information. In addition, my findings support how individuals maintain agency in their lives, including sick and student roles. Agency is what creates the ability for new knowledge to be learned and applied.

The goals of this thesis are thus to present the findings and analysis from my exploration of: (1) the presentation of nutrition messages and the process of acquiring or offering nutrition knowledge in a biomedical setting: What factors do participants believe foster their learning? How do people fit new nutritional knowledge into their understandings of the world? (2) And, to explore the application of new nutrition knowledge in the world: What structures are in place that affect the application of such knowledge? How are people navigating their environments to make new nutritional knowledge usable? The significance of this research is to fill these gaps in the research. This research provides a framework in understanding the whole process it takes to incorporate new knowledge into a person's daily life. It is a continuously active process that the individual has to engage in to make new knowledge apart of their habitus.

In Chapter Two, I outline the existing literature and research from Public Health and Anthropology that explores food and nutrition messaging, and that related to my research questions. I draw from both of these disciplines to create my foundation of understanding nutrition messaging, and how people have approached studying food and nutrition. In addition, in this chapter I begin to introduce the theoretical concepts that become important to my analysis, such as Bourdieu's concept of habitus.

In Chapter Three, I outline in detail the methods I used. I discuss the initial research design, participant recruitment, and forms of analysis. As is common in social science research, various aspects had to be adjusted along the way – I share some of the changes that occurred over the process of recruitment and interviewing. Near the end of

the chapter, I begin to explain how I used two theoretical frameworks, Phenomenology and Critical Medical Anthropology (CMA), to analyze my data.

In Chapter Four, I outline the process of constructing and retaining the nutritional messaging as I learned about it from my participants. I explore the different forms of knowledge that people in this study embodied about food, from family preferences to ethnic tastes. I look at how the position of the participant effects what nutrition knowledge is learned. I examine how the group design creates an atmosphere for learning. Furthermore, I draw all these elements together to better understand how the group design “flattens” authority to create each participant as their own expert on what is best for their body, including their use of nutrition knowledge.

In Chapter Five, I examine the application of the new nutrition knowledge in the participants’ daily lives. I focus on the challenges people faced while applying their new knowledge, from family structures to economic structures, and so on. I do not only look at the structures that create daily barriers, but also explore the agency participants possessed and displayed in how they navigated their application of nutrition knowledge to their lives. I discuss the creative ways people subverted the barriers they face, and what I saw this meant to them.

The last part of my thesis, Chapter Six, presents the conclusions I reached over the complete process of the study’s period of research, analysis, and writing. I explore the whole process of nutrition messaging from how the IMGVisits created a place for individuals to learn, and how people applied their new nutritional knowledge in daily life. My final conclusions will provide one way to understand how multiple aspects of a

person's life affect their learning and the application of knowledge in day to day life. It is my hope that these conclusions may highlight ways group visits and educational programs can approach teaching new knowledge and how to make it more accessible to participants.

CHAPTER II: BACKGROUND

In this chapter, I review previous work that has shaped the approach to my research. I draw on food studies by researchers in Public Health and in Anthropology. Public Health is a force within the United States that raises public awareness of the connection between health and nutrition from a biomedical perspective (Sabrell 1958: 741). Public Health's population educational approach has informed much of the material used in the group setting where participants were introduced to nutritional messages. At the same time, work in Anthropology informed my research design in understanding the interactions between health, culture, and nutrition messaging. Overall, anthropological approach can reveal cultural understandings of health and nutrition that can positively affect the efficacy of public health interventions.

Further in this chapter, I provide oral history and grant information related to the medical group visits, to illustrate how they were designed, to explain their goals and purposes, and to discuss the basic approach to education in the group setting. Finally, I review aspects of the group that situate the medical group visits in the larger biomedical realm and society itself.

Health and Food Studies

Public Health Perspective

As food becomes politicized through public health campaigns and city/county governmental policies (ex. California's artificial trans-fat ban or Philadelphia's trans-fat ban) to alleviate consumption-based illnesses (i.e. obesity, diabetes, cardio diseases etc.), the social position of food has transitioned from the private to public sphere (Wilson

2010: 261, Porche 2004:5, Center for Disease Control and Prevention 2012). Nutrition classes, public health initiatives, and political campaigns have taken the forefront in addressing how to fix “poor eating” habits, through strategies that range from identifying neighborhoods that are “food insecure” to eliminating individual “mindless eating” consumption patterns. The Centers of Disease Control and Prevention’s Division of Nutrition, Physical Activity, and Obesity has promoted ongoing public-health campaigns like “BAM! Body and Mind” (2010) and “Fruits and Veggies Matter!” (2009). Such programs, along with other public health nutritional initiatives, have moved to the forefront to "prevent and control obesity, chronic disease, and other health conditions through regular physical activity and good nutrition" (Centers for Disease Control 2011). To address an issue like eating, which is a part of every individual’s life, public health researchers have developed approaches to reach diverse communities in the nation.

The program “BAM! Body and Mind' has everything you need to know about all the stuff that matters.” It represents one of the earliest and now dominant public health approaches: communities need education. The assumption is that knowledgeable individuals and groups will change food consumption patterns: "Nutrition education, as its main objective, should seek to establish public demand for an adequate diet... key persons in the community must be prepared to guide individuals and institutions in selection of the right foods” (Sabrell 1958:745). The IMGVisits, in which a majority of my research took place, used an education-based approach as the primary method. The IMGVisits focused on teaching participants food and nutritional information to create better informed individuals who can make healthier choices.

This approach often predetermines a community or other subpopulation before research and intervention begins, using it as “the organizing principle for preventive action targeting the broad distribution of diseases and health determinants” (Porche 2004:5). Sonia Vega-Lopez and colleagues examine the disproportionate “barriers to health care access and utilization” of racial/ethnic minorities (2011:552). Kollanoor-Samuel et al focused their research on the Latino population, specifically the Puerto-Rican population of Hartford County, Connecticut (2011:553). Two-hundred and eleven surveys were conducted that concentrated on barriers recognized in previous research such as food insecurity (the lack of access to food), health insurance, and education. Kollanoor-Samuel et al’s analysis discovered an “independent association between household food insecurity and three out of four dimensions of health care access/utilization barriers among Puerto-Ricans” (2011:560). For future studies, the researchers suggested addressing food insecurity in “low income Puerto-Ricans with [Type II diabetes]” to raise the potential of better health care access and utilization. Kollanoor et al defined their population based on ethnic identity; populations can also be identified by such factors including: socioeconomic status, geographic area, age, gender, citizenship status, and sexual orientation.

For instance, the medical group visits used the population-based approach to design their education curriculum. Group visits focused their education on an adult (18+) population with chronic pain and/or cardiovascular risk. This subpopulation is distinguished by its "disease" alone due to the higher prevalence within the clinic. The nutritional information is then tailored to help alleviate symptoms of these particular

chronic illnesses. For example, the anti-inflammatory foods are introduced to help reduce inflammation that affects the pain levels in many chronic pain patients. Other factors about individuals, such as SES and ethnicity, are known by facilitators due to hospital records. Where individuals of any SES, ethnicity, education level, and so forth may decide to attend the visits, assumptions on these factors are avoided.

A population-based approach not only lends itself to food and education interventions; it also lends itself to advocacy for policy change. In their study, Nestle and Jacobson (2000) argue for policy change based on previous population-based studies. They explore literature that illuminates factors contributing to obesity. Furthermore, they argue that interventions by previous researchers have lacked public policy to back up their education and behavioral interventions. Nestle and Jacobson outline recommendations for health policies that “ensure the participation of health officials and researchers, educators and legislators, transportation experts, and urban planners, and businesses and non-profit groups in formulating a public health campaign with a better chance of success” (Nestle and Jacobson 2000: 12,20). Caraher and Coveney broaden their view to explore “the global control of health and to examine the ways in which food choice is molded by many interests” (2004: 591). They found that much of the literature focused on interventions to encourage health promotion “rather than tackle structural factors” (595). Caraher and Coveney argued that food policy should “seek to make the social infrastructure conducive” to healthy food decisions. While IMGVisits were not actively involved in designing policy, existing policies (or their lack)—including

government approved nutritional messages—did impact the group visits. This point will be further discussed in future chapters.

Public health has had success in politicizing food, transforming its position from the private to the public sphere. The population-based approach has been invaluable to research in identifying potential connections between accessibility and inaccessibility to health and nutrition (Hadley et al 2012). In particular, it has given researchers an arena for interventions to address not only behavior and choice, but also for acknowledgement of society's structural factors and their effects on nutrition. At the same time, one limitation of the population-based approach is the process of generalization (Raberg Kjøllestadal et al 2011:482). Cultural, regional, and personal differences in understanding health and food between people are not recognized, as one participant highlighted early in my research: *It was time for final questions after the physician's "doc talk" on cholesterol. A middle aged Hispanic woman, who wore a pink tracksuit, raised her hand. She did not have a question so much as a story to tell. She told us about her experience with the nutritionist just a few days before. She gave details of how short the visit was and how "short" the nutritionist's attitude was towards her. "No beans. No rice" were the first recommendations. "I wanted to say 'Don't forget, I'm Spanish!'" indignantly stated the participant, "'what I am supposed to eat?'"* What is missing from public health literature are cultural voices. What messages do people receive about food? How do they interpret these messages? How do culture and environment affect their food choices?

Anthropology of Food

Anthropology of food begins to answer the questions left by public health research. All four types of anthropology- archaeology, linguistics, sociocultural, and biological/physical- have devoted attention to food and nutrition. Anthropology of Food is a term mostly used in sociocultural anthropology designating a space for experts in the research of food and foodways. I have focused on sociocultural research about food, and specifically on studies that explored diet and food behaviors in relation to health. Here I highlight studies that have examined cultural voices.

Structural influences on people's perception of food are one topic of interest. Nestle (2002) explores the development of the U.S. Department of Agriculture (USDA) and its inherently conflicted nature. In 1862, the USDA was created for two purposes: to ensure sufficient and reliable food supply and "to diffuse among people of the US useful information on subjects connected with agriculture in the most general and comprehensive sense of that word" (Nestle 2002:33). Throughout the years, the more recent and contradictory mandate the USDA follows is to create "diets that promote health" and promote "the interests of the food industry" (Nestle 2002: 31). This framework that the USDA follows creates the need for the government to balance corporate and public interests, which creates dietary guidelines that balance the food companies' needs and the health of the public. Nestle asks the question of who dictates healthy food? Is it the companies trying to sell food or the nutritionists conducting the studies on food? Beck (2007) explored how media has made its way into food choice. She found that processed commercial foods made up at least some part of each meal in

families she studied in the Los Angeles area (2007: 531). Stead et al argued that healthy food may be socially “unhealthy” for adolescents, because the image that healthy food provides affects the social status of the teens who are forced to consume these items (2011:1137).

Food is also affected by society's view on body size and what constitutes the right body size. Cassidy examines across the world and time what makes a “good” body (1991:181). She found that “most people worldwide want to be big,” for it symbolizes power for survival and dominance (1991: 204). Cassidy recognizes that big is culturally defined, but she found standard deviations that size is based on for many cultures. Big is related to fat, muscular, tall, big-boned, while small is related to the opposite deviations of small-boned, short, slight, and thin (1991:184). These views on the body are very different from the U.S. ideal body of thin and petite for women, but fit ideal body views for men of muscular and tall.

Brewis (2011) examines how obesity views are directly related to the cultural ideas of what defines being “fat”. She states that the “label of obesity is laden in English with almost exclusively negative social meaning and with a loss of mind-over-body control” (2011: 106). In the United states, the negative view on being “fat” is due to the common belief a person has complete control over the circumstances that create their body shape. An obese person is someone who does not manage their food choices, their eating habits, and exercise. The individual becomes culturally define as deviant, or sick. Brewis (2011) explains the person needs to work on their deviance, their weight, to become a “normal” productive person in society.

Jane H. Lassetter explored the topic of obesity prevalence in the Native Hawaiian population, based on the assumption that participants' perceptions played a larger role than biological factors when it came to the obesity epidemic. Lassetter argues that there is a connection to food and how Hawaiians perceive health (2011:63). She conducted twenty-seven semi-structured interviews with Hawaiian off-islanders residing in Las Vegas. Her analysis uncovered a connection between health and the perception of food (65). Her participants divided health between the health of the body and the well-being of the mind. They understood that "overeating and eating food with little nutritional value was not good for their health"; however, participating in culturally sanctioned overeating like *Kanak attack*, where one eats until they feel intensely lazy, was vital to "many Native Hawaiian migrants' well-being" (69). Furthermore, Lassetter found that obesity prevalence was tied to the marginalized role of the provider, and to traditional cooking techniques. She explains that the lack of an established relationship with the physician creates fissures in patient-provider interactions. Many informants considered what they ate their "own business" (67). They viewed the nutritional classes provided by the physician as discouraging and unhelpful (67). Lassetter found that the informants *were* eating within the choices recommended by physicians; however, their traditional cooking techniques (the use of large amounts of fat) affected just how "nutritious" this food was by the time it came for consumption (67). Lassetter's anthropological approaches enabled her to uncover the intersection of ethnicity and cultural food norms, physical health, mental well-being, and food.

In their study of “food environments,” Claire Thompson et al. examined supermarket shopping routines in deprived neighborhoods to learn “how residents...shop for food and how the supermarket environment influences their choices” (2012:116). Thompson et al. conducted their research with twenty-six participants from recognized “deprived” neighborhood in Sandwell, West Midlands. Over six months, the research team used an ethnographic approach in “go-along” interviews that entailed simultaneous interviews and participatory observations occurring during a shopping trip (117). Ultimately, the researchers found that interactions between supermarket environments and deprived neighborhood residents created one of four routine approaches to grocery shopping. “Chaotic and reactive” routine shoppers had very little planning to their shopping. They relied on the environment of the shopping center to make choices, including marketing cues (2012:118). “Working around the store” routine, followers had strict patterns to purchasing, which are focused on familiarity and habit shopping. “Item by item” shoppers relied on “planning and predictable food choice practices” (2012:119). They had written lists and engaged in sale comparison. “Restricted and budgeted” purchasers had clear objectives and “made planned purchases” that were made with budget or health considerations or both (2012:120). Agency, or “reflective monitoring of personal conduct and behavior,” was found to be highest in the item by item and restricted and budgeted shoppers. These shoppers also took healthy choices into account more often when shopping; however evaluating the health of the shoppers was not a part of the study (2012: 117).

Both of these articles helped to create my understanding of how individual cultural voices can explain the connections between food understandings and health. Lassetter demonstrated not only how food systems intersect with medical systems, but also how food is a part of the medical as it informs etiologies, treatments, and maintenance of health and well-being. Thompson et al. demonstrated how one could examine the many socio cultural and structural factors affecting a person's perception of food in a single study.

Minority Health and SES research in Food Studies

I wanted to place particular emphasis on health research among minority and low SES communities in food studies, because results of the research highlight the the role of ethnicity and socioeconomic status of the participants. The results of my study reflect the larger demographics of the IMGVisits population. According to the data collected by IMGVisits physicians, 64% of the population is black, 10% of the population is Hispanic, and the last 24% collects everyone who does not fall into the two previous categories. 49% of the population is high school educated or less and 61% of the patients have an annual household income less than \$20,000 (RIP Powerpoint 2-2-13).

Public health and Anthropology of Food have both intensely studied ethnicity and socioeconomic status, though in different ways. Low socioeconomic status and the access of food has been a focus of public health food studies. Food insecurity and food deserts are two terms used frequently in this line of research. Food insecurity refers to “the state of limited and uncertain access to food due to inadequate financial resources” (Billimek and Sorkin 2012: 2160). A food desert is a designated area, such as a

neighborhood, city, or town, that does “not have access to healthy and affordable food, and fast food restaurants dominate the landscape” (Gordon et al 2011). Whereas the IMGVisits participants are from all areas of Boston, some being food deserts and other places not, the focus of this research has been in food insecurity.

Effects of, interventions to, and other confounding factors have been focuses of research in food insecurity. Billimek and Sorkin focuses on how food insecurity affects the process of care for type 2 diabetes. When decisions have to be made on whether to feed the family or purchase type 2 diabetes medication, the purchasing of food occurs first. The participants acknowledged the complications that could come from delaying the medication; however this was not as important as going without food (2163). Chilton and Booth examined African-American women’s perceptions of food insecurity through thirty-four participants recruited from three food pantries in Philadelphia, Pennsylvania (2007:117). Through participant observations, focus groups, and open-ended interviews, researchers found two forms of hunger: “Hunger of the Body” and “Hunger of the Mind” (119-120). Hunger of the body was the physical hunger that came with not having enough food in one’s house. Hunger of the mind referred to the different ways women experienced “the inability to eat because of stress” (120). Three main stressors of these women were poverty, violence, and ill health. Both forms of hunger, argued the researchers, resulted in poor nutrition, which translated to poor health outcomes (122). Learning how low economic status not only affects the security of food, but also connects to a web of interrelated factors helps us to understand the connections between the barriers discussed by participants.

“I wanted to say ‘Don’t forget, I’m Spanish!’” stated the participant, “‘what I am supposed to eat?’” When thinking about this statement again, the notions of Bourdieu’s habitus become evident. Power (1999) explains “habitus is a way of describing the embodiment of social structures and history in individuals—it is a set of dispositions, internal to the individual, that both reflects external social structures and shapes how the individual perceives the world and acts in it” (48). He argues that “food sits at the intersection of biological or material and the symbolic aspects of human life” (Power 1999:50). Food fills the biological need for energy production; however, it also lies in our social and cultural practices. Understanding the meaning of particular foods for participants will be vital in understanding the disconnection between biomedical nutrition and the participant’s perceptions of food.

To tie these ideas to public health initiatives, Mu’min Chowdhury et al. argue that in order for the promotion of “healthier” food choices to work, there must be an understanding of how people classify and choose food. They looked particularly into Bangladeshi immigrants to illustrate their argument. Mu’min Chowdhury et al found that a desire for a dietary balance and a “strong perceived link with health was apparent;” however, the classifications for healthy food revolved around “hot/cold” or “strong/weak” foods, rather than the biomedical view of health (2000:210). If these ideas around food and ethnicity were understood, health professionals could learn how to communicate about the food choices and health practices that they would like to address.

Padolsky takes the discussion of food perceptions a step further. He explores how habitus that influences food preference is not only about demarcating an ethnicity or

singular meaningful aspect of an individual. He states that food cannot always be a locating agent for a physical or geographical body or region or community. Padolsky argues that food is about the individual as much as group diversity. He particularly focuses on the fact that “food in Canadian society can thus reflect internal struggle at the individual or family levels, intra-group, intergroup solidarity, historical conflicts, rural-urban or regional difference, or a number of other significant ethnic, cross-border encounters” (2005:30-31). Padolsky creates the notion that food is a possible tangible representation of “embodied thoughts” (Rosaldo 1984:143). Embodied thoughts are the lived experience of the two inseparable concepts of cognition (thought), that a personal experience is shaped by culture and affects (emotions), which are a part of the universal experience of a human being (Rosaldo 1984:143). Padolsky’s argument touches upon one vital part of this thesis research. Biomedical nutrition, as social scientist Rosaldo discusses, views the world in dichotomies that do not exist. Nutrition and food perceptions cannot be separated from the rest of a person’s habitus.

Food studies are approached in numerous ways. Public health tends to look for the public understandings of food that can easily be translated into education, policy, and other population interventions. Anthropology of food tends to examine the private understandings and cultural voices of a population. Both public health and anthropology try to better understand the structural factors that affect populations in subtle and obvious ways. Combining approaches of public health and anthropology has resulted in a pluralistic research project that allows for the two disciplines to bridge.

What is CAM?

Complementary and Alternative Medicine (CAM) is a concept derived from two smaller terms: complementary medicine and alternative medicine. The definition of CAM is based on the definition of biomedicine. Biomedicine, or western medicine, is the “mainstream” or accepted healing practices of the United States that are based on the belief that biological factors are the basis for all ailments and illnesses (Straub 2007). It is important to recognize that biomedicine is a social construct that changes over time and place. What was accepted health practice two decades ago may not be what is practiced today? What is practiced in Hawaii might be different than what is practiced in Maine, due to resources, education differences, and population differences.

Complementary medicine is any healing practice used in conjunction with or as a “complement” to biomedical practices (MacIntosh 1999:1). Alternative medicine is any healing practice that is used to replace or to be an “alternative” to biomedicine practices (NCCAM). Generally these two terms are used together because the situation in which the healing practice is being used designates whether the practice is “complementary” or “alternative” (NCCAM). With the fusing of the two terms, the present understanding includes a very broad statement about what constitutes CAM: “complementary and alternative medicine is an umbrella term given to a collection of disparate healing practices” and “the use and practice of therapies or diagnostic techniques that fall outside of conventional biomedicine” is the general frame (Ruggie 2004:3, Straub 2007:429). The Cochrane Collaboration, an international group that facilitates the review of health care practices, states that CAM is a broad domain of healing resources that

encompasses all health systems, modulations, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. (Rees 2001: 2)

‘What is CAM?’ is a hard question to answer, since there is no universal definition for CAM. It is a cultural construct that is always changing with society. This process can be highlighted through a brief historical overview of CAM. Before 1993, the “unconventional” medicine, which was the name for all non-biomedicine medicine, had no recognition. Not until Eisenberg and colleagues published about “unconventional medicine” in *The New England Journal of Medicine*, did the biomedical profession begin to recognize the use of other medicines (1993:246). Within the same month of publication, the “Office of Alternative Medicine” opened its doors to begin researching “the merits of therapies outside the mainstream healing” (Angier 1993:1).

As research began, the majority of healing practices given the name “alternative,” and later “complimentary,” were practices used by the white U.S. citizens. Alternative medicines research did not focus, or include, minority populations. Many times medicines used by minority populations were considered outside the complementary and alternative realm and designated as “traditional” medicines. Johnston studied how “Native American traditional medicine is alive and vibrant...these traditions coexist with other formats of healing” (2002: 195). Kiesser and colleagues studied traditional, complementary, and alternative medicines (TCAM) and biomedicine to portray the medical pluralism of Mexican-Americans (2006:223). Brown et al decided that any practice African Americans were using, which was not biomedicine, fell into the CAM

category (Brown et al 2007: 751). What makes a medical practice CAM or traditional depends on who is using the practice and how the researcher sees its connection to the wider society. This is also the case with the spiritual and religious aspects of healing, such as prayer and faith healing. These healing practices fall into CAM, traditional, and religious healing depending on the time, region, and researcher (Powerpoint 9/16/2013).

For this thesis, the common understanding of CAM for participants and physicians relates closely to the first definition given of CAM: the practices, typically outside the healing practices that have in recent history been commonly accepted in the United States medical system including hospitals, clinics, and doctors. With its transition into the biomedicine realm, CAM adopted an additional name: “integrative medicine.” Integrative medicine is a term that conveys an acceptance by biomedicine, the use by biomedical institutions, and the adaptations of an alternative healing practice to fit into a biomedical setting. Again, this term is messy, since each medical practice within CAM is so diverse, with different levels of acceptance, and utilized differently by each biomedical healthcare institution.

The Development of Integrative Group Medicine Visits

To better understand how Integrative Medicine Group Visits (IMGVisits) fit into Boston Medical Center, a brief history of the hospital is needed. The merging of two hospitals, Boston University Medical Center Hospital (BUMCH) and Boston City Hospital (BCH), created Boston Medical Center (BMC). In 1855, BUMCH became known as the “Massachusetts Homeopathic Hospital” (Boston University 2012). Through the Evan’s Endowment of 1912, BUMCH became one of few hospital institutions that

had a partnership with a clinical research and education department. This endowment still supports Boston Medical Center today. It is important to note that BUMCH changed its name to MA Memorial Hospital between its establishment and the merger with BCH. During this time, the hospital had to officially drop its designation as a homeopathic hospital due to evolution in medical education requirements and the lack of student interest in homeopathic courses (McNamara 1998) Only in recent years has BMC rediscovered its homeopathic roots. BCH, established in 1864 as one of “first municipal hospital in the United States” (History 2012:1). Being a public government-run hospital meant that BCH had a diverse population of patients, including a large population of underserved. In 1996, the merger of these two hospitals created Boston Medical Center into the “largest safety net hospital in New England,” with the mission to help the underserved populations with “exceptional care, without exception” (“What makes BMC Special” 2013: 4-6)

In 2001, Boston Healing Landscape Project (BHLP) was developed at the Family Medicine Department at Boston Medical Center to examine “how the therapeutic landscape in the U.S. has changed in corresponding ways” (Barnes 2012). This program was developed with the further goal to confront the medical community with the “challenge of shaping positive response to the multiple approaches to healing being pursued by patients and their families” (Barnes 2012). BHLP helped begin rapport and understanding around the many healing practices that were being used within and outside the hospital. During this time, acupuncture was developing with the hospital as an accepted CAM practice. Highfield et al (2008) establish a free-care acupuncture clinic at

BMC to see if people, particularly adolescents, will be interested in this form of care. The researchers found that it was a success. During the years of 2004-2006, 544 visits were made, with visits increasing sixty-five percent from the first to third year (Highfield et al 2008: 629). An acupuncture clinic was established in the Pediatrics Department, Family Medicine Department, and others following this trial.

From these factors, the Initiative for Integrative Medicine and Health Disparities within the Family Medicine Department developed in 2004 after three years of a research fellowship. Dr. Saper, the spearhead for the initiative, explained how there were many complementary and alternative medicines being utilized in different capacities throughout BMC. He wanted to bring them together under one name to create more accessibility to patients and to engage interconnectedness between CAM programs (Personal Communication 11/14/2013). The mission of the initiative is “to substantially impact the quality of life for the urban underserved through providing access to integrative medicine clinical service, research, and education” (Family Medicine N.d.). The Integrative Medicine Clinic developed from this initiative and paved the pathway for IMGVisits to develop:

From here, I asked Danielle, the Integrative Medicine coordinator, about the administrative process that got IMGVisits accepted by the hospital. “Luckily, it was due to where the program was situated,” She said “we (Dr. Gardiner, Dr. Gergen-Barnett, Dr. Saper, and herself) met with the medical director of the family clinic. We just had to explain what we wanted to do, just like in the grant. Overall, the hospital administration did not get involved in the establishment of IMGVisits or other things that the Family

Medicine Department did. The Family Medicine Department is pretty autonomous. The only time that higher administration gets involved is when a department dips down in funds or tests, or another bar is established that must be met.”

As I was packing up, Danielle explained that the clinic and the IMGVisits were lucky as BMC was focused on patient-centered care. And if something is working for patients, it can be easily accepted. In addition, a doctor is teaching the class, which added a level of respect to the IMGVisits. “The three doctors are trusted and respected in the hospital, so the IMGVisits could hold its ground and be accepted.”

Through informal conversations with two physicians, I gathered a comprehensive oral history of the development of the Integrative Medicine Group Visits.

IMGVisits Development

After having a discussion about how my research was going, I took the opportunity to ask Dr. Gardiner for her oral history of the IMGVisits. “This is a fly by night introduction,” she told me. The physician began by saying there were two primers for the development of IMGvisits. “First, there is a huge wait list for integrative medicine. I want to say about 100 people on the waitlist currently. A physician can only see about four people per session to talk about utilizing integrative medicine a week. It would take years to get through the wait list, especially as it grows in size.” The second primer for change was that both her and the physician, who usually taught the IMGVisits, had both been to conferences and trained in Mindfulness Stress Based Reduction (MBSR).

The physician explained MBSR was developed by Dr. Jon Kabat-Zinn, she then continued by showing me the University of Massachusetts website about MBSR. Each group visit begins with a mindfulness-based meditation, which may be repeated once or twice more within one session. The meditation is used to engage in reflection with one's body and mind. It is training for the individuals to better understand how they are feeling physically and mentally, what they can do to support or reduce those feelings, and how to reflect on daily events of life (Kabat-Zinn Lipworth, and Burney 1985). In the first few weeks of a IMGVisits session, mindfulness eating is also introduced. An exercise is given where individuals are walked through eating a raisin, dried blueberry or another item. The participants are asked to smell, feel, hear, and slowly chew the food item. Reflections on the experience are given to understand how food creates sensations and interacts with the body. This practice is continued with the healthy lunch or snack provided at the end of each week. MBSR is a main practice continually used within the IMGVisits. This practice supports the individual in understanding themselves and being open to new information. In addition, it develops reflexivity in individuals, so they can understand what aspects of the IMGVisits, or larger daily life, need to be supported or diminished.

Additionally, the physician pointed that MBSR is a group model for health, which opened the door for creating group visits. Dr. Gergen-Barnett expanded on the MBSR's role in IMGVisits. Dr. Gergen-Barnett started with telling me that MBSR has been around since the 1970s. 40 years of scientific evidence based research had shown positive results in its use for pain and other health problems. Dr. Gardiner, Dr. Saper, and her were trained in MBSR, so it was a natural choice for the IMGVisits. It also

provided the foundation for the whole IMGV design. MBSR has a well-made curriculum for 8 weeks, so it was the best way to begin. It was the easiest way to begin the process of design.

Dr. Gardiner explained the importance of the centering pregnancy model. Dr. Gardiner continued by saying that Dr. Gergen-Barnett and her had been familiar and worked with centering pregnancy, which prompted her to take me to the website. Almost to her surprise, we saw the website had changed to Centering Health. She moved to the overview page of the website. Dr. Gardiner immediately highlighted the passage:

Centering is a model of group healthcare, which incorporates three major components: assessment, education, and support. Patients meet with their care provider and other group participants for an extended period of time, usually 90-120 minutes, at regularly scheduled visits over the course of their care. Centering promotes greater patient engagement, personal empowerment and community-building. (Centering Healthcare N.d.)

This passage defined the basics of IMGVisits, Dr. Gardiner stated. The length of time of each visit was about 120 minutes, which was positive for the participants had visits that lasted longer than the traditional 15 minutes with the physician. I asked what about the one on one factor that came from the traditional 15 minutes, Dr. Gardiner did remind me it may not be 2 hours with just the provider, but there was always time made for one on one. The assessment of health was completed throughout the 8 weeks of the IMGVisits. Education was incorporated into the weekly visits through the “doc talks” and

introduction to integrative medicines and MBSR. Support was provided by the group atmosphere.

To further pursue the point of support, Dr. Gardiner pointed out the quote:

"'Centering promotes greater patient engagement, personal empowerment and community-building' (Centering Healthcare N.d.).The centering health model and MBSR are what really allowed for a group model in healthcare to be developed." Dr. Gardiner explained the group model and the positives of the model. "The medical realm was/is originally set up in a vertical power structure for office visits. This means the doctor is in a state of power while the patient is in the quiet position of listening and following directions," she stated as she moved her left hand up to show the elevated power of the physician over the patient, which was represented by her right hand . For an example of this model, Dr. Gardiner said that if I had diabetes, she would just tell me to take my blood pressure medicine. "Vertical power, that doesn't work. The group model is more of a horizontal dynamic structure," Dr. Gardiner represented this horizontal structure by having her hands raised to the same height touching one another. She explained that the physician and co-leader become facilitators. The participants (which are the patients) have more space to talk and engage. It is a non-judgmental area for facilitators and patients. The group model also created the physician's "ability to get one message to many people. I can tell eight people once to take their blood pressure medication instead of saying it separately eight times, for example."

I asked why they added the doc talks to the IMGVisits. "It was due to people really asking for them" was her reply, "There was a consistent want for the doc talks.

Also, it creates a reason to have the physician there too, other than just as a facilitator with the MBSR instructor. It adds the medical layer. Especially, where most of the patients just don't know enough on all the things from blood pressure, cholesterol, effects of stress, and so forth."

Once the models of the IMGVisits were established, the physicians had to develop the curriculum of the program. MBSR and group medical visits were established first as a part of the original models that founded the ideas for group medical visits. The last part was incorporating complementary and alternative medicines. *Dr. Gergen-Barnett explained that they looked at what was good for pain treatment in the CAMs. She listed acupuncture, massage, yoga, and new to the group is tai chi. She explained that the IMGVisits were set up as a "smorgist board to allow people to pick and choose what they found worked effectively for them." To give them insight to all the options and modalities they had available to them for free at Boston Medical Center.*

Integrative Medicine Group Visits combines integrative medicine, MBSR techniques, and group medical visits models to create a new approach to healthcare treatment and education. The nutrition messages are nestled into all three components of IMGVisits including; nutritional doc talks, mindfulness eating, and herb supplements. As Dr. Gergen-Barnett stated, *"IMGVisits are still a work in progress. They are developing and growing to the needs of the patients."*

CHAPTER III: METHODS

This study used qualitative data collection and analysis methods to investigate what shapes a person's perception of food and nutrition to understand the accessibility and barriers of nutrition messages provided by the physician in a group visit setting. The primary site of recruitment and participant observations were at Boston Medical Center in the department of Family Medicine. The department of Family Medicine dedicated six physicians and one coordinator toward implementing a program focused on the use of complementary and alternative medicines in a biomedical setting. One of the many programs being implemented was Integrative Medicine Group Visits (IMGVisits). The IMGVisits allowed me to recruit potential participants as well as employ participant observation methodology, in addition to in-depth library research. Of the seventy-five patients in the group visits, ten consented to participate in this research.

My research question developed out of two academic interests. I have done previous research about complementary and alternative medicines (CAM) and the integration of CAM into the biomedical settings. I wanted to continue research with in this discipline, which originally drew me to the integrative medicine clinic. An initial meeting with the coordinator and one of the department physicians revealed the existence of an eight-week program focused on CAM practices. In particular, this program combined biomedicine and mindfulness practices. The curriculum section that dealt with food and nutrition also coincided with my interests. Previously, I had not had the opportunity to explore such issues outside the classroom setting and this presented itself as an ideal juncture. I found with further meetings with the physician and the coordinator

that research into this aspect of the group was needed and desired by the clinic. I suggested developing a proposal to evaluate what conveniences, as well as what barriers, existed in regards to nutritional messages. Fortunately, the clinic was also interested in highlighting such discrepancies. Subsequently, I developed a research proposal focused on determining what environmental and cultural factors shape a person's perception of food.

Institutional Review Board

In order to conduct research with human participants, I was required to take a training course on protecting human subjects and submit a research project proposal to the Boston University Medical Campus Institutional Review Board for the Protection for Human Subjects (IRB). The IRB had to verify that I was going to comply with all procedures that “protect the rights and welfare of human subjects of research” and follow “federal regulations and state laws to human research” (BUMC IRB 2013).

Following the training, I submitted my research proposal which included a structured proposal sheet and all materials that would be used in relation to potential participants. My proposal materials included a summary of the project, informed consent forms, a flyer and letter to be sent to potential informants, and interview questions that were to be used. Through careful explanations of my methods and analysis procedures and a few minor revisions, my research was found to be in compliance with the BUMC IRB.

Data Collection

Recruitment

My initial recruitment technique was to recruit a convenience population sample from both present and past group participants. A recruitment flyer would be presented to current participants by the Integrative Medicine Coordinator or by the Medical Physician, who had contact with all participants, at the end of the groups session during the allotted announcement time. If participants showed interest, the inquiry letter that was developed would be given to them for further information. In addition, an inquiry letter was to be emailed out by the coordinator to past participants, giving them a small summary and contact information for this project along with the flyer attached to the email. Not knowing the literacy of the participants, the letter and flyer were written at a 6th grade reading level in compliance with the IRB to ensure participants would understand it regardless of their reading level.

When recruitment began, I discovered that some of my recruitment methods had to be adapted to make actual application feasible. The recruitment letter was still presented by the coordinator at both present group visits that I attended (April to May 2013 and July to August 2013). Since I attended both presentations of the flyer, I answered potential participants' questions, which led to the inquiry letter not being passed out to participants. I also found that participants preferred that I tell them about the research rather than reading the flyer. The flyer was mainly used to keep the contact information. After further discussions with the coordinator, it was decided to mail the inquiry letters and flyers out, instead of using the email format. This form of contact

allowed for a better association between the group visits and the research for participants received all materials from the hospital, including group visits information, in the mail.

In addition to these small adaptations, I also had the opportunity to "piggy back" off another coinciding department study. The coordinator was completing interviews with group visit participants for a study the Family Medicine Department was conducting. For their research, the coordinator and co-investigators had IRB approval to implement "cold call" recruitment, which entails calling a participant without a prior engagement to ask him or her to participate in the study. During these phone calls, interested participants were asked if they would be interested in conducting an additional interview with me.

Each one of these methods proved valuable. However, the most fruitful methods were the presentation of the flyer during the group visits with me available for questions, and the phone call recruitment. To my understanding, these methods work best because a relationship and sense of trust had been developed with participants during group visits. By the time recruitment with flyers was completed, I had been participating with the group members for four to eight weeks, and relationships and trust had been established. The calling recruitment created trust because the coordinator and investigators already knew participants. This confidence in the coordinator and others made my research appear more trustworthy because it was they who were asking. The mailing of letters was the least fruitful most likely due to the lack of an established relationship. For instance, one participant stated that she had been rude to me until she realized I had a "bubbly" personality.

Participants

I designed the inclusion criteria for the study to be simple. A potential participant had to be participating or had participated in the group visits. Luckily, all potential participants for my study would fit the additional requirements stated set forth by IRB, of being 18 years or older and from the Boston area, due to the requirements of eligibility for the group visits itself. I initially projected 20 to 25 participants for the study. I revised my projected number of participants to ten to fifteen when I learned that the population of the participants was small. I realize that a small number would still allow for a large enough sample to find saturation of responses and generalizable data. In addition, the realization of three month time restraint on the research project and finding participants willing to participate created the need to reduce the size of the sample population. As one coordinator stated, "patients can be like herding cats" (Personal Communication: 7-7-2013). Even so, this small population was large enough to allow my research to find common threads between participants' experiences and perceptions around food and nutrition.

Following the recruitment process, sixteen group members expressed interest in my research project either to me or to the Integrative Medicine coordinator, and provided their contact information. Out of these sixteen people, three group members were unreachable, one was no longer interested, and two decided not to participate due to family and transportation complications. The remaining ten group members participated in the study. Seven of these participants I had met prior to recruitment through participant

observations at the active group visits. The last three were from past groups, who reached me by phone or email.

Table 2.1: Characteristics of Group Member Respondents

Age	Number	Gender	
30-39	2	Male	5
40-49	1	Female	5
50-59	4		
60-69	1		
70-79	2		

As seen in the Table 2.1, the distribution of participants was divided evenly between male and female (5:5). The age range was between 30 years to 79 years with an average of 50 years old. In addition, eight participants were born in the United States, while two were born outside the United States. Of those born outside the United States - one in Ireland, and the other in Honduras. Nine interviewees were recruited for the group visits due to chronic pain. One had been recruited due to their pre-diabetic status. Participants also sought relief for additional medical complications, such as anxiety, obesity, hypertension, and sleep disorders. Other than the recruitment requirements of diabetes and/or chronic pain, common comorbidities seen in the population are hypertension, obesity, and hyperlipidemia (high cholesterol) (RIP PowerPoint 2-2-13).

The sample population is about 1/7th of the whole population (75 total). The patient demographics of this study are representable to the whole population; however,

the demographics are not statistically representative. Sixty-one percent of the patients have an annual household income that is less than twenty-thousand dollars a year (RIP Powerpoint 2-2-13). The whole population was sixty-four percent black, ten percent hispanic, twenty-six percent was other. Seventy-one percent of the population is female and the mean age is 49.5 years (RIP Powerpoint 2-2-13). As I stated in the previous chapter, the sample population reflected the race percentage breakdown that was found within the population of IMGVists participants. Using more of a grounded approach, I did not collect what race participants would assign themselves. Opting not to ask participants to choose a race allowed the complexities of their family heritage and their identities to develop through their conversations of food.

Interviews

I designed a semi-structured interview guide with the objective to learn about participants' experiences and perceptions of food, nutrition, and health. Specifically, I wanted to learn more about the cultural and environmental factors affecting participants' food choices. Furthermore, I wanted to explore how the participants integrate and adapt the IMGVisits' nutritional messages into their ways of viewing food and health behaviors. The purpose of this study was to understand how the life of a person affects food choices, especially nutritional messages that are provided by healthcare providers. The guide leads the interviewees to answer questions on how a foundation can be created for culturally appropriate and specific nutritional message that fit the participants' daily lives.

I conducted semi-structured interviews, which allowed me to inquire about the participants' particular interests of concern and learn more about the use of nutritional messages. My goal was to complete all the semi-structured interviews in a "go-along" interview style. "Go-along" interviews entail simultaneous semi-structured interviews and participatory observations (Thompson et al 2012). These interviews were to occur during grocery shopping trips with participants. These trips were to take place where the participants chose. In application, only one participant agreed to complete a "go-along" interview. The other participants preferred to have a traditional sit-down interview. I determined eligibility of participants by checking with the coordinator that they were current or previous patients of the group visits.

Interviews were scheduled for approximately one to two hours; the length of time was chosen to allow ample time for the informant to fully answer each question. Interviews were scheduled for the convenience of the participants, which included the date, time, and place of meeting. These interviews were to take place in a locale in Boston, selected by the participant. Majority of these interviews took place at the Family Medicine Clinic, while only three took place near the residences of participants. The places chosen were commonly semi-private, quiet areas that allowed for the interview to take place in a comfortable safe environment for both the interviewer and informant. The informant was reminded that the interview was on a voluntary basis, and permission was asked before digital recording took place. There were no complaints about digital recording from any of the informants. Each informant was also given the informed consent sheet, which we reviewed and signed before the interview began.

Face to face interviews were used to allow for rapport to occur and to create a space for questions to be answered to their highest potential. In addition, questions were designed to build upon each other to make transitions between questions fluid. Probes were utilized throughout the interview process. The probe of silence was used to allow informants to think without guidance from the interview and produce answers on their own (Bernard 2011:162). The echo probe was used to repeat information back to the informant to make sure the interviewer understood the information (162-163). This probe also allowed for the informant to hear their own thoughts, so there would be an inclination to fix or add more to the statement if he or she thought something was missing. The tell-me-more probe was implemented to provoke more information from the participants about a specific part of their story (163). The “uh-huh” probe was used to encourage informants to continue talking and show that I was still listening contently to their story (163). Each of these probes aided in each question being fully answered before moving onto the next question. Interview length ranged from 26 minutes to 1 hour 45 minutes, with an average of about 50 minutes. Once the interview was complete, each informant was thanked for their time and participation.

Participant Observations

I attended three different eight-week sessions spanning from January to August 2013. I completed sixteen meetings that lasted between two and three hours. These meetings took place once a week for eight week periods; creating one group session. I completed some other participant observations at the family medicine department and nutritional kitchen. These places allowed for informal conversations about the group

visits. I also completed participant observations at nine separate food markets in and around Boston. I went grocery shopping to learn how people shop in these stores, what nutritional messages are provided, and to get a better idea what is available at markets where participants possibly shop. I tried to make the effort to go to specific markets where participants mentioned were places they shopped. During these participant observation trips, material culture such as photos and flyers were collected. Researchers have discovered that these items capture ways that people erect and reinforce the cultural messages important to them (O'Toole & Were: 2008: 618). Another material culture item that was taken note of was food choices of participants. The food chosen and created is a tangible product made through these cultural and societal influences.

Data Analysis

Transcription

I transcribed my interviews using ExpressScribe or Audio Speed Changer. ExpressScribe and Audio Speed Changer are free software that allows for keyboard control on playback and speed of vocal playback. These tools were helpful transcription tools. The playback speed control and back/foreground volume control allowed for easy to transcribe documents, when otherwise may have been difficult. I had to schedule interviews around participants' schedules, which caused space between interviews to vary greatly. Thus transcriptions took place as they could throughout the summer, and many were not touched until near the end of the interview process. However, extensive notes were taken throughout each interview that allowed for adjustment of questions throughout the interview process to occur.

Dedoose and Coding

I uploaded all interviews and field notes to Dedoose for content coding. Dedoose, being a qualitative research analysis program, allowed me “to facilitate the management and analysis of the data” (Dedoose 2011). The program gives the ability to create categories into which segments of interviews or other materials can be placed. Overall, Dedoose is organizing software that allows the researcher to see research patterns and themes in more detail and depth. Coding was designed to be multi-step process. The first round of coding I used methods such as structural coding and in vivo coding. In vivo coding is first round coding that takes words or short phrases that were actively used within the qualitative record, which allows me easy access to important terms and phrases that participants are using to discuss nutritional messages (Saldana 2009:91). Structural coding allowed me to code segments of data under a conceptual phrase that represented the topic of inquiry (84). This coding form allowed me to see what topics were important to multiple participants. I used the methods of pattern coding and theoretical coding to discover emerging themes across qualitative data in my second round of coding. Pattern codes are “explanatory or inferential coding...they pull together a lot of material into a more meaningful and parsimonious unit of analysis” (210). Pattern coding allowed me to see larger themes that brought together what seemed to be highly relatable codes across different forms of data. Theoretical codes are codes that function as “an umbrella” pulling together accounts of all other codes into a formed argument (223). Theoretical coding allowed me to see the larger web of how my themes interconnected into my final

analysis. This final coding step allowed me to organize my codes into major themes and subthemes that created the outline for my larger argument.

I also applied theoretical frameworks to my analysis. The two frameworks were phenomenology and critical medical anthropology (CMA). Phenomenology is “the study of phenomena as they appear to the consciousnesses of an individual or a group of people; the study of things as they appear in our lived experiences” (Desjarlais and Throop 2011:88). Using the phenomenological approach allowed me to focus on the lived experience of the participant and to understand their experience from their perspective. In addition, this theoretical approach allowed me, as a researcher, to investigate the factors of an individual’s experience that affect and interact with the perceptions of the nutritional messages being provided at the group visits.

CMA theoretical approach seeks to understand the causes of health disparities in relation to the larger social systems. This theoretical approach is “concerned with the ways power differences shape social process” (Baer et al 1986:95). Furthermore, power within the capitalist world system links to the access provided and control over health care systems, which in turn directly affect an individual’s health (96). This power includes material and nonmaterial resources of a society. The definition of health directly emerges from this concept of power: “access to and control over the material (i.e. drugs, clothes, food, etc.) and non-material (i.e. relationships, laws, policies, language) resources that sustain and promote life at a high level of satisfaction” (95). The CMA approach allows me to interpret and understand the daily life experiences of my participants, within social, political, historical, and economic contexts. CMA establishes the background for the

phenomenological analysis to create the larger picture of how participants' experiences are related to the larger political economic and power structures.

CHAPTER IV: IMGVisits AND NUTRITION KNOWLEDGE

Switching gears again, Dr. Gardiner passed out the healthy choice shopping list, food pyramid from Harvard University Public Health Department. Beginning with the shopping list, Dr. Gardiner took us through most of the foods individually. Yams and sweet potatoes were one of the first on the list. Edith¹ spoke first: “What is the difference between the two? How do you tell them apart?” With a laugh in her voice, Dr. Gardiner said that they label them in the store and that’s how she can tell them apart. Olivia commented that she mashed sweet potatoes, while yams cook better in bits. The meditation master mentioned the color difference as a way to tell them apart: sweet potatoes are more red while yams are more orange. Dr. Gardiner interjected that the color is important. It is the beta-carotene in yams and sweet potatoes which is good for the eyes, and that makes them the orange /red color. Angie stated she didn’t like either. Lee then asked whether baking or boiling breaks down the sugars in yams/sweet potatoes. Dr. Gardiner said she hadn’t heard there was a difference in chemical compound change just by different ways of cooking. She would have to look it up before answering that question.

As a participant, I found myself letting the information wash over me during this conversation, like many of the other nutrition doc talks. There was just so much information to synthesize, between physicians’ detailed explanations and participants’ informational tidbits. Everyone in the group was sharing their knowledge, making it hard for me, as a researcher, to keep up with my own synthesis of this new knowledge. From a

¹ To protect their privacy, the names of participants in this study are replaced with pseudonyms. This is a suggested guideline from the American Anthropological Association.

clinical perspective, nutrition knowledge represents information based on scientific “knowledge of nutrients and nutrition,” disseminated by healthcare professionals for patients to learn and apply to life (Parmenter et al 2000, Worsley 2002). However, the IMGVisits defined nutrition knowledge as a person’s understanding of the effects of food on the body, based on a person’s life experiences. “Humans then are prime information processors... so they will have different beliefs and knowledge” (Worsley 2002).

Worsley's work, like my research, points to the constructivist view of knowledge development, which emphasizes the “importance of knowledge, beliefs, and skills” that each individual brings to a learning atmosphere (“Classroom” 1995). The field notes above suggest the typical rhythm with which these forms of knowledge were presented: the physician states nutritional fact; participants offer questions and their nutrition knowledge; then the physician brings the conversation back to more biomedical nutrition knowledge (and “not knowing”). New understandings build on this previous knowledge, new information, and the individual’s readiness to learn (“Classroom” 1995), with various factors affecting each participant’s synthesis of the knowledge.

Where Do Participants Sit With Nutrition Knowledge?

I found myself a seat around the perimeter of the room in one of the many mismatched chairs and began my customary fidgeting with my pen. Not having a chronic illness and not being with the group for each of its weekly meetings added to my apprehension about sitting in on this intimate eight person group, which included the doctor and meditation master. The members took time to get to know each other by commiserating over their pain conditions. Most were there because of pain. Only one

gentleman had come because of fatigue and stress in his home life. People talked about how they “got” the pain, how they worked through it, the medication they were on, their ideas about the effects of those medications, and the procedures they had been through. They discussed how chronic illness had changed their lives, with special emphasis on work.

Chronic illness creates a particular “sick role” for these individuals in society, which Parsons describes as a social category in which a person is “disabled from fulfilling normal social obligations” (1951). A central concept of this concept revolves around the passivity of the “sick” individual, according to which he or she is supposed to passively follow orders to become better. However, Scheper-Hughes and Lock (1986) explain that a sick role may also be ‘an act of refusal’ that signifies a refusal to endure, to *cope* with societal norms and expectations. The sick role represents societal problems that are being individualized into a single human body.

Through their commiseration over pain and its effects on their lives, study participants described their transition into a state of being removed from social obligations, including work. One participant explained *she had a lawyer and her job knew that she was light duty with doctor appointments as a priority. She was participating in the IMGVisits, a back pain study, and other doctor-provided healing practices to become active with her young son again. Such an example suggests not passivity as a central factor, but rather an active effort to manage the positioning of the sick role.*

Many participants talked about trying to avoid a passive sick role: *One Latina woman, Carlina, explained how she tried to ignore the status of being ill—how she kept working even after the doctor had told her she should not do so. The doctor kept giving her notes to excuse her from working, but she threw them out and continued to work. Her boss found out only when her doctor faxed a note, at which point he talked to her and asked if she had received other notes. Carlina stated that she loved her job and did not want to give it up, but her boss enforced the doctor’s note and she had to stop working. She was in this class to feel better.*

Leder (1990) argues that individuals are “frequently oblivious” to their body in day to day activity. The body becomes a “background canvas,” only moving to the forefront when an acute or chronic illness, like pain, makes us “unusually aware of our physical being” (Shilling 2002). This was the case for many participants in the IMGVisits. Their conversations about pain, especially about “*trying not to let the pain become them,*” represent ways their bodies have shifted from the background to the foreground of daily life. They also illustrate how the sick role does not encompass the whole being, but rather can function as one among many roles or defining characteristics for an individual (Varul 2010). Charmaz (2000) describes how ‘a woman who uses a wheelchair because of multiple sclerosis becomes a disabled mother, handicapped driver, disabled worker, and wheelchair dancer.’” Like her, Carlina and other participants wanted to resist the imposition of a sick role on their identity.

The work of Scheper-Hughes and Lock (1986), Shilling (2002), and Parsons (1951) on sick roles point to the stages a person takes to become an IMGVisits patient

and participant. The individual first becomes aware of their body's having a problem—a deviance—requiring work to return to an acceptable normal (Shilling 2002, Scheper-Hughes and Lock 1986). The participants actively adopt different approaches to fix the deviant body, which may have included various conventional therapies. However, previous approaches did not help them to manage their bodies in the ways participants wanted, either by not alleviating the symptoms or addressing the core problem. Scheper-Hughes and Lock (1986) would suggest that the core problem may not even be in the human body, but manifestation of structural violence, which a regular biomedicine may not have the ability to address. A physician describes this process as “exhausting all other biomedical resources.”

They then decide to follow physicians' recommendations to try a group clinical therapy. They complete the bureaucratic requirements of being recommended, undergoing a clinical consultation to assess interest, and attending an individual or group orientation session (BMC Webinar 11/14/2013). The participants have already begun the process of wanting to change their situation by the point they reach the IMGVisits. In the “stages of change model,” used frequently by physicians, the participants are described as being in the action stage. They have noticed the deviance in their body (contemplative), decided to search for help (determination), and completed many actions to correct their body (action). The participants could be considered to be in an “extended action stage,” searching to improve their health (Straub2007).

From one angle, these actions rely on the physician's expertise to manage the deviant body into the world of health (Parsons 1951, Crossley 1998, Scheper-Hughes and

Lock 1986). However, participants did not view their choice to attend the IMGVisits in this way. *Many said that they were here because their doctor suggested they try it out. Aleese, a well-spoken woman, stated that she had wanted alternatives to pain medication, but that it had been extremely difficult to find a doctor who would help her find what she wanted for care. A number of others agreed, while nods and mmhmm's indicated others' support for her statement. Two mentioned that visit time itself was too short in a biomedicine setting. Dr. Gergen-Barnett reiterated these statements as she wrote them on the flipchart, adding, "What you are getting in biomedicine is not what you need."*

I found that participants began the process of working on their bodies with their frame of knowledge of what is good for their bodies. Many participants may have ignored their body and its health when the body was considered to be normally functioning, including the relationship between food and health. When asked about their decisions to try new nutritional messages, many of their responses focused on their health. An illness role, or a potential illness role, creates a bigger motivation for food choice and healthy eating than other factors in life (Sun 2008). Jamie, a soft-spoken 30 year old, who is a self-proclaimed "foodie", summed it up: *"Well, if you pay attention to your health and care about the future of your body [you have] the good sense to mind what you eat."* Participants' desire to remove the defining characteristic of being sick represents a position of readiness to activate their previous knowledge of food and body. It could be explained as the participants wanting to remove the title of sick from their table placard. Aleese's and Jamie's commentaries, along with those of other participants,

demonstrate how each was prompted “to search for assistance in restoring” oneself in a way that would create the “capacity to play social roles in a normal way” (Shilling 2002, Parsons 1951). The drive for restoration has brought them to the clinic, ready to learn about new ways to manage their body’s deviance.

What types of Nutrition Knowledge do Participants Bring to the Table?

The connection between a healthy body and food choices is one dimension of nutrition knowledge that constitutes a part of people’s worldview. It is therefore important for any new education program like the IMGVisits to recognize previously held knowledge, insofar as it affects the process of constructing new knowledge. Indeed, the approach known as “constructivist education” capitalizes “on learners’ previous experiences, multiple perspectives, and opportunities to embed learning in relevant social context” (Hunter and Krantz 2010). The IMGVisits may not directly attempt to embed information in the life-worlds of the participants, but all knowledge utilized by the participant will be synthesized within his or her life-world.

Schutz (1945) argues that a person constructs their view of the world, their “life-world,” based on shared and private “stocks of knowledge” and “natural attitudes”. While natural attitudes are the common-sense conceptions of the world, a stock of knowledge serves a person “as a scheme of interpretation of his past and present experiences, and also determines his anticipation of things to come” (Schutz 1945:74). However, Schutz recognizes that the real world is not only created by the present living population, but also by the social and cultural constructions of our predecessors. Knowledge is a composition of all these factors. Michelle Rosaldo further explores how the construction

of knowledge becomes an intricate part of a person's being through "embodied thoughts." She acknowledges that all personal experiences derive from a person's life-world, adding that, "cultural models provide a basis for the organization of activities, responses, perceptions, and experiences by the conscious self" (1984:140). However, Rosaldo recognizes that scientists separate and dichotomize a person's lived experience into cognition and emotions. She explains that cognition (thought) is a personal experience shaped by culture, while affects (emotions) are universal. Conversely, these two parts are never separated in lived experience but are, rather, "embodied thoughts" (Rosaldo 1984:143).

The notion of the embodiment of thoughts involves blurring traditional Western boundaries between mind and body. As Scheper-Hughes and Lock state "it is not always possible to see where nature ends and culture begins in the symbolic equation" of the body, for the body takes on representation of the culture that become natural aspects of the body (1987:19). Nutritional knowledge becomes embodied and part of the lived experience. Sobo (1997) illustrates the embodiment of knowledge in her research of Jamaican food consumption and body image. She focuses on how food is used to shape the "correct" physical body that conveys health and sociability. For instance, red wine builds healthy blood, while junk food creates bad fat that perpetuates body decay (Sobo 1997: 259). For a person to gain the ideal body shape dictated by conventional beliefs, one must eat the correct foods as defined by the culture, which are then embodied in the shape and consistency of the body.

Schutz and others show how the synthesis of particular biomedical nutrition knowledge becomes complicated, particularly because biomedicine has a tendency to present its knowledge, including nutrition knowledge, as something separate from a person's life-world and thus can be easily placed as an object into anyone's life-world. However, from a phenomenological perspective the previous knowledge someone has is embodied or embedded into a person's being.

Ellison examines authoritative knowledge as a body of knowledge that holds a high status of power within a particular social group (2003: 322). Ellison states "biomedical hierarchies of hospitals, medical clinics, and epidemiology tend to reproduce and privilege" technological interventions, professional and medical expertise, "while occluding ethnomedical knowledge" and embodied knowledge (2003: 323). Unlike other biomedical programs, the IMGVisits give space for previous knowledge to be brought to the table, considering its importance to synthesizing new information created during the group visits. Through my research, I learned that people are constantly acquiring food knowledge throughout their life that ties deeply into how they approach food. Moreover, I got a glimpse into how they interpreted their experiences as they constructed new knowledge.

Just as I finished setting up my interview papers, Frankie came around the corner into the abandoned waiting room. I could barely see her in the glass that formed the rest of the half wall before she turned the corner. She is about 5'4" and has an athletic build. I thanked her for meeting me. She told me that the demo kitchen she had just attended was really fun. Wearing khaki shorts and a long sleeve blue button-down with sandals,

she was dressed for comfort. She became animated describing her experience at the demonstration kitchen. Her hands moved quickly as she talked. I really think she could have been an auctioneer. We were talking loudly, which drove another gentleman, who had been on break, out of the space.

We walked through the consent form, signed it, and started the interview: “I am from Honduras. Born there and everything, so my favorite food was something called marmahon. It is like a couscous. It is big couscous and you eat it with chicken and stuff like that. Then it has a broth. It is like a stew I guess. That was my favorite meal. And we had friends who were Arab being in Honduras, they were from El-Salvador. We ate a lot of grape leaves, and this is going to make me hungry talking about these. And the food in Honduras would be pupusas. Have you had these?” I could barely keep up; I said “No, I haven’t.” “Oh man, they are so good,” she said, pitying my having missed out on something so tasty.

Ethnic heritage was one of the first factors that participants brought to the table. Bonnekeesan explains, “Food is seem[ingly] innocent and safe” to talk about, though such discussions produce “a wide range of ideas and beliefs as well as areas of emerging resistance to cultural diversity” (2010: 280). Vallianatos and Raine (2009) found that food is used to convey “meaning that is actively used in the construction of self.” Food becomes one outward way to share and represent knowledge acquired through living in a particular culture. Before explaining her favorite foods to me, Frankie had to explain where she came from, where her neighbor’s cooking came from, and whence her other favorite foods derived. It was a way to locate, explain, and represent the self.

Furthermore, it is suggestive of a narrative style that needs to be constructed to reference cultural conventions. Renato Rosaldo (1986) argues that more attention should be given to how personal stories are told by the individual. Through a discussion of Ilongot hunting stories, he illustrates differences between how a researcher and an Ilongot hunter retell an event. Expressions of excitement, emphases on particular events, improvisation—all are lost in the researcher’s story. However, those same elements of the narration are vital for the hunter. They represent the success of the hunt and the importance of quick improvisation and alertness, both highly valued by the Ilongot. The culturally constructed narration becomes the reference to the reality, the life-world of the individual.

Ethnicity and food are more complicated than simple identity markers. People define their ethnicity and divide foods in different ways (Buckser 1999, Beyers 2008). William, for example, begins to explore how he uses his personal experiences as an Irish immigrant to learn about the “American diet.”

I: Where did you learn these foods were healthy? Was it from...

W: Well I always knew what I grew up with was healthy.

I: So you just tried to replicate that?

W: Well... but then you become Americanized. You like pizza. You like Chinese food. And then, you know I didn't have my first pizza until I was 19.

I: Wow that is awesome. How was that?

W: I didn't have my first Chinese food until I was 19.

I: Wow. Is that when you came to...?

W: Yeah. Came to America.

I: How was that to approach that? It must look so different than vegetables.

W: First, once it was so weird. I looked at it. (Holding hands up like holding a slice of pizza and moving it side to side “looking at it”). But then you get to like that stuff. But I have been backing off of that stuff. But don’t get me wrong I like it, but because my cholesterol is high, my blood pressure is high borderline diabetic.

I: You just have to back away?

W: Yea. Yea.

I: So do you think you ate it a lot more after trying it at 19? Was that more of your meals?

W: Oh yea. The basic you know was veg, meat or chicken or fish. That was the way we grew up and that was the way it was.

I: Right.

W: You know very few fried foods.

I: Right so it was when you came to the U.S.?

W: Yea.

I: Then you ate more of the Chinese and...

W: Exactly.

I: Ok and now you switch more back?

W: Yea. I have to. I have to.

Vallianatos and Raine’s (2009) work with Arabic and South Asian immigrant women in Canada touches upon another important aspect to participants, which is the connection to family knowledge. The first place a person learns of nutrition knowledge is from family cooking. The researchers found that these women used food as a way to

teach values, well-being, and culture to their children. Greenhalgh, Helman, and Chowdhury (1998) found that “successful management of diabetes requires that we understand the lifestyle, beliefs, attitudes, and family and social networks of the patients being treated.” The researchers argue that the family taught health through a different model of nutritional food and bodies, based on foods being “hot/cold” or “strong/weak” (Chowdhury et al 2000). Cassidy (1982) addresses how patients carry multiple models of health, with implications for their understandings of health and their bodies. Remembering that patients embody multiple models of what is healthy, nutritious food, and body can help biomedical professionals to employ and synthesize models of understanding to better transmit new knowledge (1982: 325).

Greenhalgh et al (2011) found that a family member must eat what the rest of the family is eating, because this is one way to be established as a family member. Jack, an elderly African American, arrived wearing clothes that were too big for him, due to recent weight loss that he attributes to the mindfulness eating practices he has picked up from IMGVisits. He explained his own concept of family food knowledge:

JJ: Back then you know, back when I was married and living at home. We didn't have dieticians. My wife was the dietician.

I: Yeah.

JJ: And when I was back with my mother and father, my mother was the dietician. You know we couldn't afford damn dieticians. Those were for people who had money.

I: Yea. So, the cooks or the people who were cooking were the ones who were really defining, decided the food.

JJ: Yup.

Family memories are some of the first embodied experiences a person develops. Not only is the connection between health and food established, but also taste preferences, parental roles, and gendered tasks. For Jack, cooking falls into the labor division of women. Furthermore, providing food and nutrition falls into women's domain of authority. The gendered and parental roles can become an important aspect of family memories. While many participants are single-person family units, others live in households where the females are delegated and accepted as the authority of nutrition. IMGVisits may have to contend with teaching people not only how to change their nutrition consumption, but also how to empower them to make their own food choices in a family context. For example, Aleese explores not only the socialization of food authority, but the development of certain emotions in relation to food. She explains how a family experience led her not to like fish, particularly salmon cakes:

AF: I have a great story what she did to us one time.

I: What?

AF: I hated salmon cakes. It was big. So apparently we sit down for dinner, mom, dad, my brothers and me and we are eating salmon cakes. And I don't like them anyway; they still taste nasty to me. But something didn't taste right. Something was wrong with the salmon cakes. "Well nothing should be different, I used the same cooking oil, the same everything" my mother said. My father had put motor oil into a mayonnaise jar and left it. It got incorporated into the used oil and my mother cooked the salmon cakes in the motor oil.

I: Oh my goodness

AF: So I didn't like them before and certainly until this day I don't want them anymore.

I: She doesn't live it down does she?

AF: No no no. We still remind her of that. She is 90 now, but it is still a running joke.

Through these lived experiences, nutrition knowledge as embodied thoughts linked to affective states is constructed. Such lived experiences accumulate throughout a lifetime, as the built environment interacts with a person's life-world.

Bourdieu's theory of habitus is a foundation of lived experiences, developed over a lifetime, through interactions with the built environment. As discussed in Chapter III, habitus is “a set of dispositions, internal to the individual, that both reflects external social structures and shapes how the individual perceives the world and acts in it” (Power 1999:48). Amir (2011) expands by defining habitus as a “way of describing the embodiment of social structures and history in individuals.” As a biological need, food embodies sociocultural meanings for human life. Culture, ethnicity, and family memories of nutrition and traditional foods create the embodied history that is part of the habitus. Habitus is shaped, in part, by the food people eat.

Media operates as another powerful structure affecting participants' outlook on nutrition, particularly through talk shows and news shows presenting health findings. *Near the end of a doc talk, Edith asked if it was true that it was healthy to drink chia seeds with water between meals to create a “filled” feeling. This way you are less hungry and less likely to snack on nutritionally poor food between meals. Dr. Gergen-Barnett asked where she heard this. Edith said, “Dr. Oz.”* On multiple occasions, participants mentioned “Dr. Oz” as a source of health knowledge. They also brought up information they had learned from other shows, when the doc talks presented them with new

nutritional knowledge that contradicted what they had previously learned. *People had many questions on why all fruits were always taught as healthy, while there were ones that had way more sugar in them than others. “Why are mangos presented as healthy in research?” may have been one of the many questions. Dr. Gergen-Barnett said that all these facts were self-learned throughout the years. She had not been taught them in med school. It was practice in self-reflection as well as double checking sources to make informed decisions. Frankie spoke up saying media doesn’t make it any easier to learn about healthy food. The media bombards us with ads for food that are not nutritious. Frankie asked “Why not just tell us what’s good to eat?” Dr. Gergen-Barnett’s reply was “There are a lot of things that want to be sold.”*

Information mediated by talk shows and other commercial outlets may be so ingrained in a person’s life-world that it becomes a natural attitude, a kind of common-sense knowledge that one assumes everyone else knows.² Such sites, both mentioned and unmentioned, may all be areas where nutrition knowledge develops and enters into a person’s understanding of the world—especially when considering what participants generally critiqued about the IMGVisits.

Edith asked for her survey back, saying she had thought of an idea. She explained that she wanted more ideas on how to cook meals. She explained that toast and tea would otherwise be all she would eat without switching things up. She is now cooking for herself and feels so dumb not knowing what to prepare. During group visits and interviews,

² While participants mentioned these two forms of media in class, they did not discuss other kinds, such as cooking shows. I realize that this may be due to a majority of the participants being of low economic status or preferences in television shows; however, I did not pursue this line of research.

participants observed that recipes were the one thing they thought would improve the IMGVisits. How are we to read this interest? Are participants looking for the skills to cook the foods being presented? Do they need inspiration to know what foods can be cooked with others? Or is it something more? Are they trying to find a way to connect this new food with their habitus?

Lucy, an 86-year-old straight-talking woman with graying curly hair trimmed short, explained her view on connecting previous knowledge to new.

L: I think they need you to figure out a way to, if you can figure out a way for people to get them to participate in a way that they feel they are a part of it, not just being taught, you know that they are a part of umm (30 second pause)

I: Of learning of these foods?

L: Yeah. yeah. And I also think it is important to do more with the class and encourage people that don't speak up to encourage them to speak up. Also, for instance, you could go around the circle and ask the people, if they are from Haiti what do you eat? It is a way to do a cross-cultural transference because people in Haiti don't eat something that I do. You know, my parents are Southern, but I was born in Massachusetts. And some people, you know, there was a guy in my program that he was a Muslim. So I think this program is an opportunity to transfer from knowledge to other people just like customs, foods, etc. And behaviors. I thought it was very difficult for people who spoke English as their second language very very difficult for sometimes they didn't understand because of the mentioning of food being said. I would have like to know how to cook a Haitian dish.

As Lucy began to explore, she felt that people needed individual time to talk about their previous knowledge, as a way to create better understandings of the new knowledge being provided. She wanted space for others, like herself, to learn about further nutrition knowledge that she might have been able to use in her daily life. Lucy was aware that new nutrition knowledge must be fit into previous culturally constructed knowledge for a person to assimilate it into their life-world.

The design of the IMGVisits may not leave time to delve into and tailor new nutritional messaging directly to each person's habitus. They do, however, have class activities that establish a safe place for learning beyond the constructivist view of understanding "previous knowledge, new information, and readiness to learn" ("Classroom" 1995). The IMGVisits created space for social support that allowed people to explore their own understanding, share information, and choose what works for them.

Group Setting, Social Support, and Nutrition Knowledge

"Ok, let's recap," Dr. Gergen-Barnett said as she moved to the board, "What are take-homes from the last eight weeks for you?" I was surprised to see that the first eight things were food related; from the saying "eat your medicine" to glycemic index information, to mindful eating. A pause followed the rapid fire of the first group of points. William was the first to break the silence. "The mind is a big powerful thing," he said. He went on to explain that he had not wanted to talk at the first group, but had kept his pain to himself. It was not until a few meetings that he warmed up and felt as though he could talk. Robert continued, saying he actually found himself coming out of his "comfort zone" within the group, to talk and share ideas. He felt as though people really wanted to listen to him. Aleese followed up by saying how she liked that the group came from diverse life backgrounds. She had realized that everyone here has pain helps you gain a better understanding of the group members, and that you yourself are not actually alone. We all learn together in the process, a co-creating of habitus.

Through the three different groups and multiple weeks spent with each, I learned how important social support can be, whether in creating the table setting, the atmosphere

for participants, or the dissemination of nutrition knowledge. Jackson (2005) examines the application of “liminality” in understanding a clinic’s relationship to chronic pain patients. She explains that pain—especially chronic pain—because it is physically invisible is ambiguous. Its undetermined origin renders patients “matter out of place” (2005: 333). Douglas's term "matter out of place" is used to explain any phenomena that do not appear to fit into in a culture’s established categories (1966: 36). Pain, however, does not fit into any one origin, diagnosis, or treatment, making it an illness that doesn't fit into a traditional biomedical category (Jackson 2005:333).

Constructions of chronic illness, including pain, support Jackson's findings. Wellard (1998) has explored the biomedical, psychological, and social constructions of chronic illness. She found that distinguishing the individual from the norm prevails throughout all categories, making chronically ill people "responsible for their illness" (Wellard 1998: 52-54). Couceiro-Bueno specifically examines the construction of pain. He argues that all pain, from physical to emotional, becomes something from which individuals want to separate, in order to become another being (Courcerio-Bueno 2009: 306).

For Jackson, the liminal state becomes a breeding ground for stigma, vocalized by both medical professionals and patients, even in group self-help settings (2005: 334). This vocalized stigma becomes a part of the chronically ill patient’s habitus, leading them to embody the sentiments used to label them daily. While participants may have experienced themselves as living in a liminal state, I did not observe chronic illness being

stigmatized in the clinical setting. Rather, the group medical visit created a space for social support, a place to connect to others in similar situations and share life experiences.

Lavoie et al (2013) explains the phenomenon of social support in group therapy, applying the terms “social event” and “affiliation.” “Social event” refers to the space where people have time to talk and connect, while “affiliation” is where “the group acts as a community in which participants share common experiences” (2013:4). Mackenzie et al (2007) suggest that these shared experiences create “social relationships [that] buffer the severity of individual perceptions of life stressors” and provide “support to handle the environmental demand.” Indeed, this is the nature of social support: shared experiences in this group setting helped dissipate the participants’ feelings of being “matter out of place” (Lavoie et al 2013, Jackson 2005). It also created a table for participants to exchange information and co-produce understandings about the nutritional messages they were learning in the class. The IMGVisits create a place where healing practices are applied to daily life through shared narratives:

Edith begins a conversation with the group. She says it was so hard to “place the oxygen mask on herself first,” because she always would help someone out before herself. She was referring to Dr. Gergen-Barnett’s use of the metaphor of “putting your own oxygen mask on, before helping others” during an airplane emergency, to illustrate why a pain sufferer should take care of him- or herself before the needs of others. Angie nodded: “It’s a hard process, but I am practicing, especially now that I am in pain all the time.” Aleese added that Edith should focus on her own health: “It is hard, but pain is not something to mess around with.” Edith agreed. The pain was the only reason she was

even considering saying no to her family's needs. She had always helped others, but could then easily be laid up in bed for the day in great pain. Now she wanted to learn to say no, even if it took a long time, because she knew she needed to for her health. Dr. Gergen-Barnett said that was a great start: just saying it.

The group setting gave these women a place to speak the common language of chronic pain. They, along with the other participants, came together in shared suffering. They understood how pain had limited each of them, but were now trying to live their lives without pain. Recalling the image of the wheelchair dancer, the IMGVisits allow the participants to set aside the role of "disabled." People understand how a chronic illness impinges on other aspects of life. Behaviors and thought-processes that revolve around the pain or other chronic illness become the norm, as the group established its own comfort level.

Support and Knowledge

Scheper-Hughes and Lock (1986) explore the role of the medical clinic, arguing that medicine "wears two faces" when working with a sick person. The clinic can be the "antidote" that addresses the deviance and refusal to endure. Parsons (1978) explains this potential clinical role as isolating the sick from the well, "in order to prevent the use of sickness as an active, collective protest strategy." Yet the clinic can also provide a "reprieve" from suffering that creates the "opportunity for more autonomous and creative action" (Scheper-Hughes and Lock 1986: 139).

Scheper-Hughes and Lock's model focuses on the political economy of health and illness. The idea that a person and their body, by refusing to cope, thus become deviant

and reflect a larger rejection of social suffering. This observation further relates to Jackson's argument about the status of being liminal. The category of chronic illness creates this liminal state, once the illness progresses past the stage of being acute but curable, and biomedicine's traditional goal of bringing the patient to a "normal state of health" is no longer achievable (Wellard 1998:49). Chronic illness becomes the care of a sub-healthy patient, who occupies a state between health and disease (Zhan 2009).

It could be considered that Jackson is talking about one aspect of the social suffering discussed by Scheper-Hughes and Lock. Participants like Carlina struggle with being unable to work, or like Edith to help their families or fulfill other daily activities. This struggle creates social suffering. Through the mindfulness training and shared experiences, the clinic allows participants to commiserate. The commiseration allows participants to reflect in a larger sense their position as a group in society; chronically ill patients. It also allows for personal reflection of position in life in relationship to their illness. For example, an individual may be the female matriarch, the loving grandmother, who cannot show her love through picking up her child due to the chronic back pain. I found that the IMGVisits did not adhere to Parsons's model of subjugating patients and creating more stigma as Jackson suggested, but rather implemented the second "face" of Scheper-Hughes and Lock. The view that the clinic can create the "opportunity for more autonomous and creative action" aligns with the physicians' expectations for the IMGVisits and with many of my own observations of group visits.

The physicians expected that the group visits would create a place where participants felt empowered to make informed decisions. With this objective in mind,

they actively created a welcoming table for everyone to sit at and learn. *There is the ability for group members to talk to one another, commiserate and help one another. Understanding is facilitated by group interaction and guided by the physician and co-leader. It is powerful, Dr. Gardiner stated.* Shared experiences, “which refers to the interaction between the group members during the weekly drop-in class,” enable the “co-production” of knowledge (Mackenzie et al 2007, Lavoie et al 2013). In turn, co-production of knowledge is the very process by which people synthesize the understandings that are shared, with physicians only facilitating where they encounter information gaps. *Lee then asked whether it is baking or boiling that breaks down the sugars in yams/sweet potatoes. Dr. Gardiner says she hadn't heard there was a difference in chemical compound change just by different ways of cooking. She would have to look it up before answering that question.*

The food knowledge generated through co-production goes beyond the biomedical nutrition knowledge presented in the doc talks. For example, participants provided shopping tips to help others access the foods suggested in the doc talks: *The next statement on the board pointed to canola oil as a really good option that is low in saturated fat, but with a high cooking temperature. Edith said that she had found a great cooking oil at Price Right. She said it was 1/2 canola oil and 1/2 olive oil. She uses it for a lot of her cooking. Dr. Gergen-Barnett responded, saying that was a great option.*

Participants asked many questions about how to prepare and cook the food options, while also trying to provide each other with support and insights. *Dr. Gardiner moved on in the list to “Berries: blueberries, strawberries, blackberries.” Beside these*

food items was the note “frozen=lower cost, pick from wild=free.” Dr. Gardiner made sure to point out that buying frozen was just as healthy and cheaper! Frankie asked about making smoothies—was that a good choice? She had been making frozen homemade treats with her “yo-nanas” machine. Dr. Gardiner thought it was a great way to consume these ingredients. Angie asked whether the nutrient unit was similar; the consensus was, yes. She then observed that it was something she had had, but hadn’t used much. For some reason, she always bought kitchen items; now she was going to have to try it.

The IMGVisits and their clinic wear the second face of Scheper-Hughes and Lock’s argument (1986). The physicians, co-leaders, and overall clinic do not present themselves at the table as the “antidote,” but rather a place of “reprieve.” (1986: 139). Shared experiences and co-production of knowledge helps create the connection between individuals to realize the social suffering; however, the individuals ultimately have the autonomy to choose and consume information in their own way to reduce their feelings of social and personal suffering.

During one of the eight week sessions, participants go to the Nutritional Resource Center to watch a meal cooked at the demonstration kitchen, and to learn about healthy food choices from a nutritionist. *After the demonstration kitchen, William, Aleese, and I walked out together. I listened to them chat. They exchanged recipe sheets, while talking about beets which, William commented, he really likes. In the recipe-exchange box outside the Demo Kitchen, Aleese found one for beets. She gave it to him, so he could cook one of his favorites. He told her that he was new to all the foods we had just eaten. Even the beans were new to him. Aleese, in turn, explained that she had been a*

vegetarian now for 20 years, so she loved beans. The nutrition knowledge held by the participants thereby supported and enriched the formal instruction, providing information ranging from shopping lists to recipes, strengthening the basis from which participants could make informed decisions.

Flattening Authority and Nutrition Knowledge

In Parsons' sick role, the physician-patient dynamic operates as a hierarchy. The physician's knowledge about illness and treatment establishes his or her authority and related power, while the patient must obediently follow directions in hope of becoming well (Varul 2010). In contrast, the concept of flattened authority, or a horizontal dynamic, is based on changing these roles. More specifically, "The accessibility of knowledge" provided in the IMGVisits setting is designed to "[flatten] the knowledge-power hierarchy" (Kirmayer et al 2013). The different forms of exchange that build rapport and a social network for participants and facilitators of the IMGVisits contributes to this model of flattened authority.

What Did the Physicians Expect?

The group model, Dr. Gardiner explained, is more of a dynamic, horizontal structure (informal conversation June 2013). She went on: the first mechanism to flatten authority requires the physicians and co-leader to allow participants space to talk, engage, and affiliate with one another, while serving as facilitators of the group. The table becomes round, with everyone considered equal in authority. The group enacts this imagery by sitting in a round circle, where no person is behind or ahead of another. While this begins to flatten authority, there remains the challenge of the physician's presence, as

someone who had particular knowledge. For example, many of the participants directed their questions to the physician, who might answer them, allow others to interrupt with answers, or defer to the group to create an answer.

The process of being a facilitator still exerts some control over the group and its direction. However, the physicians and co-leaders made every effort to become as much a part of the group as they could, through being honest and giving space for others to talk. At the beginning of the chapter, Edith's and Dr. Gardiner's conversation on how to tell the difference between a sweet potato and yam illustrates how a physician and co-leaders becomes a regular member of the table. The physician speaks honestly about her own nutrition knowledge, even when it falls outside her expertise. This attitude of humility and acknowledged ignorance contributes to the social support and social ties created in the IMGVisits, with related effects on the accessibility of nutrition knowledge, as discussed earlier.

The IMGVisits implement another mechanism to flatten authority called the “toolbox” method. *As the introduction continued, Dr. Gardiner took time to explain that acupuncture, massage, yoga, and other activities would happen each week for participants to try, to help them learn how to manage their pain and other chronic illnesses. But it was up to the participants to choose what methods work best for them, to continue those after the IMGVisits. She emphasized that the participants were “empowered to say no when they need to.”* Likewise, during each group's first IMGVisit, and throughout all eight weeks, she and Dr. Gergen-Barnett reiterated that participants were allowed to pick and choose what methods worked best for them, usually

using the metaphor of each participant having a toolbox. The methods being taught were tools, and each person had to choose which tools were best for them. In trying to assure that all the tools would remain available to the participants, the IMGVisits drew only on therapeutic practices accessible through BMC. The physicians did not want to give the participants a *taste of something they couldn't do outside the group freely and accessibly, especially where some CAM practices are so expensive*. This approach in particular addressed what otherwise frequently function as barriers to access.

The toolbox method proved successful, by allowing participants to learn and use nutrition knowledge in ways that worked for them. Take Sharon, for example—a hip hop dancer in her mid-twenties with a lot of spunk, who loved to wear huge colorful earrings. During one of the doc talks, Dr. Gergen-Barnett was discussing the anti-inflammatory diet. *Sharon, Olivia, and others were talking over each other about what food they enjoy eating, their thoughts on whether the food from the anti-inflammatory diet would taste good or not, and questions about how to use the food being presented. Dr. Gergen-Barnett brought the group back together, saying, “Remember to eat in moderation.” She explained that people did not have to completely change their diet to follow the new food pyramid, which is about anti-inflammatory foods. “It’s to reduce inflammation that is helping cause or aggravate your pain.” Sharon spoke up, “Oh yeah, I am here for the pain. I forgot why I was here.” Dr. Gergen-Barnett laughed with the group, “Yes, it is not just a diet course.”* While Sharon resisted learning nutrition knowledge at the beginning of IMGVisits, as the group progressed she found nutrition knowledge that applied to her habitus. *Dr. Gergen-Barnett asked what our thoughts were on the*

IMGVisits. Sharon piped up, explaining that she loved the salads that they created for the luncheons. These salads led her to try different veggies, leafy greens, and beans, because she had never thought about them before. She also had been trying to make different salads at home. The toolbox method gave Sharon the authority to decide what worked best for her when constructing her nutrition knowledge. Co-creating knowledge empowers people to expand their habitus in relation to how they view their liminal state and to what actions are best for them to take to alleviate their sickness.

Furthermore, the hospital provides additional resources that the participants may not necessarily be able to receive anywhere else that helps support the tools provided at the IMGVisits. Physicians and patient navigators assess and provide resources from social work services, including disability forms, parking vouchers for the hospital, various testings for free, social work consultations, housing lawyers, and more. These resources allow participants to address the daily struggles that are affecting health, so individuals can focus on tools to heal themselves. The physician and clinic bring a therapeutic alliance between the participant and the healthcare world. The alliance represents the goal to support the individuals in every way possible to clinic; to give the individual control over one's own health.

Conclusion

Nestle et al. argue, "Eating behaviors are acquired over a lifetime; to change them requires alteration in habits that must be continued permanently—long beyond any short-term period of intervention" (1998: S50). Nutrition knowledge develops in an individual's habitus as a result of cultural determinants, family preferences, and other lived

experiences. Each individual's habitus is different, making an individual's knowledge and the new nutrition knowledge that is brought to the table unique. The physicians of the IMGVisits recognize that "dietary advice is far easier to give than to accept and adopt" (Nestle et al 1998: S50). This recognition leads to the model of the flat, round table, where no one person is an authority. It is a table where lived experiences can be expressed, shared experiences created, and "tools" provided, not force fed. The flattening of authority and social support allows each participant to feel welcomed to the table, as a place where each one can produce, accept, and consume knowledge in ways that work within his or her habitus.

CHAPTER V: NUTRITION KNOWLEDGE IN A WORLD OF STRUCTURES

“Grains! What do you think of?” Dr. Gergen-Barnett asked as she pointed to the bottom of the retired USDA food pyramid. “Glycemic Index from last week,” I offered. Dr. Gergen-Barnett, laughing, replied, “That is why I think people are fat. We have been eating grains, which have been recommended too much. There is so much sugar in grains that we have high sugar intakes, too.” The conversation moved on to the dairy section of the food pyramid, which she related to the same issue of grains. The cow industry demanded help for their production which, in turn, led the government to make these recommendations to the public. “Oh those lobbyists” William said with a mischievous smile. Dr. Gergen-Barnett furthered the conversation by saying that these recommendations do now include exercise; however, she added, it was still not good enough: “Food is political sometimes. We need to remember that food is not pristine or unaffected by the structures in society.”

As I began to organize my scattered notes, I noticed that structures and their effects regularly arose in IMGVisit discussions. The word “structure” is a common term, applied to many aspects of a person’s life—and not necessarily just the brick and mortar kind. For example, participants focused their discussions on family structures, with side notes ranging from ethnic and cultural rules, to political-economic structures, to infrastructures related to transportation and grocery stores. I will address these different structures throughout this chapter, but first, pose the question, what *are* structures?

Many researchers divide “structure” into two distinct but interconnected parts of a whole. First, there is an “unequal distribution of power and resources,” which is

“nobody’s fault” (Sewell Jr. 1992:4, Lane et al 2007: 417, Farmer 2004: 307). Through time and practice, structures become tangible or intangible processes that become parts of society that cannot be pinpointed to any particular person or period of time. For example, Farmer (2004) explores how Haiti’s poverty stricken economic position was developed through slavery, French embargoes, and the AIDs stigma that spanned over 200 years.

Second, structures encompass the resources (or lack thereof), that either enable or constrain a person to act as they choose within society. For example, Baer et al. subdivide such resources into material and nonmaterial categories. Material resources are those graspable objects that carry capitalized value in a society (e.g., money, houses, cars, or clothes). Non-material resources entail abstract capital, whose value derives from symbolic investment—education, laws, honor, relationships, prestige, and the like (1986:95). These objects “can be used to enhance or maintain power” (Giddens 1979).

To develop my definition of structure, I turn to the work of Pierre Bourdieu (1986), who divides the resources that people utilize into three kinds of capital: economic, cultural, and social. “Economic capital” refers to the accumulation of different forms of material wealth. “Cultural capital” involves information, whether in an embodied state (i.e. permanent disposition of mind and body), an objectified (material) state (i.e. pictures, books, instruments, machines, diplomas, etc) or an institutional state (e.g., location within an education system). “Social capital” points to the sum of potential resources that derive from networks of formal and informal relationships (Bourdieu 1986). Bourdieu argues that capital from any of these categories may or may not carry

symbolic importance (i.e. honor, prestige, attention) deriving from socially instilled schemas. For example, in the United State owning a Mercedes vehicle (material capital) carries additional prestige, because it is known as an expensive car. People who own this vehicle therefore derive more prestige than the individual who owns a Ford Focus. This added importance given to specific capital is called symbolic capital (Schwartz 1997).

Bourdieu draws on his analysis of capital to examine how the different kinds come together to generate structures. He argues that, first, an education system reproduces the cognitive and social fundamental notions of the society, reinforcing class stratification. Second, the class stratification results from habitus, where the individuals embody their social placement that the educational system and social life has taught them as their proper position. The embodiment of social placement also creates the lens in which the world is seen through. The structures of the society and their effects on the individual become expected. Individuals reproduce this naturalized view of how society works (Bourdieu and Wacquant 1992). Sewell Jr. states, “Structures, in short, empower agents differentially, which also implies that they embody the desires, intentions, and knowledge of agents differentially as well” (1992: 21).

In Bourdieu’s original work, habitus was a way to understand social class and social mobility. His works about capitals supported his exploration of habitus, for capitals comprise the different elements that indicate a person’s social position. While it can be argued that health is an indicator of social status, the goal of the IMGVisits is not for social mobility. The IMGVisits cause participants to reflect on habitus and provide different forms of capital to participants with the only goal being health betterment. With

this in mind, I constructed a definition of structures. For my purposes, structures are social systems that generate and reinforce hierarchies of power. They are expressed through the macro-cultural, sociological, and political-economic arrangements that give individuals access or non-access to the different forms of capital. (Bourdieu 1986, Baer et al. 1986).

Agency and Adaptation in a World of Structures

A common assumption by researchers is that structures are both fluid, on the one hand, and reinforced by its actors over time, on the other, even as the actors themselves are seen as static parts of the equation (Williams 1995: 585). Yet my findings suggest that people are not simply static pieces within the structures that constitute their environment. Instead, they participate actively in the process of building and applying new nutrition knowledge. The term “agency” is used to describe this phenomenon, in which individuals act as active individuals. Wohldman defines agency as an actor utilizing resources to accomplish goals (Wohldman 2013:456). Sewell Jr. characterizes agents as “hav[ing] knowledge of the schemas that inform social life and have access to some measure of human and non-human resources” (1992: 20). Frank (2006) and Barnes (2009) suggest that agency is limited by specific “cultural confinements,” reminding us that people can only work within the cultural and social frameworks familiar to them. Decisions are made within the social, political, and economic forces that constrain each individual (Barnes 2009: 144).

Bourdieu’s understanding of structures creates a bridge between my observations about structures and agency. As stated above, habitus “provides individuals with class-

dependent, pre-disposed, yet seemingly ‘naturalized’ ways of thinking, feeling, acting, and classifying the social work and their location within it” (Williams 1995: 585-586). A habitus “only exists in and through the concrete practices of the individual, embodied agents, situated in time and space, and their interaction with others and their environment” (Williams 1995: 585). Constant reinforcement of a particular view creates the habitus. Bourdieu (1979) asserts that it is difficult to change one’s habitus, given these daily reinforcements, but a person can still alter their habitus or even create a new one. To succeed, however, the individual must constantly put effort into thinking, acting, and embodying a new way of being. Such actions are what create “the junior clerk who bluffs his way into being accepted as a well-heeled investor and by good luck turns pretension into reality” (Bourdieu 1979).

Wohldman explores how agency can improve food choices. She asserts, as Bourdieu does, that small changes in a person’s habitus can create change in the larger structural systems, such as what foods are eaten in particular social classes (2013:450). One such small change can involve applying new knowledge to new contexts. By introducing new ways to apply knowledge, navigating daily challenges can become easier. For example, Dr. Gergen-Barnett provided a tip about how to grocery shop effectively. *She was completing the list of appropriate foods, when people began to ask how you shop for them. Robert was the most outspoken, asking, “How do we avoid all the bad foods that are in the grocery store?” Dr. Gergen-Barnett asked us a question back: “What did our ancestors eat waaaaaay back? What did the cavemen eat?”*

“Vegetables and meat” were simultaneous answers. Dr. Gergen-Barnett said,

“Yes and?”

“Fruit,” piped in Frankie.

“Yes!” Dr. Gergen-Barnett replied, “The cavemen were very healthy.” She continued by adding that they had lots of exercise chasing and hunting food. They ate fruits, vegetables, lean meat, and dairy like milk and eggs. “Cavemen were healthy enough to survive and live. Today, we should eat like our ancestors: stay with the basics.” She then asked where they kept these items in the grocery store. One participant, a soft-spoken woman, said, “Around the outside of the store usually.”

“Exactly!” Dr. Gergen-Barnett’ replied. “We should shop around the perimeter of the store for most of our needs. We can find the healthiest choices easily around the edges of the stores. The middle is where all the pre-processed, corn-filled products reside. Of course,” she added with a smile, she understood entering the middle of the store for soap. Everyone burst out laughing.

The example highlights how old knowledge, presented in a new light, gave participants a new way to engage with their grocery store more effectively. In addition, it suggests that individuals can use “common sense” knowledge to navigate structures. Barnes suggests that knowledge includes not only individual knowledge, but also a “common sense,” that is, a “general form of thought common to a particular period and population” (2009: 144).

Eaton et al. (1988) wrote an article, based on Stone Age hunter-gatherers’ diet, which became a diet fad. The researchers argued that human consumption patterns,

particularly sugar, carbohydrate, and sodium consumption, have become incompatible with the daily life of a modern human. This “mismatch” between lifestyle factors fosters “diseases of civilizations,” including the chronic illnesses of obesity and diabetes (1988: 739). Eaton et al. argue that, to reduce the chances of developing such diseases, people should return to eating like the hunter-gatherers of 10,000 years ago (1988: 747). The paper became a sensation, leading to a popular “caveman diet” of the early 1990s, which lingers on today. A basic knowledge of human evolution and, possibly, this diet help shed light on the suggestions Dr. Gergen-Barnett provided. Without the group’s acquiring the basics about evolutionary thought, trying to understand the connection between what cavemen ate and what a human should eat today would not have worked.

Learning how to navigate an environment like a grocery store in new ways suggests another important term: adaptation. Usually used in ecological anthropology, adaptation is defined as the ways in which “individuals respond to changes in their environment by morphological and functional responses, particularly focusing on chemical changes” (Moran 2007:6-7). This definition encompasses behavioral choices, physical-chemical evolution, and environmental effects. I focus on adaptation as behavioral changes due to environmental factors. It is closely connected to structures, because the physical built environment in which individuals live is designed and affected by structures (political economic arrangements) as much as individuals themselves are affected (Baer 1996: 453).

Elroy (1996) reminds us that agency and adaptation are processes, not a final outcome. The changes a person makes are usually imperfect and always changing (Elroy

1996:521). These adaptations result in changes in habitus that ultimately change how the person interacts with their daily environment. Agency and adaptation allow people to be as fluid as the structure in which they live. Each person deploys different values in different contexts, leading to different decisions.

Challenges to the Modification of Habitus

These different decisions are based on the usable capital at hand. Participants manipulate their situation for the best advantage. The rest of the chapter will highlight the structures that study participants identified as most challenging, and explore the lived experience of how they adapted to these challenges.

Family Food Preparers

Family Food Preparers were particularly challenged by their need and desire to utilize their new nutrition knowledge in an unchanged social environment. Aleese, for example, explains that from her experience of being a longtime family food preparer, she has become "*more concerned with other people's eating habits than mine own.*" The transition to implementing new knowledge requires Aleese and others to focus on what other family members expected for meals. Her case also highlights an important point—that people most often eat in the presence of others. Nestle et al. explain that social facilitation affects the amount and choice of foods eaten, due to the influence of whom one eats with, and how many people are present. The researchers emphasize how “family involvement is important in making and sustaining dietary choice,” particularly in studies about disease risk reduction (Nestle et al 1998: S51).

Eating habits develop over a lifetime in relation to changing structural influences, including employment, education, health conditions, and marriage. However, childhood is a significant time for food choice development. Starting from a young age, children require care and attention from the adults in their life, while also creating new dynamics for adults in food choices. Researchers have published limited research into how family food preparers and children affect each other's food behaviors (Hannon et al 2003: 78). For example, Hannon et al. (2003) found that children's intake of fresh vegetables, fruit, and grain correlated with the family food preparers' consumption and preference for food (2003:81). The parents' habitus becomes the child's reference point in creating their own habitus. However, adolescents and older children were found to stray from their family food preparers' food options (2003:82). Tyson, a man with a contagious laugh and a prominent voice, explained how the older children began to change the dynamics of eating at home during a lunch at IMGVisits. *Tyson made the quiet comment that the fruit was so delicious. Some people nodded as they munched, but Tyson continued the conversation, saying he doesn't get much fruit at home. Frankie asked why. He explained that his children do not eat fruit because they don't like it. His kids are 18 and 21 years old and so, old enough to make own decisions; however, this does leave him to purchase and to eat fruit alone and anything that is more "healthy."*

While Tyson found older children began to change food purchase in the home, William discovered that cultural shifts in the United States also changed his family's food choices.

W: Umm we didn't have choices growing up. you know.

I: Like how?

W: What was put in front of you was what you had. you know what i mean?

I: Yeah

W: I see families today where there might be three different things on the menu for the kids.

I: wow

W: One wants pizza. The other one wants mac and cheese and the other wants...I would give them a boot to the ass, you know what I mean. I can't believe some of my friends' houses that they are like that. "I don't want that" and the other one, "I want mac and cheese"... so "I want, I want." You know, pizza or whatever. I am scratching my head—that in itself isn't good. You know, and something else, I notice is a lot of younger kids don't like vegetables. When I was growing up, I loved every vegetable. Whatever it is, the color it is! I don't know.

I even notice that the friends of mine with young kids. Their tendency towards fast food and quicker foods, they are leaning towards more that now because they have kids where they didn't before. One of my friends now she brings the kids to Five Guys you know. To give them a treat. When I said to her, "Is it really for the kids, or for you?" And she is starting to get into the cycle of it is easier to drive up the street.

I: So is it more convenient for her, or it is really for the kids to enjoy?

W: I think it is an excuse. I will say. I think it is culture is changing gradually.

Bourcier et al. (2003) explore food strategies used by family food preparers to change eating habits for children and other family members. While the article focuses on ways in which family food preparers bring home healthy food, make food, and try to set a good example, William touches on other strategies, which are highly affected by the structures in which he and these families live: fast food nearby, family structure, convenience, and the authority of particular family members. As the built environment and family

relationships slowly shift, so does the habitus of the individuals that live within that environment. These shifts, in turn, create a particular habitus for the individuals.

Cherie touches upon how as the family food preparer can become more of a manager than someone that creates food behaviors for the family.

I: So what significance, if any, do these food messages have for you and your family?

C: They taste good. I know they are healthy for you. I haven't tried them with the family but I am sure the baby would eat half the stuff that I tried here. He has tried hummus, he likes hummus.

I: So it definitely would not be a conflict in introducing the new foods like you said about incorporating the turkey burger.

C: At some point I want to do it, to make one burger or a real small pack of turkey burger and make one burger, out of it and see. And make some hamburgers on the side, just in case they are like these are gross.

I: So introducing to the family

C: Yeah.

I: So for your house you do all the cooking?

C: Well, when I have the time yes.

Cherie recognizes that her child is more open to trying new foods, but realizes that she has to prepare an additional choice in case the child or other family members do not like the turkey burger. In addition, Cherie works full time, which limits the time she has to prepare meals. This challenge will be further touched upon. However, this excerpt shows how even finding a time to introduce new foods or to create a meal for the family to eat can be a challenge.

William's observation of multiple menus and going out to eat may be a way to manage providing food in a particular time and to cater to what children and family members will eat. In addition, this cultural shift may change the assumption people make about how applicable changes in habitus can be. Family food providers who once had the ability to influence children's eating behaviors may not have the same ability to control food intake. Cherie may want to change what she consumes, but she may not be able to change her children's attitude towards foods they are not accustomed to. While she may want to make healthier meals, she yields to the demands of making a meal that the children will eat.

Cherie's passage also begins to explore how implementation and revisiting the habitus in light of new knowledge is a cycle. There is no direct translation of new knowledge into existing cultural frames, but rather a slow process of navigating and establishing foundations for the new knowledge to be positioned. Aleese highlights this process with her family too. A longtime vegetarian in a family that eats meat, Aleese had to manage how to provide the protein for her family with her personal vegetarian eating preferences:

I: When you cooked meals even now do you...

A: I still cook meat. Yes, it was interesting. Some things were always difficult. Flipping that poor little chicken wing bone back or taking out all that stuff, but what I chose for me is not what. I mean I have these children that need. And I still cook meat for the people in my life.

I: So you found the balance?

A: Well I found the balance on how to cook meat without tasting it. You know when everyone said wow this tastes good, and you know I don't taste

it. But I think from having to eat meat for so long, I remember the color and smell and things like that

Aleese, Cherie, and others express how balancing the food choices of the family involves more than researchers' focus on the actual preparer of the food, but rather on how to manage preparing for multiple food preferences. The foundation of knowledge in a person's habitus may not provide ways to balance such expectations with their new nutrition knowledge. An individual will need to actively change their habitus to make the nutrition knowledge feasible.

Cooking Skills and Recipe Knowledge

Hartmann et al. argue that "food guidelines simply inform people about healthy food choices and good eating practices. However, to translate food guidelines into actual daily meal preparation needs more than nutrition knowledge alone" (2013:125). Aleese and Cherie touch on this aspect, pointing to the need for preparing and cooking skills. Many participants discussed their lack of knowledge about how to utilize the nutrition information provided in class. Edith illustrated this challenge in the last chapter: she wanted more suggestions about what to cook, or she would eat tea and toast *without switching things up*. Cherie explains how the new food would be more accessible to her if she knew more about how to prepare one of her new favorite foods from the IMGVisits:

I: so, what is some of the new information you learned from the class?

C: Like which ones were healthy for you, like which oils to cook with and which one were fat oils. The tofu I tried there, that tofu was very good. But I won't get it and make it because I would not know how to cook it. Because you need to know how to cook it.

I: Do you think if they had time to teach it in the class you would be cooking it?

C: Absolutely. They told me to eat tofu because I am going through the change and that is supposed to help. So, if I could learn how to cook it. yea

Cherie's experience is the same as that of many people in the IMGvisits and the United States as a whole. In her study, Beck found that meals included processed commercial foods in at least moderate amounts per meal (2007: 544). Processed commercial foods are designed to be ready to eat or almost ready to eat right from the package and require little cooking skills. These processed meals have been incorporated in the habitus of many Americans, leading to the reduction of cooking knowledge throughout time. While knowledge of food has been developed, there are still more changes needed to the habitus through additional cultural capital. Martin placed a humorous spin on this notion:

I: Why would someone not want to prepare these foods?

MM: Because they are complicated. The actual recipe is complicated. You have to go to some Johnson and Wales cooking school to learn it.

Caraher et al (1999) examined the state of cooking in England, finding that less than half of their participants cooked daily, which may not include their spouses cooking (1999:593). Furthermore, seven meals weekly were made and eaten at home (1999:593). Americans were found to spend 48% of their food budget dining outside the home (Wohldmann 2013: 450). Caraher et al also reported that nearly a tenth of the population cited "not knowing how to cook" as a factor of food choice (1999:597). Overall, the study discovered that people who know techniques and skills of cooking had more confidence in the kitchen (1999: 597). Hartmann et al explored cooking skills in relation to frequency of consumption of healthy food groups: namely, fruits and vegetables (2013: 125). The researchers discovered cooking enjoyment was found to be the most important

predictor of cooking skills (2013: 130). The more a person enjoyed the process of cooking the higher chance of the individual possessed a higher level of cooking skills. Hartmann et al found that these people could prepare different foods and eat more healthy variety (2013:130). Both studies represent the importance of cooking as a gateway to the preparation of and enjoyment of healthy food choices. This challenge of attaining more cultural capital is one that can be difficult to address. One participant had a suggestion to make the cooking skill more accessible in the demonstration kitchen and in discussions of cooking:

I: What are your thoughts on the demo kitchen you went to? Was it useful or ..?

L: For one thing it was too small. There wasn't enough space.

I: Yea. I know you mentioned on the phone it was really quick too. Was it too fast?

L: Well. Under necessity she had to have some of the food already prepared in order to make that pasta and chicken. She had to be prepared, but that is different than when you are starting from scratch yourself. I think the timing. You know when you go to a demonstration or a cooking show, they already have the stuff.

I: Right.

L: You know it is not the same timing as if you go ahead and when you cook and start from scratch and do it. It is going to take an extra amount of minutes for you to boil the pasta and cut up the chicken and dadada versus coming in and a person already has a bowl of pasta and

I: Throwing it together?

L: Right. I don't think that is going to give you a good idea or confidence. You know you need confidence when you cook.

I: Yeah. So how do you think you can build confidence for people in the group to cook?

L: I would do it more frequently. There are enough sessions that everybody in the group can have time to cook something: one of their favorites.

Studies have begun to recognize how the cooking practice is gendered. Hartmann et al stated that the "highest cooking skills were reported by women" (2013:120). The cooking skills were highest in 40-49 year age group, which declined as ages got younger (2013:128). Overall, females were found to be more health conscious in cooking, while males were found to focus on convenience food (2013:128). Caraher et al results showed that 94.9 per cent of females and 78.4 per cent of males had confidence in cooking (1999: 596). However, these results were found in a survey format. The confidence and cooking were subjective. Each individual could define what cooking was and measure their confidence. William comments on this structural design in how changes have helped develop lower cooking skills:

I: Yeah, that makes a lot of sense. So, what are some of the reasons or what foods from the course might someone not want to eat? Are not going to cook?

W: I think, well I am only speaking from experience, a lot of Americans number one don't know how to cook.

I: Right.

W: Because they are so busy remaining in school and work and everything else it is much easier for them to grab something, so...

I: Yeah.

W: You know, I honestly know that a lot of American girls I know that couldn't hard boil an egg. They couldn't it is not part of their...well before it was different. During my parents' era, your parents', it was different. But now a woman is equal to man and the breadwinner I think. And they're not spending as much time in the kitchen and obviously their

daughters are not being taught because they don't have time to teach them. It is a trickle-down effect I think.

I: Yeah.

W: And I think they would if they could. And I don't think a lot of them have the time or the know-how.

The missing knowledge of skills and techniques needed to cook food affect the variety of food choices. Family preferences and ethnic tastes can influence what skills and techniques someone has acquired to cook. William describes how younger generations may not have someone to pass skills and techniques down to them. While people face challenges and expectations, people have their own ways to change their habitus. Creative solutions are developed to translate knowledge into existing cultural frames.

In the first demonstration kitchen I attended, the question of family was brought up. How are we going to feed these foods to our family? *She told that people who were cooking for themselves and family could add these little tidbits into their home cooking easily. The rest of the family did not even have to know about these changes. She told us that we could sneak healthy food into the household, which she called "stealth health."* She mentioned like taking ground beef and pouring out the fat as you cook to make it leaner. I found in later groups that "stealth health" was already an ongoing process for many family food preparers. Cherie was interested in adding turkey burgers and Aleese had been adding carrots to chili for a number of years already. Olivia talked about how she "compromised" with her father to provide healthier food: *Olivia, excited, stated that she loves arugula, but her dad doesn't. "Do you cook for your dad," I asked. "Yes," she*

replied. She explained to me that he is a picky eater. For example, if she was to make chicken at night, he would not eat it. He would ask for steak. "Is it hard to cook for him?" I asked. "No, I compromise," she responded. Olivia gave me the example of the dinner she made a few nights ago. He wanted fish and chips. Instead of fried fish, she baked the fish and he still liked it! Using knowledge of alternative ways to cook, Olivia used this capital to provide healthier food choices to her father that worked within his habitus and her changing habitus.

Economic Capital

Caraher et al's study established that economic capital was a factor in determining how much people could cook: it influenced whether there was a home caretaker, level of education, and usage of cookbooks (1999: 592-593). Economic capital was a big factor for participants. When asked about barriers this is what some stated:

Lucy:

I: So, thinking about yourself and others in the group. what might prevent someone from using the food recommendations?

L: Price and familiarity. Inaccessibility. Plus, you may not have the the large grocery store variety.

William

I: Why would someone not want to prepare such foods? I know you mentioned color.

W: Yeah. Could be time consuming so a lot of people wouldn't bother with it. The time to prepare something. Umm. The expense again. I think that you may need a lot things to make one nice little meal you know, like a salad. There is a lot of expense following a salad. You know, if you want to do it the healthy way with the beets, the nuts, and that. You probably need eight to ten different things for one little plate. You know? That would be my thinking. It wouldn't bother me, you know, but I think.

I: Just buying all those items

W: Yeah, financially it would right now, but I think a lot of people would rather just buy a prepared salad to go and eat it.

Socioeconomic status (SES) is a complex variable, which is one part of economic and a proxy for social and cultural capital, that has been highly researched in relation to food access and choice. Wang et al (2007) examined what physical characteristics of neighborhoods were associated with high body mass index. Low SES neighborhoods were associated with worse health and high body mass index (2007: 496). The researchers assert that this pattern holds whether the neighborhood is a food desert or not. The researchers argued the main reason was due to affordable healthy foods not being accessible. Small food providers in many of the neighborhoods had little to no healthy food at an affordable price. Transportation to areas of better food choice was not feasible either (2007:496-497). Konitten et al argued that low SES individuals “considered price and/or familiarity more important in their food choices” (2012: 873). The researchers explain that with fewer financial resources, people are less likely to “take health aspects into account in their food purchasing decisions” (2012:873). The different forms of capital are interconnected, so as one capital is limited, other kinds of capital can become limited. Konitten et al explore this relationship between economic capital and cultural capital (i.e. education), including formal and informal sources (2012:878). People with higher SES have the ability to purchase food “just to try” and have access to more ways to learn how to cook the new food (878-879). Beyond the challenges that these researchers uncovered, I found that participants had a range of coping mechanisms to deal with

limited personal and familial economies. Finding new ways to reduce costs to afford new foods, as well as old foods, became a balancing act for participants:

Martin: I do. I do eat out once in a while. Chinese once in a while. Pizza once in a while, but I am trying to cut down. It is expensive and it is not healthy food. So, I am learning and trying to find a place to learn how to cook better for myself.

Martin began to manage his budget by reducing shopping dollars used outside the house, especially as he gained cooking skills. Martin utilized the cultural capital the IMGVisits and other networks had began to teach him to reduce the economic capital strains.

Through this reduction, Martin was hoping to be able to purchase more healthy food choices that he was learning to use. Lucy adapted to her limited economy by learning about the environment of grocery stores within her range of transportation.

L.: Save-a-Lot sells a quart of milk for 99 cents a quart.

I: Wow.

L: And Stop 'n' Shop has different prices. Because one Stop 'n' Shop a quart of milk will go for \$1.49. And another will go for \$1.99. So, I really have to look and take notice before I go shopping.

Using the knowledge of store prices, availability of items, and comparing prices, Lucy was able to make more affordable and healthy choices. Unlike Wang et al's (2007) research, Lucy had larger stores and more availability in her area to purchase healthy choices, as well as new information. Martin and Lucy represent a commonly recognized case of limited finances. However, these participants have explored ways to utilize their forms of capital to create solutions incorporating the new IMGVisits information into their habitus.

Jamie represents yet another way to understand how to work with limited economic capital and new nutrition knowledge: *Trader Joe's, because its umm they have a great selection of healthy and organic food for cheap prices. I mean I can't beat that. I mean it's a small store but they have a comprehensive selection for the size of the store and especially for the price. And Whole Foods is just too expensive for me.*

While Konittinen et al (2012) found low SES individuals considered price and familiarity more important in their food choice, and higher SES individuals took health into consideration, Jamie represents how this may not be the full picture. He used his familiarity with stores and knowledge of prices to analyze his options for healthy choices. Jamie and other participants took the various forms of capital from their lives, including the IMGVisits information, to inform their decision-making.

Time and Transportation

Lucy and Jamie's story also begins to highlight two more barriers of participants: time and transportation. While not conclusively connected, these challenges are quite often correlated with each other. Time available to shop is "one of the more pervasive factors that affect" an individual's shopping behavior (Park 1989: 423). Koch (2012) completed semi-structured interviews to understand the process of grocery shopping. Participants reported that time affected grocery shopping from its conception to completion. Koch explains that participants found planning meals and creating the list based off this planning was affected by time as much as the actual shopping in the store (33). Within the additional time before shopping, participants had to rely on memory and well-known food preferences of the family structure (2012: 34). This meant that newer

nutrition knowledge was not always remembered and ingrained in memory. New foods or ideas for cooking may not be implemented due to not picking up the right ingredients.

In addition, limited time to shop meant people could only take transportation so far and take time to search out new foods for so long (2012: 34-35). This impedes the process of searching the store for new foods. Winne (2008) found that more than 32 per cent of Hartford, Connecticut residents “on the city’s buses were using them to do all or some of their food shopping. Of that group 60 per cent reported that they experienced difficulty food shopping due to their dependence on the buses.” Participants recognized travel and time as a challenge to daily life:

Lucy and Jack both explain how they depend on rides from others or have to shop locally:

Lucy:

I: Is there a particular day you go?

Lucy: No. If I see I am running low on stuff. Umm there is no particular day. It also depends on when I can get a ride because I don’t drive. So, I have to depend on one of my relatives or friends to take me home.

Jack:

I: Is there a particular reason you decided to shop at these different places?

Jack: Well no uhh, if I am in the neighborhood like the Roche Brothers like my son lives in Norwood so I will stop at Roche brothers if I have the money to shop. I will shop there. Mostly I go to Stop ‘n’ Shop and Star Market because they are in my neighborhood.

I: So, it is the convenience of having them close?

Jack: Yes.

Participants discussed the effects of chronic illness on shopping through small details of traveling stories, such as statements about poor drivers and how much pain they were in

that day. Edith explains one of her experiences with chronic pain and the bus ride to the IMGVisits. *Edith told us of her most recent trip on the bus. The bus was packed, but she had to take this one to make her connection. She got onto the bus standing, which frightens her due to her back issues. A woman came on and shoved her baby stroller into her, almost tipping Edith over. Edith explained that she luckily caught herself or it could have been serious. She told us that this added to her pain for the day, which made her not as active in the group as she wished to be.* Time and transportation are also affected by the person's health status for the day. It can affect how much time the participant will allot to shopping, as well as how far they are willing to travel. This structure is an example of how various kinds of capital are interconnected. These examples also highlight how different forms of capital could be used to overcome this structure. If economic capital was available, these participants could purchase a car or taxi ride back and forth from the supermarket. Cultural capital could be used to find the cheapest ride to the store, or discover another place where food is available. Both of these participants rely on their social capital to attain rides from people who have the economic capital to have a vehicle.

Grocery Shopping

After trying Bok Choy at a friend's, I knew I that I wanted to cook it at home. I went to my local grocery store. One hour later, I had no luck finding the vegetable I desired. I decided next time, I would stop at the grocery store a few more blocks away the next day. I found that I wasted another hour, including the search time and walk home. Finally, I stopped at one more Asian grocery store even farther from my house. I was so

hoping that I would find the Bok Choy here. To my frustration, there were so many types of Choy in another language. After asking for some English translations from some friendly shoppers, I found the right “Choy” I was looking for to bring home. My experience seemed simple at first to me, until I realized this is what many of the participants during the IMGVisits were sharing. The use of the grocery store itself was an embodiment of structures. The participants had new knowledge, new food choices. They first had to figure out finances, time to shop, and transportation to the store. Once there, the participants had to manage their time, including searching for their food choice. If it was not there, then where should they look next?

When Martin and I talked about his grocery shopping experience, he found that his nervousness in crowds, and the size and selection of his grocery store, limited what he could purchase:

I: Can you give me an example of what might not be accessible?

M: A certain number of produce I want to get.

I: So produce is hard to get sometimes? (Martin nods in agreement) Is there anything else you are finding hard to get?

M: Sometimes just navigating where I am going. It is too big. And it gets overwhelming because it is so big in there.

I: Yeah just too much happening in an area?

M: Yeah. I don't like crowds as it is. And I struggle with that. It is hard. It is hard. I think I feel a rush because I don't like crowds.

While participants did find challenges, each participant did adapt their habitus and the forms of capital to get their desired outcomes. Lucy and Jack found their informal social networks that travelled to grocery stores to take rides to reach more food options.

Robert used the economic capital of a camera phone to help him find the quinoa that he wanted to add to his diet. *Robert laughed as he answered my question about the demo kitchen: "I like it. I memorized how she cooked by watching her in the overhead mirror." When I asked him his thoughts on the meal, he told me he loved the quinoa. He had tried to find it at his store, but he could not at first. He didn't know how to pronounce it or even where to look. Luckily, he chuckled again, he had taken a picture of the label that quinoa had come in with the permission of the nutritionist. "I took that to a store clerk. She knew exactly where to find it and how to pronounce it."*

Lucy also found ways to bring food to her home without travelling:

Lucy: Mhmm and also I participate in a program called 2 dollars a bag. It's a program that various social services agencies sponsor... You pay two dollars every two weeks and you get a bag of vegetables and sometimes fruit.

I: That is nice produce, which sometimes can be difficult...

Lucy: Yeah and I go to the Hawthorne Youth and Community Center. That's the one I got to.

Food Pantry

While Lucy uses a local food pantry, a portion of the participants used the Preventative Food Pantry located in the Nutrition Resource Center of Boston Medical Center. Jamie discusses his experience utilizing the food pantry:

Jamie: Here, because I can get flax seeds and sweet potatoes here. And I get oh I forgot to ask about cabbage today. They have good foods that really don't have a lot of pesticides on them. And the foods that usually do carry a lot of pesticides on them apples and strawberries and what else, celery. I don't get here. I get them organic at Trader Joe's.

I: So you can ask about cabbage. Can you ask for certain foods at this food pantry when you go there?

Jamie: Well by now they know me so they know I am on a special diet so I can't take 75% of the cart they offer. So, I don't feel bad asking hey do you guys have instead of white rice, brown rice? And I am surprised most of the time they have stuff. And when they say no. It is ok let's go, but like today I asked for more sweet potatoes.

The food pantry at BMC is available to anyone who has a referral from their physician. During IMGVisits, physicians would discuss this option to participants, making sure that everyone knew that it was available and making referrals for eligible participants. The food pantry became one option that the IMGVisits could provide to help alleviate barriers to healthy food.

Conclusion

Highfield et al's (2008) model of "if you build it, they will come" fits into how Jamie and other participants utilized nutrition information. The researchers describe how the group set up a free-care acupuncture clinic in Boston Medical Center. This clinic was the first of its kind and faced the uncertainty whether it would be used by minority adolescent and pediatric populations for whom it was designed. Highfield et al found that, when given the chance to use a clinic within their means, minority adolescents and others would utilize the clinic: "Visits increased 65 percent from the first to the third year of operation" (2008: 629). As with this clinic, Jamie and others came to IMGVisits to gain cultural capital and learn information. Some of the information needed to be adapted into the world of structures, while some cultural capital, such as learning about the BMC food pantry (a specific alternative structure), made food choices easier by opening doors to economic capital, in this case free healthy choice groceries. Participants are creative in confronting barriers and share knowledge of how to subvert them. They utilize the

different types of capital they have available to them to help reinforce the new habitus they desire to attain. This new habitus may not cause social mobility, as Bourdieu discusses, but does cause a change in health status. IMGVisits and other lived experiences gave participants additional capital to reinforce the new nutrition knowledge. Through these reinforcements, the information is adapted to their habitus to create a new lens to see the world through. People have ways to manage and resist structures.

CHAPTER VI: BRINGING IT ALL TOGETHER

I walked into the small familiar conference room. To my surprise, there were more participants than I had ever seen in a single week. I was running late, but I made it for the meditation. The meditation master ended with “Namaste.” A brief discussion ensued about the translation of Namaste: “I bow to the God within you.” The participants enjoyed this conversation. They practiced bowing, the praying hand motion, and saying Namaste to one another. Dr. Gergen-Barnett brought the group back together to begin recapping the last eight weeks of the program. Malia began with saying, “I can’t believe the group is over.”

I could not agree more with Malia’s sentiment as my research comes to an end. I began my research with the intention to contribute to the Integrative Group Medicine Visits by understanding what participants’ are getting out of the nutrition messaging. This question led to further sub-questions: How is knowledge constructed? What knowledge do people have about nutrition and food? What is their position in learning new knowledge, and what about the IMGVisits creates a space for learning? What factors create access and challenges for participants? What structures do participants’ narratives highlight?

In chapter four, I explore the construction of nutrition knowledge. I first examine the initial nutrition knowledge that participants brought to the IMGVisits and their positionality in relation to learning new knowledge. Many participants are in a position of chronic illness. Parsons’ sick role concept explains that people who are ill become “disabled from fulfilling normal social obligations” (1951). Individuals take on a passive

sick role, where authoritative physicians give directions on how to become better. My data analysis shows how participants do not fit the passive sick role that Parsons describes. They may be removed from normal social obligations, but the participants take an active role in regaining their pre-sick identity. This active desire to fulfill roles that were previously significant to the participant creates a position of openness to new nutrition knowledge.

Furthermore, the group design is important in helping promote motivation to learn new nutrition information that may contradict previously held knowledge. Different from and consciously working against Parsons' sick role, IMGVisits implement the model of "flattening authority" for expressing individual knowledge and shared experience. The facilitators take a therapeutic alliance role rather than an authoritative role as described by Parsons. The participants became experts of their own health and they took the initiative in understanding how the new knowledge did or did not apply to them. Overall, this aspect of my study illustrates how the "flattening authority" model in group medical visits is a useful way to introduce new knowledge to individuals.

In chapter five, I explore how participants apply newly adopted knowledge. Structures are social systems that generate and reinforce hierarchies of power (Bourdieu 1986, Baer et al. 1986). Participants' narratives focus attention on structures, from family structure to cultural restraints to the economic system. While challenges developed from these structures, participants are not just victims of structural violence. They adapt to daily challenges. Human agents utilize available forms of capital to meet goals that otherwise may seem unattainable. Through their own empowerment, and information

provided at the IMGVisits, participants used their resources to apply the new nutrition information. For instance, participants who knew of the food pantry at Boston Medical Center would get a prescription to use it, thus availing themselves of fruits, vegetables, and other healthy choices.

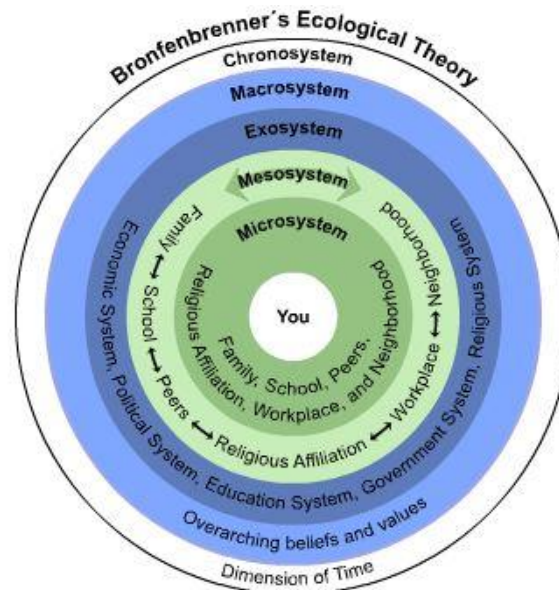
Understanding How this Looks

To understand how people interact with their outside world, researchers have developed many models (Moran 2007, Bronfenbrenner 1977, Baer et al 1986, etc). Bronfenbrenner's ecological theory of human development explores how interactions with others and the environment are key to child development. He argues that “human development takes place through processes of progressively more complex reciprocal interaction between an active, evolving biopsychological human organism and the persons, objects, and symbols in its immediate environment” (Bronfenbrenner 2004: 38).

Bronfenbrenner divides the environment into five fields. The microsphere is the immediate environment (i.e. family, school, church, neighborhood, community groups, etc). The mesosphere is the relationship between aspects of the microsphere, like family members talking to school personnel. The exosystem is the relationship of the microsphere to elements that do not interact directly with the individual, such as the economic system or government. Macrosystem is the culture the child lives in, including the ethnicity, religious group, and social class. Finally, Bronfenbrenner has the chronosystem, which is the dimension of time. This level represents how environmental effects develop over time (North American Community for Cultural Ecology 2012). Bronfenbrenner asserts that these environments interact with one another; however, they

interact with the individual in different degrees (Bronfenbrenner 1977, Bronfenbrenner & Morris 2005). For example, the exosystem may lay a person off, an act which could affect day to day financial choices that would usually be a part of the normal purchasing behaviors.

Fig. 6.1 Bronfenbrenner’s Model



While Bronfenbrenner focuses on child development, researchers have used his theory and model in other ways to understand the interaction of the existing environments on an individual (Jordan 2005, Johnston et al 2007, Kulik & Rayyan 2006, etc). I found that this model was useful in understanding the positions of participants in relation to the newly constructed knowledge from the IMGVisits and the application of new nutrition knowledge.

First, the participant and their habitus are situated in the center. Second, the microsystem is the immediate environment, including the IMGVisits. Third, the

mesosystem is the area where the microsystem, including IMGVisits, interacts with the exosystem. Fourth, the exosystem are the larger structures of society, such as economic, political, and education system. Fifth, the macrosystem contains the cultural beliefs and values that create the lens in which people view the world. It can be cultural practices, such as insects not being a suitable or accepted protein in the United States, to pork not being an edible meat in traditional Islamic beliefs. Lastly, is the chronosystem, the dimension of time, which is where all the concentric circles interact and change within it.

The IMGVisits reside in the microsystem because they interact directly with the participant and create a social group that the participant can reside in. Through shared experiences, empowerment to learn new knowledge, and facilitator/member support, participants assimilate new knowledge provided by the IMGVisits into their existing habitus. Individuals also learn of social suffering. They are not alone in their chronic illness. While not pushed, the IMGVisits support people to stay in contact with one another to help support each other in their suffering beyond the IMGVisits. IMGVisits could be considered the community groups or school that Bronfenbrenner expects in a child's life. Support is given to work together to become "better."

IMGVisits also provide more information about the other environmental fields for participants to use in their individual interactions with the structures in their lives. For example, the IMGVisits describe how government food recommendation can be influenced by lobbyists and the food industry. It also includes the mindfulness-based stress reduction practices as well. As discussed in the background and chapter four, mindfulness meditation and mindfulness eating contributes to the individual being more

in tune with the physical and emotional reactions of their body. They are more aware of the feelings that allow for adjustments in behavior or thoughts to support or reduce particular reactions within the body and mind. Portia Nelson's poem, "There's a Hole in my Sidewalk: Autobiography in Five Short Chapters," that is often read in the IMGVisits, touches upon this transformation:

Chapter One

I walk down the street.
There is a deep hole in the sidewalk.
I fall in.
I am lost.... I am helpless.
It isn't my fault.
It takes forever to find a way out.

Chapter Two

I walk down the street.
There is a deep hole in the sidewalk.
I pretend that I don't see it.
I fall in again.
I can't believe I am in this same place.
But, it isn't my fault.
It still takes a long time to get out.

Chapter Three

I walk down the same street.
There is a deep hole in the sidewalk.
I *see* it is there.
I still fall in ... it's a habit ... but, my eyes are open.
I know where I am.
It is *my* fault.
I get out immediately.

Chapter Four

I walk down the same street.
There is a deep hole in the sidewalk.
I walk around it.

Chapter Five

I walk down another street.

This reflexivity creates a more open active individual in the world that can navigate the world around them. This navigation may be learning what sidewalk holes to avoid or what foods can help reduce their inflammation that is aggravating their pain.

While this process is occurring, the IMGVisits are also interacting with the larger concentric circles of an individual's life to help support the health improvements that the IMGVisits are fostering in the individual. IMGVisits are a part of the mesosystem, when they are interacting with the structures in an individual's life. The interactions include social work consultations, letters for electricity, housing resources, food pantry access, disability forms, and all the other resources that the hospital provides through the IMGVisits. While Bronfenbrenner asserts that the individual does not have direct interactions with the larger environmental fields, the participants of this research interact with all fields, such as the family structure, political system, and economic system. It may be through bringing the letter for electricity or applying for disability. It happens for all participants when they begin to apply their new nutrition knowledge.

Some of these systems, the structures, create challenges. Through the interactions with these multiple fields and the usage of the forms of capitals that arise from these different fields, participants can subvert the structures that challenge their application of new knowledge. In the previous chapter, for example, Lucy had a challenge with the economic system. She could not afford a car for transportation of groceries. To navigate around this barrier, Lucy relied on her social capital of friends with vehicles to gain transportation to the store.

Bronfenbrenner's model also highlights how time is important to this process of learning and applying knowledge. As participants' actively reinforce the knowledge over time, the knowledge will be embodied into the habitus, making the new choices and behaviors from the IMGVisits a part of daily life. In addition, the IMGVisits change over time some of the outside factors that affect health, such as finding a home for a homeless participant or providing access to healthy food choices at the food pantry. All these changes over time become a part of the lens through which participants view their world.

Singer's (1995) work adds an additional layer to consider the position of the IMGVisits in Bronfenbrenner's model. Singer explains that there are two forms of activist interventions: systems-correcting and systems-challenging praxis. The IMGVisits are a part of the systems-correct praxis. The group visits try to "correct" or create subversions around structures for participants. Through the work inside and outside the clinic, the IMGVisits provide navigation to healthcare options, food information, and other resources that support the health of marginalized individuals. The system-challenging praxis is "concerned with unmasking the origins of social inequality" (1995: 90). Participants have system-correcting and system-challenging responses within the IMGVisits and beyond. Participants utilize the system-correcting resources provided by the IMGVisits, but also build resources outside the basic information provided. The participants create alliances with one another and gather an understanding of their social suffering. In addition, the participants' co-create knowledge and provide additional knowledge to one another that the group may not provide.

The IMGVisits have many moving pieces that work continuously to change the environment and individuals that interact within it. There are many strengths that the IMGVisits have from which other, similar, groups could draw. The first strength is in the group setting. Individuals not only have the ability to support one another and share experiences, but can co-create knowledge that they can apply to their lives. The second strength would be flattening authority. This concept allows for individuals to be experts on their own body. Readiness to learn, in addition to mindfulness practice, develops reflection and openness to learning. The third strength would be the additional support and outreach that the clinic provides to the patients. These strengths provide a therapeutic alliance that helps an individual with many facets of their lives, both in and outside the clinic setting. They provide holistic system-correcting support for improvement of health.

By building upon these strengths, the IMGVisits have ways to create a system-challenging praxis that improves community alliance and agency. Smaller ways to improve these qualities is by building a longer lasting community within the IMGVisits. One way would be creating a formal contact list that participants can add themselves to after their eight week session is complete. Some participants suggested, during week eight of their session, making future monthly group visits that anyone from any previous sessions could join to continue to reinforce both the social support and their new knowledge. In Chapter Four, Lucy suggests having time within the group visits for people to share and practice cooking skills in a more formal presentation to allow for each to learn and connect with one another through new skills and cultural foods.

Another suggestion by participants included lists of locations of available food or resources that would be easily obtainable by participants. The lists could include community groups as resources for people to reach out to as well.

To begin to connect with the larger community, an addition to the program could be visits to grocery stores, providing hands on practice of navigating a supermarket. The IMGVisits could reach out to other community groups, such as Food and Fitness Coalitions, to create alliances and support for the individuals during and after their sessions in the clinic are complete. This could help reinforce nutritional information learned within the IMGVisits. By reaching out to community groups, the IMGVisits could create larger alliances and support for patients, families, and beyond. These alliances could create an active understanding of social suffering and structural violence. This understanding is the first step in involvement and development of new solutions and activism directed at larger societal issues. These strengths and possible developments could help the IMGVisits do similar work, providing a foundation for individual, community, and societal improvement. The IMGVisits and other similar groups can work within the system-correcting praxis and systems-challenging praxis to create social and societal change that creates the structural violence and social suffering

This research creates a better understanding and reviews the potential benefits of the IMGVisits and other potential group medical visits in teaching new knowledge. The application of new nutritional knowledge is a process that is influenced by all aspects of an individual's life. Furthermore, this research highlights how individuals take on an active role in their health and apply new salutogenic knowledge and practices.

The study nevertheless has limitations. First, the population was a convenience sample, including those willing to talk about their food and class experiences. Additional factors affecting the efficacy of biomedical education may not have arisen. Furthermore, other participants may face challenges that were not seen during this study. The second limitation was my inability to recruit people to participate in a “go-along” interview. These observations could have shed additional light on how people process and apply nutrition information.

Recommendations for future research would include alleviation of some of the limitations this study faced. A longer term study would allow for more opportunities to attend group classes, go grocery shopping or even cook with participants. These participatory observational methods would give a better understanding of how each structure affects the use of nutritional knowledge. More research into how people decide to accept and implement information would provide strategies to strengthen the introduction and teaching of new knowledge. Further, research into changes in policies, such as the Massachusetts Supplement Nutrition Assistance Program (SNAP) cutbacks, would provide insight into what new information or strategies could be implemented by groups like the IMGVisits to make nutrition knowledge feasible to use (Center on Budget and Policy Priorities 2013). This research is just the beginning to understanding accessibility and barriers in the process of learning and applying new nutrition knowledge.

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