

RESEARCH PAPER

Challenges of a healthy lifestyle for socially disadvantaged people of Dutch, Moroccan and Turkish origin in the Netherlands: a focus group study

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(Received 19 December 2013; accepted 19 August 2014)

Lifestyle interventions often fail to successfully reach individuals with lower socio-economic status (SES), possibly because of the individual behavioural orientation to health behaviour and because limited research has included the target groups' perspectives in the development of interventions. Certainly, in order to make lifestyle interventions more applicable, target groups' viewpoints should be taken into account. In order to tailor an effective lifestyle intervention to groups with lower SES of different ethnic origins, 14 focus group interviews were conducted with Turkish, Moroccan and Dutch male and female groups. The target groups' responses highlight their viewpoint and their dilemmas with regard to physical activity behaviour and healthy eating. Exploration of the target groups' behaviour in terms of their own logic revealed three prominent themes. Firstly, some individuals find it difficult to maintain healthy eating habits and regular physical activities, as their concept of a healthy life comprises competing values and activities. Secondly, social norms and social practices of others influence health behaviour. Thirdly, respondents' answers reflect how they deal with the dilemma of competing values and norms. They use different ways of reasoning to make sense of their own (health) behaviour. Taken together, the results of this study suggest that considering physical activity and eating as collective social practices rather than as determinants of health will provide new opportunities to initiate healthy lifestyles and to make lifestyle interventions more applicable to target groups' realities.

Keywords: ethnic minorities; collective lifestyle; lifestyle interventions; the Netherlands; social practice; qualitative research

Introduction

In recent years, the focus of health promotion in western societies has largely been on promoting health behaviours, such as physical activity and a healthy diet. Unfortunately, ever since lifestyle programmes have been launched and evaluated, most of them have had limited impacts (Michie, Jochelson, Markham, & Bridle, 2009). In addition,

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socio-economic inequalities may even widen as individuals with lower socio-economic status (SES) and ethnic minorities, who often have a low SES, are not reached for these lifestyle interventions and show low participation rates (El Fakiri, Hoes, Uitewaal, Frenken, & Bruijnzeels, 2008; Magnee et al., 2013).

A possible reason for these shortcomings might be the individual behavioural orientation in lifestyle interventions and the narrow understanding of behaviour as individual rational choice abstracted from the context in which it takes place. Often, health promotion activities are based on social cognitive theories (Bartholomew, Parcel, Kok, & Gottlieb, 2006) that focus on how individual cognitions and characteristics determine health behaviour. Critics have argued that the focus on individual characteristics not only tends to stress individual responsibility for health and disease (Ayo, 2012; Lupton, 1995), but also has left us with a gap in understanding human behaviour and its complexity (Becker, 2013; Buchanan, 2000). However, models and theories that focus on social and structural factors are also common in the field of health promotion, like the social ecological model (Tones & Green, 2004). In these models, structural factors like economic resources are ascribed to determine (health) behaviour.

These models have also been criticised for the way they operationalise structural factors from a scientific cause-and-effect perspective (Krumeich & Meershoek, 2014). The emphasis on the cause-and-effect relationship generates the ideology that (health) risks can be fully controlled (Crawford, 2004). As behaviour rarely results merely from the sum of individual and economic forces, these (linear) theories fail to fully comprehend behaviour produced by complex relationships (Goodson, 2010). Frohlich, Corin, and Potvin (2001) have also pointed out that health behaviour is not merely the product of structure, but that social structures and social practices mutually shape each other. Therefore, they have advocated that behaviour (e.g. smoking) should not be seen as individual risk factors stripped from their meaning, but rather as existing in a collective contextualised dimension that takes into account the interaction of social practices and structural factors (Frohlich, Potvin, Chabot, & Corin, 2002). It has been argued that health promotion activities so far have paid insufficient attention to this continuous process that shapes local circumstances and guides human behaviour (Krumeich, Weijts, Reddy, & Meijer-Weitz, 2001).

To achieve a better understanding of (health) behaviour, researchers advocate understanding (health) behaviour within what they call the 'social context' that shapes people's viewpoints, social norms and behaviour, rather than from an individual health behaviour perspective (Burke, Joseph, Pasick, & Barker, 2009; Poland et al., 2006). Frohlich et al. (2001) provide a theoretical framework, entitled 'collective lifestyles', in which structure (material resources) and agency (choice) are not viewed as separate forces that generate disease, but as interrelated aspects in the 'social production of disease'. Furthermore, they argue that it is important to understand which aspects of context influence disease outcomes, and how the individual and his/her context interact in the generation of disease. The framework recognises that behaviours (practices) occur in social settings and are not merely individual determinants, but collective practices. Therefore, in our analysis we draw on this framework in order to better understand how low SES groups with different ethnic origins perceive (health) behaviours such as healthy eating and physical activity in their context.

This insight will generate an understanding of (health) behaviour that does not merely see individual behaviour and characteristics as health determinants but recognises (health) behaviour as social practices that provide opportunities to initiate healthy lifestyles.

Methodology

This study is the first part of a project that aims to adapt an existing lifestyle intervention in a way that will be more applicable and accessible for people with lower SES of different ethnic origins. The existing lifestyle intervention showed beneficial effects on diabetes incidence in a group of people between 40 and 70 years old. However, the dropout rate was higher among low SES individuals than among people with higher SES (Roumen et al., 2011). In the Netherlands, people of Turkish and Moroccan origin constitute the largest ethnic minority groups (CBS, 2013). Therefore, 14 focus group discussions were held with five Turkish, five Moroccan and four Dutch groups of between three and 13 male or female participants, between May and November 2011. A total of 99 individuals took part. All interviews were held in Dutch and took between 75 and 180 min. Interviews were tape-recorded with the respondent's audio-taped or written consent. At the end of each interview, the participants completed a short demographic questionnaire and received a 10 euro gift voucher. The study protocol was approved by the medical ethics committee azM/UM (Maastricht, The Netherlands).

Participants were recruited via local community workers, chairmen of mosques and persons in the target population, mostly in disadvantaged neighbourhoods in medium-sized cities (35,000–150,000 inhabitants) in the Netherlands. Persons were approached during leisure-time activities in mosques or community centres. The interviews were held in the settings in which the participants usually meet, to provide a safe and familiar environment in which they would feel comfortable to speak freely (Crossley, 2002). Of the 99 participants, 93 provided information about their educational level, with 59 reporting a low education level (none, primary or basic vocational education), 26 reporting a medium level of education (secondary vocational school or high school) and 8 reporting being highly educated (high professional education or university education) according to Statistics Netherlands' definition (Verweij, 2008). The mean participant age of groups varied between 42 and 66 years.

Each focus group was moderated by one of the first two authors, and a topic list was used to guide the interviews. The moderator addressed very broad issues, like eating and physical activity, and how these activities are practiced in daily life. Questions asked during the interviews aimed to elicit perceived barriers and facilitators towards a healthy diet and physical activity, perceptions of benefits and disadvantages of a healthy diet and physical activity, and preferred methods of nutrition and physical activity education. If participants could not convey their feelings in Dutch, they were encouraged to express themselves in their first language and the intermediary translated for the researchers. Although the questions asked were directed at individual behaviour, participants described their practices with regard to their (health) behaviour in the context of their daily life. During the interviews, discussions were stimulated and interviewees were encouraged to share ideas on how adopting health behaviour could become less strenuous. In this way, focus group discussions can offer valuable contextual data on health behaviour. Although the accounts people give during focus group discussions are not only pre-existing views and ideas, but also products of the social interaction with other focus group members, focus group data can reflect ideas and viewpoints on health and behaviour that are products of an interaction in the participants' daily life (Green & Thorogood, 2009). Focus group data can also illustrate how participants negotiate values and social norms in a context, in which they are embedded and given meaning (Radley & Billig, 1996).

The focus group interviews were transcribed verbatim by the researchers (D.T. and A.B.). First, the researchers read several transcripts and assigned codes (employing words used by participants) to common themes (Boeije, 2005). Both researchers then coded one interview independently and categorised participants' accounts under the main themes identified. Differences in categorisation were discussed, and consensus was reached. The first author used a finalised codebook to analyse the remaining interviews using NVivo software (version 9.2). In the second step of the analysis, the first author studied the accounts of the main themes identified. Participants listed structural factors, such as price and availability, as constraints, when asked for barriers and enablers towards health behaviour. However, a frequently emerging theme, when participants described their everyday experiences with healthy eating and physical activities, was the influence of social practices of others and the dilemma of competing activities and obligations. Therefore, this reference was chosen as the central theme for further analysis. In the third stage, the first author refined patterns in this theme to analyse how participants give meaning to their daily activities and which social norms and values are reproduced in their explanations and negotiations.

Results

Our results highlight how social practices shape eating habits and physical activity routines. In order to elucidate our participants' talk about social practices such as healthy eating and physical activity, we first present their view of a healthy lifestyle.

Participants' view of a healthy lifestyle

Lower body weight and freedom from disease were often mentioned as benefits of a healthy diet and being sufficiently physically active. Most participants mentioned that eating healthy food and being physically active contributed to their health, whereas overweight put their health at risk.

We all know that being too heavy is not good for your health. (Woman, Dutch origin)

This view on health reflects the biomedical ideology that being too heavy equals unhealthiness (Becker, 2013; Lupton, 2013). The healthy overweight individual becomes a person who is 'potentially sick' (Crawford, 1994; McNaughton, 2013). Although participants reproduced the health prevention message, their viewpoint on health is more complex and ambivalent. Participants also emphasised the absence of stress, the presence of relaxation and having a pleasant, carefree and enjoyable (social) life as very important contributors to their health, and addressed the collective nature of feeling healthy, going beyond the individual level of health.

Interviewer: What are important things for you to live healthily?

M1: Relaxation and pleasure.

M2: Pleasure.

M3: Pleasure in your life.

M1: We talk about physical activity, we talk about food, but inner calm, we do not talk about that. But that is also very important [for your health]. (Men, Dutch origin)

Do you know what it is? Living healthily is when you do not have any stress. What counts is that you have a good life together with your children and your wife. That is much healthier. (Man, Turkish origin)

The following paragraphs illustrate how these values associated with feeling healthy are likely to collide in daily life with health behaviours such as physical activity and healthy eating, how participants deal with competing (social) norms, and how their viewpoint and their behaviour mutually shape each other.

How collectives influence (healthy) eating habits

Participants repeatedly referred to social influences with regard to eating as hindering lifestyle change. Participants mentioned that social events and the act of hospitality are hurdles in maintaining healthy eating habits. They indicated that on social occasions, they were more likely to eat something unhealthy or more than they intended.

M1: No, that is right. If you have company it is more difficult to say 'no' to a tasty snack. If you sit there alone, you could say 'No, I won't take it'. If you sit with four or five men around the table here and you play billiards and play darts and someone offers a plate with snacks, then you don't say 'No, I want an apple'.

Interviewer: And why?

M2: Because they will laugh if you eat an apple. (Men, Dutch origin)

Sharing food and eating together shapes social relationships with others, and the atmosphere of events can partly be created by the foods that are consumed. Social norms of what is considered as socially appropriate are at stake at social events, in this case, unhealthy snacks instead of apples. Another social norm is reflected in the responses of several female participants. They indicated that they think it is impolite to refuse food that is offered to them.

W1: When you go to a party, they say 'Oh, don't be unsociable, come on [eat]'.

W2: You let yourself be persuaded, and then you regret it. Then I think, 'I should not have eaten it'.

W1: Then you do not want to displease someone, or they have bought a lot of food. Then you think I will eat a little. That's how it goes. (Women, Dutch origin)

It is not polite to say 'no' [when someone offers food]. (Woman, Moroccan origin)

When one is eating with others, health and social norms are likely to conflict. Asking people to eat healthily might require them to behave differently from others in their social network, and people might fear putting these relationships at risk (Rosen, 2013). Another aspect that respondents mentioned relates to the enjoyment of those social events.

I know for sure, that I would lose 10–15 kilos if I had another mentality and ate healthily. But then I would have to miss out on so much, and that is the same as when you sit together. I can be sociable when I drink a bottle of beer, but if I had to drink water when we sit together, I wouldn't like that. (Man, Dutch origin)

In this case, the person refers to drinking beer not as a social norm but as an item that contributes to his enjoyment of the event. Apart from social events, (social) habits within the family were perceived as constraints to healthy eating. Various Turkish and Moroccan women reported cooking several dishes per day to satisfy each family member's food preferences.

It is a lot of work. I cook a lot of food. I have diabetes [...], and my children haven't got it and my husband either. If I cook something else, I always have double work. (Woman, Moroccan origin)

These women want to please all family members to cherish the family relationship, and individual goals are subordinate to the collective well-being. Eating is not an individual act but often performed with others; and competing values, like, in this case, caring for the family, can limit a person's willingness to comply with health recommendations (Crawford, 2004). When individuals change their eating habits, this also can affect others who take part in the act of eating, as the following quote illustrates:

The doctor told me to watch out for fat because of the diabetes. And ever since I've automatically eaten light products. And I still eat those. My husband automatically ate it as well. He had to. (Woman, Dutch origin)

Like this woman, several other participants were suffering from diabetes or had other health complaints. Dutch families, however, seemed to be more likely to support the person's change in lifestyle, whereas Turkish and Moroccan participants reported being less supported or to give less support to change eating habits.

Eating is often not an individual decision but an activity that is deeply embedded in social life and also depends on the social practices of others. Social practices are shaped by social norms and values and by opportunities emerging in specific social situations. In daily life, individuals interact in specific social situations that produce health-related behaviours (Dean, 1989).

How collectives influence physical activity

Like in the case of healthy eating, physical activity behaviour is the product of (together with other things, like structural factors) social practices and social relations. Several men recalled being fairly active in the past. However, many reported an end to their leisure-time activity when demands of work and family interfered with being physically active. Many participants also cited other duties like work, household chores and child care as time-consuming demands that interfered with being physically active.

You are getting older, you have kids and you do not have any time anymore to exercise because you are busy with the kids and so on. Probably with your work too, when you have to work in shifts. (Man, Dutch origin)

Here, it becomes evident again that individuals do not act in a vacuum but function in a web of social relations, with whom they share habits and routines. Certain duties and responsibilities are attached to social roles and social norms. In this case, being a father means wanting to care for the family, financially and socially. Physical activity becomes subordinate and is perceived as an extra effort, which is time-consuming and requires extra energy.

Yes, time of course. You have your work, your house, your family, and all the stress at home and at your work and activities, as today they all cost time. There are so many other factors that cost time. (Man, Moroccan origin)

Participants indicated that when physical activity is integrated in their daily routine, it is perceived as less demanding. However, participants also perceive that they have to choose between competing activities, and other priorities such as social contacts that are valued as being just as relevant for a healthy life as being physically active. Both activities (fostering social contacts and physical activity) comprise values that are important to individuals, and the decision as to what is most valuable to them can result in a dilemma.

How social support can dilute the conflict of competing values

Most of our participants want to comply with the health norm. However, as mentioned previously, social influences with regard to healthy eating and physical activity can be perceived as a barrier. Yet, participants stated that combining health behaviour with sociability could enable them to initiate and maintain healthy eating patterns and physical activity behaviour. In this way, social relations can provide opportunities to initiate and maintain a healthy lifestyle. Exercising with someone else encourages participants to be physically active.

- M1: Exercising, I went to the gym with my daughter. That was good. [...] But I can't be bothered to go alone. I have to have a friend who goes with me. Then it is more fun.
- M2: To talk and to discuss things. (Men, Turkish origin)

This statement reveals that health behaviour, when combined with something pleasant, is perceived as less demanding. Many participants were not motivated to be physically active on their own and would prefer to be physically active in a group.

I would like to exercise with people the same age, so that you start at the same level and can build up your fitness together. (Woman, Dutch origin)

As described above, participants indicated that being part of a group is motivating, as it is more enjoyable to exercise with others. Several participants also acknowledged the power of social support to motivate and encourage them to eat healthily and dilute the conflict of competing values.

I said that you have more support [in a group]. [...] Yes, when you watch your diet with a group of people then you call one another. You ask to go for a walk, and with a group you go. Then you are able to stick to the regularity and the appointments. (Woman, Turkish origin)

This statement indicates that, apart from reducing demands, embedding health behaviour in an encouraging social context also ensures commitment.

Ways to justify current behaviour and to deal with the dilemma of competing values

Healthy eating and physical activity are experienced as interfering with daily responsibilities and other values. In order to find solutions for this dilemma, people generate

different ways to make sense of their own behaviour. This is reflected in the different ways participants reacted to the question of whether they were interested in lifestyle advice. Whereas, most Moroccan and Turkish women and some other participants were interested in counselling, several others stated that they were not interested in lifestyle advice. Persons who were not interested in lifestyle advice gave various explanations. One way in which they explained their disinterest was by emphasising that they were already taking care of their health. Dutch participants in particular stated that they were already eating healthily and were sufficiently physically active.

I move enough. I definitely move enough. I find that I move enough. And I feel good!
(Woman, Dutch origin)

Others stated that they were already actively monitoring their health. The following man has regular health checks and in this way takes responsibility for his health.

[...] My doctor checks my blood every year. They measure for diabetes and other things. And when the glucose level is too high, then I will have to watch it. (Man, Dutch origin)

Other participants implied a second way to make sense of their own behaviour; they compared themselves with others or emphasised their 'good choices'.

I eat convenience food, but I do not smoke and I do not drink. And my neighbour smokes and he also drinks [alcohol]. (Man, Dutch origin)

This reaction shows another way to deal with the tension between the contradicting values of a healthy life. Participants seek to balance their behaviour and, to them, allowing themselves some unhealthy behaviour makes sense as they feel that they make up for this with other healthy activities. Several participants used a third way. They did not perceive the need for dietary advice, as they were not affected by an illness yet. They interpret the fact of not being ill as having a good lifestyle.

I feel healthy. Thus I assume, I suppose, that I have eaten healthily so far. (Man, Turkish origin)

This person trusts his inner feeling for what his body needs and does not see the need to take action before he is bothered by health complaints. Making decisions on the basis of how he feels makes sense to him. As long as he feels good, he feels free to continue with his lifestyle as usual.

All these ways of sense-making show that individuals draw upon their own experiences and interpret these to construct their viewpoint(s) on what constitutes a healthy lifestyle. These different ways of reasoning provide them with solutions to deal with the dilemma of competing values and norms.

Discussion

In order to adapt lifestyle interventions for specific groups, it is important to understand the meaning that the target groups attach to their behaviour and a healthy life. This understanding will enable lifestyle intervention developers to optimise programme components that will best suit the target groups' needs and are therefore more likely to be

relevant to them (Krumeich et al., 2001). Our study offers a deeper insight into relevant aspects that play a role in initiating healthy lifestyles. Our results reaffirm that eating healthily and physical activity should not be seen as individual health behaviours but as collective social practices. Eating and physical activity are not always conscious processes, and so-called health behaviour is often not considered as such. These behaviours are often guided by daily routines, social norms and values, rather than by the constant effort to be healthy (Williams, 1995).

Although interviewing people about their (health) behaviour inevitably generates normative accounts of how people think they should act, and although what they say is not necessarily similar to what they do, focus groups reflect an interaction of individuals similar to a situation in their daily life and therefore can provide valuable insight into how people deal with dilemmas (Cornwell, 1984; Radley & Billig, 1996). Therefore, our data give valuable insight into our target groups' concerns, and the dilemmas that they experience in their daily life. Although our results cannot be generalised across the target populations, they provide useful ideas and opportunities to adapt lifestyle interventions with strategies that are generated by a sample of the target population itself.

Our analysis of accounts of healthy lifestyles reveals three main aspects. Firstly, our participants, regardless of their ethnic origin, struggle to maintain health behaviour because of competing values and norms. Health behaviour advocated in lifestyle interventions clashes with other norms and values, and people struggle to combine conflicting norms and values in their daily routine. Other research has illuminated similar challenges experienced by persons engaged in lifestyle intervention programmes. Descriptions of balancing and negotiating between pleasure-seeking and health-seeking were also mentioned in a study of Finnish adults (Jallinoja, Pajari, & Absetz, 2010). Taking this dilemma seriously will enable solutions to be found for this conflict. Considering health behaviour as social practice and combining it with other values like enjoyment and sociability might dilute this conflict.

The second aspect is that, for the initiation and maintenance of health behaviour, social practices of others are a source of resistance on the one hand and a potential enabler to elude the conflict of competing values on the other. The appreciation of social support has also been described by Hanlon, Morris, and Nabbs (2010). Social cohesion in interventions, such as giving participants time to socialise during activities, contributes to programme appreciation and is one successful ingredient for lifestyle interventions (Hanlon et al., 2010). More recently, other researchers have also identified group-based interventions as significantly more effective than other modes of delivery (Cleland, Granados, Crawford, Winzenberg, & Ball, 2012) and have emphasised the importance of a 'socially supported approach' (Mansfield & Rich, 2013). Thus, creating a supportive environment in order to address health behaviour in lifestyle interventions seems important to facilitate behaviour change.

Interaction with others and the social environment also influences participants' view of a healthy lifestyle and the accounts they produce. Therefore, the third aspect that our analysis illustrates is how people deal with the dilemma of competing values and reflect on their own behaviour in times when great emphasis has been placed on personal responsibility. The increased emphasis on lifestyle modification to prevent non-communicable diseases (Lupton, 2012; Minkler, 1999) and the emphasis on lifestyle as an individual's choice can evoke a feeling of responsibility for one's own health and illness (Greener, Douglas, & van Teijlingen, 2010; Lewis et al., 2010). Like in other studies, some of our participants used 'techniques of neutralisation', like

rationalisations, justifications and defining the (health) norms as irrelevant to their current situation, to protect themselves from self-blame (Heikkinen, Patja, & Jallinoja, 2010; Peretti-Watel & Moatti, 2006). Our participants try to combine health norms with the demands of everyday life and represent themselves as responsible citizens who are health conscious and balance risky and healthy behaviours. Their view on health has emerged through experiences and talk with others, and in the focus group interviews this process is activated again. People are aware of the health norm and, because they struggle to produce a view in which both the health norm and their desire for pleasure and joy have a place, they start to justify their behaviour. Similar discourses were observed by Katainen (2006) in her analysis of web discussions on smoking and Backett, Davison, and Mullen's (1994) studies in which respondents talked about trading 'good' behaviour for 'bad' behaviour to balance their overall health.

It is worth mentioning that, with regard to the themes discussed here, no major differences between ethnic groups were noted, except that Moroccan and Turkish women showed more interest in lifestyle advice than other groups and that, in general, Dutch participants seemed to get more support within their social network to follow lifestyle advice.

Conclusion

In this article, we identified elements that are important for the development of a lifestyle intervention targeting people with low SES of different ethnic origins. Our results emphasise the need to pay attention to the struggle of competing values and norms in daily life. Social practices should not merely be considered as health enhancing or damaging determinants. Strategies focusing on individual behaviour should be integrated within an approach that recognises the collective nature of lifestyle. One possibility would be to utilise the power of social support to elude the conflict of competing norms and values. Taking the social practices and daily circumstances of the target population into account seems crucial to initiate healthy lifestyles. In the next step of this project, future research will identify how these aspects can be implemented in a lifestyle intervention targeting people with low SES of different ethnic origins.

Acknowledgements

We thank the participants in our focus group interviews for sharing their thoughts and experiences with us, and *LekkerLangLeven* (cooperation between the Dutch Diabetes Research Foundation, the Dutch Kidney Foundation and the Netherlands Heart Foundation) for supporting this research. The authors also thank the reviewers for the useful comments on an earlier version of this manuscript.

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