CANADIAN FAMILY WELLNESS: EXPLORING CAREGIVER PERCEPTIONS OF PHYSICAL WELLNESS OF FAMILIES WITH CHILDREN AGES 2 TO 8

A Thesis Proposal Submitted to the
College of Graduate and Postdoctoral Studies
In Partial Fulfillment of the Requirements
For the Degree of Master of Education
In the Department of Educational Psychology and Special Education
University of Saskatchewan
Saskatoon

By

BRITTNEY KIEFER

© Copyright Brittney Kiefer, May 2024. All rights reserved. Unless otherwise copyright of the material in this thesis belongs to the author
Permission To Use
In presenting this thesis/dissertation in partial fulfillment of the requirements for a Postgraduate degree from the University of Saskatchewan, I agree that the Libraries of this University may make it freely available for inspection. I further agree that permission for copying of this thesis/dissertation in any manner, in whole or in part, for scholarly purposes may be granted by the professor or professors who supervised my thesis/dissertation work or, in their absence, by the Head of the Department of Educational Psychology and Special Education or the Dean of the College in which my thesis work was done. It is understood that any copying or publication or use of this thesis/dissertation or parts thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and to the University of Saskatchewan in any scholarly use which may be made of any material in my thesis.

Requests for permission to copy or to make other uses of materials in this thesis in whole or part should be addressed to:

Head of the Department of Educational Psychology and Special Education
College of Education, University of Saskatchewan
28 Campus Drive
Saskatoon, Saskatchewan S7N 0X1

OR

Dean
College of Graduate and Postdoctoral Studies
University of Saskatchewan
116 Thorvaldson Building, 110 Science Place
Saskatoon, Saskatchewan S7N 5C9
Abstract

In this thesis, the focus is on caregivers’ perceptions and experiences of family physical wellness in the context of play, outdoor interactions, and physical activity in relation to two theoretical frameworks: Swarbrick and Yudof’s (2015) eight dimensions of wellness and the five domains of the social determinants of health (SDOH) (WHO, 2008; Healthy People 2030, n.d.-c). According to Prilleltensky and Nelson (2000), family wellness denotes caregivers' enjoyment of both physical and intellectual wellness, alongside having adequate financial wellness resources and a supportive environment for both the child and caregiver’s wellness. In semi-structured qualitative interviews, nineteen caregivers (n = 19) were asked about their family physical wellness, inclusive of four physical wellness dimensions (exercise, healthy eating, time away from TV and screens, sleep). Currently, there is minimal research exploring caregivers’ perceptions and experiences of their own wellness as a well as their family’s wellness. This study aims to determine the contribution of the caregiver in their family’s wellness and their perspectives and shared insights as to how they are doing. The results of this study, through thematic analysis, revealed four significant themes and several subthemes and sub subthemes that were important to caregivers and families: (1) Environmental Wellness with subthemes (a) location matters, (b) impact of weather, and (c) outdoor interactions; (2) Physical Wellness with subthemes (a) exercise, (b) healthy eating, (c) time away from TV and screens, and (d) sleep; (3) Self-care with subthemes (a) the shoulds and societal pressures, and (b) conscious self-care advocates; and (4) Play with subthemes (a) learning through play, (b) outdoor play, (c) social and family connections, and (d) playful life balance. The implications of these shared themes, in connection to current literature, provides future research directions in the realm of family wellness.

Key words: family physical wellness, caregivers, complex, wellness model, experiences.
Acknowledgements

I commence by acknowledging my utmost, profound gratitude to my esteemed mentor and primary supervisor, Dr. Laurie Hellsten. Throughout the entirety of my research journey, her guidance and compassion have been my steadfast companions. The mentorship bestowed upon me by my supervisory committee members, namely Dr. Laureen McIntyre, Dr. Sherri-Lynn Skwarchuk, and Dr. Brenton Button, warrants sincere acknowledgment. The unwavering support and encouragement extended by both my supervisor and committee were pivotal in shaping my academic path. I am forever grateful. Thank you to the caregivers who generously contributed their time and insights during the interviews for my research. Your perspectives and personal narratives have left a deeply meaningful impression. My appreciation extends to the boundless love and motivation I received from my cherished friends, loving and devoted partner (Christian), parents (Bev & Walter), twin brother (Garrett), extended family, and colleagues. The endless conversations and consultations, spanning early morning to late evening, were an immense source of insight, reassurance, and light for me, instilling in me the belief that I am capable and to never give up. Lastly, my appreciation encompasses the University of Saskatchewan and the University of Manitoba, whose combined circles of support have granted me the unique opportunity to embark on this journey towards a master's degree.
# Table Of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>PERMISSION TO USE</td>
<td>ii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>iii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iv</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>ix</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>x</td>
</tr>
<tr>
<td>LAND ACKNOWLEDGEMENT</td>
<td>xi</td>
</tr>
<tr>
<td><strong>1.0 CHAPTER ONE: INTRODUCTION</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Background to the Problem</td>
<td></td>
</tr>
<tr>
<td>1.1.1 Family Wellness</td>
<td>3</td>
</tr>
<tr>
<td>1.1.2 Pandemic, Technology, and Physical Wellness</td>
<td>5</td>
</tr>
<tr>
<td>1.2 Theoretical Frameworks</td>
<td>8</td>
</tr>
<tr>
<td>1.3 Purpose of Study</td>
<td>12</td>
</tr>
<tr>
<td>1.3.1 Research Question</td>
<td>12</td>
</tr>
<tr>
<td>1.4 Significance of the Study</td>
<td>13</td>
</tr>
<tr>
<td>1.5 Positionality Statement</td>
<td>13</td>
</tr>
<tr>
<td>1.6 Definitions</td>
<td>15</td>
</tr>
<tr>
<td>1.6.1 Wellness</td>
<td>15</td>
</tr>
<tr>
<td>1.6.2 Physical wellness</td>
<td>15</td>
</tr>
<tr>
<td>1.6.3 Emotional wellness</td>
<td>15</td>
</tr>
<tr>
<td>1.6.4 Social wellness</td>
<td>15</td>
</tr>
<tr>
<td>1.6.5 Financial wellness</td>
<td>15</td>
</tr>
<tr>
<td>1.6.6 Occupational wellness</td>
<td>16</td>
</tr>
<tr>
<td>1.6.7 Environmental wellness</td>
<td>16</td>
</tr>
<tr>
<td>1.6.8 Intellectual wellness</td>
<td>16</td>
</tr>
<tr>
<td>1.6.9 Spiritual wellness</td>
<td>16</td>
</tr>
<tr>
<td>1.6.10 Wellbeing</td>
<td>16</td>
</tr>
<tr>
<td>1.6.11 Eight dimensions of wellness</td>
<td>16</td>
</tr>
<tr>
<td>1.6.12 Five domains of Social Determinants of Health (SDOH)</td>
<td>16</td>
</tr>
<tr>
<td>1.6.13 Family wellness</td>
<td>16</td>
</tr>
<tr>
<td>1.6.15 Interpersonal and intrapersonal relationships</td>
<td>17</td>
</tr>
</tbody>
</table>
2.0 CHAPTER TWO: LITERATURE REVIEW .................................................................19
  2.1 Defining Wellness .................................................................................................19
    2.1.1 How Families are living in Canada .................................................................22
    2.1.2 Global Insights .................................................................................................24
  2.2 Canadian Context of Wellness .............................................................................26
    2.2.1 Challenges to Workplace Wellness .................................................................26
    2.2.2 Defining Wellbeing ..........................................................................................26
    2.2.3 Caregiver Relationship to Family Physical Wellness .........................................27
  2.3 Theoretical Foundation: Wellness Instruments and Models ..............................27
  2.4 Theoretical Framework Selection Rationale: Swarbrick and SDOH ....................39
  2.5 Wellness Defined ..................................................................................................40
    2.5.1 Measuring Wellness .........................................................................................40
    2.5.2 Physical Wellness ..............................................................................................41
  2.6 Summary ................................................................................................................49

3.0 CHAPTER THREE: METHODOLOGY .................................................................51
  3.1 Research Questions and Design ............................................................................51
  3.2 Participants .............................................................................................................53
  3.3 Data Generation .....................................................................................................54
  3.4 Data Analysis ..........................................................................................................55
    3.4.1 Trustworthiness .............................................................................................59
  3.5 Ethics .......................................................................................................................61
  3.6 Summary ................................................................................................................62

4.0 CHAPTER FOUR: FINDINGS ................................................................................63
  4.1 Participants ..............................................................................................................63
    4.1.1 Wellness Defined by the Families ..................................................................65
5.3.2 Limitations of Current Study .......................................................... 152
5.4 Short-Term and Long-Term Implications ........................................ 154
  5.4.3 Implications for Model Development ........................................... 156
5.5 Directions for Future Research ....................................................... 159
5.6 Conclusions .................................................................................. 161
APPENDIX A: INFORMED CONSENT ...................................................... 163
APPENDIX B: PRE-INTERVIEW QUESTIONS ........................................ 166
APPENDIX C: EMAIL RECRUITMENT ADVERTISEMENT ...................... 170
APPENDIX D: WELLNESS QUESTIONNAIRE ........................................ 172
APPENDIX E: ETHICS APPROVAL DOCUMENTATION .......................... 178
REFERENCES .................................................................................... 180
List of Tables
Table 2.1. Components of Wellness Theory Models Over Time...........................................20
Table 2.2. Family Physical Wellness Research Findings....................................................43
Table 4.1. Demographic Details for the Study Participants.................................................63
Table 4.2. Importance of Wellness Dimension as Perceived by the Family.........................98
# List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Social determinants of health (SDOH)</td>
<td>9</td>
</tr>
<tr>
<td>1.2</td>
<td>Eight dimensions of wellness or Wellness inventory-r</td>
<td>10</td>
</tr>
<tr>
<td>1.3</td>
<td>Theoretical Frameworks</td>
<td>12</td>
</tr>
<tr>
<td>2.1</td>
<td>Wellness Timeline</td>
<td>21</td>
</tr>
<tr>
<td>2.2</td>
<td>Four quadrant model of high-level wellness</td>
<td>28</td>
</tr>
<tr>
<td>2.3</td>
<td>Illness-wellness continuum</td>
<td>29</td>
</tr>
<tr>
<td>2.4</td>
<td>Iceberg model of health</td>
<td>30</td>
</tr>
<tr>
<td>2.5</td>
<td>The wellness energy system</td>
<td>31</td>
</tr>
<tr>
<td>2.6</td>
<td>Hettler’s hexagon</td>
<td>33</td>
</tr>
<tr>
<td>2.7</td>
<td>The Wheel of Wellness</td>
<td>35</td>
</tr>
<tr>
<td>2.8</td>
<td>The Indivisible Self</td>
<td>36</td>
</tr>
<tr>
<td>2.9</td>
<td>Eight dimensions of wellness</td>
<td>38</td>
</tr>
<tr>
<td>3.1</td>
<td>Thesis Project Timeline</td>
<td>55</td>
</tr>
<tr>
<td>4.1</td>
<td>Themes and Subthemes</td>
<td>65</td>
</tr>
<tr>
<td>4.2</td>
<td>Environmental Wellness Theme</td>
<td>66</td>
</tr>
<tr>
<td>4.3</td>
<td>Physical Wellness Theme</td>
<td>79</td>
</tr>
<tr>
<td>4.4</td>
<td>Self-care Theme</td>
<td>100</td>
</tr>
<tr>
<td>4.5</td>
<td>Play Theme</td>
<td>109</td>
</tr>
<tr>
<td>5.1</td>
<td>Wellness is multidimensional and complex</td>
<td>116</td>
</tr>
</tbody>
</table>
Land Acknowledgement

I wish to acknowledge that this research is conducted within the ancestral domain of the First Nations and Metis peoples, specifically on Treaty 6 territory. I humbly honor the ancestors of these beautiful lands and waters, who diligently cared for both, and its diverse inhabitants. I affirm my connection to the land and people of this region. I pledge my dedication to fostering this bond and enhancing the wellness of those that live here currently, and those yet to be. My mom is from Nova Scotia and her parents were both multi-generational Canadians. Her roots are intertwined with connections to both Ireland and Scotland. My dad originates from Alberta, with his familial roots stemming from Orscholz, Germany. My dad’s father (grandfather) emigrated to Calgary, Alberta, Canada in the 1950’s seeking a new life from the upheaval of WWII. Presently, I am situated in Calgary, Alberta as a non-indigenous person committed and grateful to be learning and understanding from the people who have lived and continue to live here. I acknowledge that I live, work, and play on the traditional territories of Blackfoot Confederacy (Siksika, Kainai, Piikani), the Tsuut’ina, the Iyarhe Nakoda Nations, the Métis Nation (Region 3), and all people who make their homes in the Treaty 7 region of Southern Alberta.
1.0 Chapter 1: Introduction

Wellness is a multidimensional phenomenon that impacts a person’s identity, functioning, daily routine, and how one relates to themselves and others (Corbin & Pangrazi, 2001; Fullen, 2016; Knez et al., 2020; Myers & Sweeney, 2004; Roscoe, 2009). As of January 2023, the World Health Organization (WHO) official website has adopted the term *wellbeing* to characterize what was previously referred to as *wellness*. The adjustment in terminology is observed in the WHO’s Health Promotion Glossary of Terms 2021 document (WHO, 2021) where *wellbeing* is listed as a *new term* (p. 10). WHO’s newly defined term *wellbeing* is centred on quality of life and the capacity of individuals and communities to contribute meaningfully and purposefully within the global context (WHO, 2021). Before this recent modification, WHO described *wellness* as “the optimal state of health of individuals and groups” expressed as “a positive approach to living” (Smith et al., 2006, p. 344). Upon examining Smith and colleagues' 2006 reference to WHO’S glossary and referring to WHO’s 2020 Basic Document glossary, it has been determined that WHO updated its definition of wellness. The term wellbeing is now being used to describe “a positive state experienced by individuals and societies” (WHO, 2021, p. 10), replacing the previous characterization of wellness.

Contrary to the need to replace the term wellness with wellbeing, Simons and Baldwin’s (2021) doctor-patient relationship examination highlighted a distinction between these two terms based on the concept of responsibility. They argue that wellbeing is external to an individual “whereas wellness is usually measured by the responsibility of the individual” (Simons & Baldwin, 2021, p. 986). Echoing this differentiation between wellness and wellbeing, Roscoe (2009) noted that wellness is "personal, dynamic, and multidimensional" (p. 225). Building upon Roscoe's (2009) perspective, Carter and Andersen (2023) underscored that wellness involves cumulative and positive individual actions aimed at achieving an overall state of wellbeing. In conjunction with Roscoe’s (2009) perspective and definitions of *wellness* and *wellbeing*, I chose to focus my thesis on the individual elements and specific components that fall within the sphere of personal influence and action. Hence, my attention was directed to the terms connected to *wellness* as opposed to those related to wellbeing.

The essence of wellness is rooted in its subjective complexity (Fasone, 2017; Jensen & Allen, 1993; Miller & Foster, 2010; GWI, 2022). In terms of its definition and measurement, wellness has been conceptualized in various ways, sometimes vaguely, and across multiple
disciplines and contexts (Dodge et al., 2012; McMahon & Fleury, 2012; Miller & Foster, 2010; Roscoe, 2009; Travis & Ryan, 2004). When the U.S.A.’s wellness movement gained popularity in the 1980s, it eclipsed the historical and global exploration of wellness that dated back to 3,000 to 1,500 BCE (Gamby, 2021). Credited with having developed the first working definition of wellness in North America (Larson, 1999), the World Health Organization (WHO) defined wellness “as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1948, p. 2; WHO, 2020). The WHO also emphasized, at the First World Health Assembly in Geneva in 1948, that every human being had a fundamental right to "...the highest attainable standard of health... [physical, mental, and social well-being]” (WHO, 1948, p. 2; WHO, 2020). The composition of wellness has been articulated to encompass three fundamental dimensions: physical, mental, and social wellness (WHO, 1948; WHO, 2020). These underlying wellness dimensions informed subsequent wellness conceptualizations and theories. Halbert Dunn (1959), an American public health chief introduced the term “high-level wellness” (1959) as part of the first model of wellness. As with Dunn (1959), researchers who followed him adhered to and expanded upon the three foundational dimensions of wellness, as defined by the WHO (WHO, 1948; WHO, 2020).


In exploring how wellness has been defined and theorized, it is essential to also trace the evolution of wellness awareness, particularly through media influence. The comprehension of wellness can be attributed to the emergence of media influences in the 1980s (such as celebrity fitness trends, television, magazines, etc.), as well as the rise of online influences in the 2000s (such as through Instagram, Facebook, Twitter, and other social media platforms) (Cookingham & Ryan, 2015; Global Wellness Institute (GWI), 2018a; Vogels et al., 2022). As Lupton (2014) pointed out the “digital society…” has always had significant influence and “power in shaping social relations…the family… public health” and wellness (p. 175). Lupton (2014) further
highlighted that the World Wide Web became publicly accessible in 1994, gaining recognition as the “social web” (p. 175), and health-related apps facilitated access to wellness tracking and health promotion. Simultaneously, as Crawford (1980) pointed out, the widespread adoption of fitness routines endorsed by celebrities, coupled with the dissemination of messages about dieting, exercise regimens, and overall wellness through television and magazines, led to a cultural shift of “healthism” (p. 365), emphasizing a heightened focus on prioritizing wellness. Access to information has accelerated, profoundly shaping individuals’ perceptions and experiences of wellness (Fox, 2011; Trask, 2009). During the 1980s and 2000s, the wellness industry also gained wide popularity in North America, which was driven by a combination of clinical and non-clinical perspectives from humanistic psychologists and holistic physicians to experts in the fields of self-help, life coaching, nutrition, dieting, fitness, and workplace wellness (GWI, 2018a). Some synonyms frequently used to describe wellness included wellbeing, optimal health, healthy lifestyle, quality of life, life satisfaction, flourishing, thriving, self-care, and happiness (Adams et al., 1997; Barnett et al., 2007; Crose et al., 1992; Lambert et al., 2015; Myers et al., 1998; Myers & Sweeney, 1999; National Wellness Institute, 1983; Renger et al., 2000; Seligman & Csikszentmihalyi, 2000). For many Canadians, these terms are valuable, focus on positive aspects of wellness, and are common terms in their daily language. As wellness has historically been defined ambiguously, it can be challenging to develop programming to support an individual’s or group’s wellness and even more challenging to assess changes in wellness (Dodge et al., 2012; Oliver, 2018; Wert, 2020). Health professionals (Ardell, 1977; Brady et al., 2018; Malloy et al., 2013; Søvold et al., 2021; Trinkoff et al., 2022), psychologists and social workers (Barnett et al., 2007; Cox & Steiner, 2013; McGarrigle et al., 2011; Myers & Sweeney, 2005a), educators (Amaya et al., 2019; Greenberg, 1985; Pettit & Peabody, 2008; Sinclair, 2004), and others have consistently advocated for the prioritization of wellness both societally and individually, actively dedicating nearly a century to the progression of health and wellness promotion.

1.1 Background to the Problem

1.1.1 Family Wellness

According to Dunn (1959), family wellness is dependent on the intellectual wisdom and engagement of retired community members. Thus, family wellness and growth, including child development as well as emotional and social wellness for all family members, can be
strengthened through intergenerational relationships. Prilleltensky and Nelson (2000) added to this perspective by noting that family wellness was achieved through a balance of supportive, affectionate relationships and personal development opportunities for each member. Prilleltensky and Nelson (2000) stated that “[caregivers] who enjoy physical and psychological health, and who have access to adequate financial resources, will be in a good position to provide a wellness-enhancing environment for their children” (p. 87).

While the significance of wellness considerations in familiar structures is highlighted, a clear overarching definition of wellness and empirically validated wellness measures are the major obstacles to understanding wellness (Roscoe, 2009). Additionally, it’s unclear what family wellness is, how it is measured, and how a family’s physical wellness needs are met. Literature on how family wellness is measured and defined as well as how a family’s physical wellness needs are met, is lacking (Columna et al., 2017; Kokorelias et al., 2019; Pitchford et al., 2016). As Beckwith (2018) noted in their study exploring how caregivers experienced wellness, there is a focus on “[caregiving] styles (Baumrind, 1971; 1991; Robinson et al., 2001), [caregiving] skills (Hurley et al., 2014; O’Dell et al., 1982; Sanders, 1999),… poor [caregiver] mental health (Amrock & Weitzman, 2014; Baydar et al., 2003; Olfson et al., 2003), and [caregiver] stress (Berry & Jones, 1995; Loyd & Abidin, 1985; West et al., 2009)” (p. 5). Beckwith's (2018) inquiry deepened our understanding of caregiver wellness needs by examining how individuals explore wellness within the context of counselling and the role that counselling plays in assisting caregivers and families in reaching a state of wellness. Nevertheless, it is crucial to comprehend and address the distinct wellness needs of each family member, as well as their interrelated and collective wellness needs, to achieve family wellness. Children are also a part of the familial structure. Their wellness needs should be considered and it’s also important to acknowledge their influence on familial wellness. With increasing age, children grow their capacity to reciprocate, contribute to, and impact family wellness (Prilleltensky & Nelson, 2000). Therefore, it is vital to consider the wellness needs of both caregivers and children.

Given the emphasized focus of this research on the physical wellness of Canadian families, it was essential to present a selection of the existing literature pertaining to family wellness. The goal of the investigation was not to be limited to one specific dimension, (i.e., physical wellness, environmental wellness, emotional wellness etc.) or the wellness of one population (child wellness, caregiver wellness, etc.). Historically, literature does not capture
caregiver perceptions of their own physical wellness when caring for children aged 2 to 8 years (Columna et al., 2017; Linville et al., 2018; López-Aymes et al., 2021; Thompson et al., 2010; Zovko et al., 2021). Usually, when the literature includes caregivers in the discussion, the focus is on a caregiver’s influence on children’s physical activity level (Barnett & Chick, 1986; Burdette, 2004; Gordon, 2018; Jago et al., 2014; Kaseva, 2017; Myrhaug & Østensjø, 2014; Wilk et al., 2018) and/or eating habits (Dwyer et al., 2008; McMinn et al., 2013; Pratt et al., 2017; Zhao et al., 2013), caregiver role-modeling behaviours (Kaseva, 2017; Moreno, 2011; Schoeppe, 2016; Yang et al., 1996), caregiver perspectives on a specific intervention program (Craig et al., 2013; Haines et al., 2018; Hennessy et al., 2020; Nelson & Laurendeau, 2001; Prilleltensky, et al., 2001; Wilhite et al., 2012), or focus on obesity-prevention/weight maintenance and reduction (O’Kane et al., 2017; Po'e et al., 2013; Uijtdewilligen, 2017; Zhao et al., 2013). Potentially, the primary key term in researching family wellness was wellbeing as explored by Hunter (2017), Koltz et al. (2021), and Newland (2015), rather than wellness as explored by researchers such as Corbin and Pangrazi (2001), Fullen (2016), Holdsworth (2019), Knez et al. (2020), Myers & Sweeney (2004), Roscoe (2009), Smith et al. (2006), and Swarbrick and Yudof (2015). Upon review of the available literature, a notable gap persists in addressing a qualitative focus on caregiver perceptions of wellness for the family in Canada.

1.1.2 Pandemic, Technology, and Physical Wellness

The global COVID-19 pandemic transformed, disrupted, and in some cases halted how Canadian families experience physical wellness. Canadian provinces quickly devised their own plans on how to support communities and families in staying safe and healthy. Moore and colleagues (2020) recently conducted a national child and youth survey about movement and play during COVID-19. Regardless of the context of pandemic, the authors stated that “healthy movement behaviours contribute to the physical and mental health of children and youth including a more robust immune system” (p. 2). During the pandemic, public health messaging across the nation was delivered in a conflicting manner. At times citizens were advised to socially distance, wear a mask, self-isolate, and stay at home while at other times it was promoted to get outside and continue staying physically active (Petersen et al., 2021).

Since the pandemic, connecting in-person has shifted to a reliance on technological connectivity (Juvonen et al., 2021). Increasingly, the reliance on virtual or online communication for work, school, and other familial meetings has become more commonplace. A survey of about
1,700 American adults, conducted by the Pew Research Centre (2021), reported that 72% of their children are now spending more time on screens than before the pandemic (McClain et al., 2021), playing video games 20% more, and using smartphones 14% more. The survey also noted that about a third of adults attempted cutting back on smartphone and internet usage during the pandemic (McClain et al., 2021). Pandya and Lodha (2021) further pointed out the difficulty in distinguishing what was considered healthy social connectedness via digital media and communicated that the prolonged use of screen time during the pandemic threatened a person’s physical and mental wellness.

According to the national Canadian Community Health Survey (Moore et al., 2020), caregivers reported that their children “were less active, played outside less, were more sedentary, engaged in more recreational screen-based activities, and slept more during the COVID-19 virus outbreak compared with before the restrictions” (p. 6). Moreover, Bahkiri and Grandee (2020) extended this assertion by indicating that children were experiencing a more sedentary lifestyle than prior to COVID-19. A shift in technology use during the pandemic has deeply impacted child and youth’s mental and physical wellness in a multi-faceted way, including increased stress, social isolation, and disruptions in physical activity access and routines (de Figueiredo et al., 2021; Samji et al., 2022; Tso et al., 2020). Factors such as caregiver perspectives on their child’s increased engagement in screen time and daytime sleeping as well as family structure demographics (e.g., household income, level of education, lone-caregiver, lone-child, etc.) were highlighted (Colley & Watt, 2022). Although not the main discussion of the national CCHS, Canadian adults have also been impacted in various ways and may experience “significant long-term implications for both physical and mental health” (di Sebastiano et al., 2020, p. 7). Both the quantity of caregivers within this demographic and their individual perception and experiences of physical activity was undisclosed, thus requiring further investigation.

During the COVID-19 restrictions, McCarthy et al. (2021) conducted a 22-week study on physical activity behavior in the UK. Using an app called BetterPoints the researchers observed large decreases in physical activity among adult participants. BetterPoints “offers rewards (points, lottery style tickets, and virtual rewards such as medals) for the amount of physical activity tracked per week” (McCarthy et al., 2021, p.3). McCarthy et al. (2021) examined other physical data apps, such as the Fitbit, which also illustrated a decline in physical activity. In the
Canadian context, Fitbit logged a 14% decline in Canadians’ step activity in March 2020 when compared to the previous year (di Sebastiano et al., 2020). Observations indicated an age-related impact on physical activity levels. Younger individuals demonstrated greater activity levels before lockdown measures were implemented, which declined afterward, whereas those aged 65 and older sustained higher activity levels, rebounding swiftly after restrictions were eased, and recovering their physical activity levels more rapidly (McCarthy et al., 2021). According to ParticipACTION’s Report Card on Physical Activity for Children and Youth (ParticipACTION, 2020) fewer than 20% of children and youth in Canada were adhering to “national guidelines regarding physical activity, sedentary habits, and sleep behaviours” (p. 21). Contributing factors to the decline in physical activity, particularly for younger individuals, include heightened worry and concern about COVID-19. Additionally, the shift to remote work and increased responsibilities for childcare and other home tasks, typically handled externally, may have played a role (Hammami et al., 2022; McCarthy et al., 2021).

When reviewing the Fitbit, CCHS, and other data from the past couple of years it is unclear how many of these adults are caregivers (di Sebastiano et al., 2020; fitbit, 2020; Moore et al., 2020). Studies do support that physical activity involvement of both Canadian caregivers and children were affected amid the pandemic (Colley & Watt, 2022; Samji et al., 2022). For example, a recent study by Seal et al. (2023) revealed that a significant consequence of COVID-19 for both caregivers and their children with ADHD was a reduction in physical activity participation. However, their study focused on 15 families from one demographic, (i.e. families with children aged 7 to 12 with ADHD), and the relationship between caregiver activity and child activity remains unexplored. In the existing literature, a lack of caregiver perceptions of their own physical activity and more comprehensively their overall physical wellness, which includes but is not limited to physical activity, has been particularly noticeable (Miller & Foster, 2010). Furthermore, an in-depth account of a caregiver’s perspective on sleep, healthy eating, time away from TVs and screens, and exercise is missing. For instance, Pyper et al. (2016) conducted a Canadian study, involving more than 3,000 caregivers, investigating three out of the four dimensions of physical wellness. The authors examined how caregiver physical wellness behaviours, including screen time, physical activity, and healthy eating, can influence child wellness (Pyper et al., 2016). Yet, omitted from their paper was a discussion on sleep, due to lacking Canadian national sleep hygiene guidelines, as well as a caregiver’s own perceptions and
experiences of wellness. All four familial physical wellness dimensions, including the three dimensions mentioned previously as well as sleep, seem to be reviewed in an American study by Jansen et al. (2021). Conversely, they highlighted a different thesis, how caregiver stress may be linked with various food caregiving practices. Additionally, caregiver perceptions of their own relationship to these four physical wellness behaviours were again missing. Gayatri and Puspitasari (2023)’s study recognized the impact of the pandemic on caregiver physical wellness. Nonetheless, these recent studies illuminate the oversight in acknowledging caregiver perspectives on their experiences regarding family physical wellness. By providing an integrated view and considering how both children and caregivers are affected, an enriched understanding of family physical wellness can be explored and promoted.

1.2 Theoretical Frameworks

Researchers have endeavoured to identify the lack of attention on caregivers’ physical wellness by proposing various theories. Two theoretical frameworks were used to better understand the literature, guide the study design, implementation and analysis, and further advance research into family physical wellness: (1) the five domains of social determinants of health (SDOH) (WHO, 2008; Healthy People 2030, n.d.-c); and (2) Swarbrick's eight dimensions of wellness, or the wellness inventory-r (Swarbrick & Yudof, 2015).

The SDOH is a framework established by the World Health Organization (WHO). In 2004, the SDOH was developed for the purpose of understanding the factors that influence health outcomes in different communities and clarifying how to meet an internationally shared goal of achieving health equity (WHO, 2008). Although the Black Report and the follow-up Health Divide in the United Kingdom in 1980 (Townsend et al., 1992) made significant contributions to the study of the SDOH, several iterations of the framework have since identified key determinants that construct the SDOH globally (Brennan Ramirez et al., 2008; Dahlgren & Whitehead, 1991, 2021; Lynch et al., 2000; Marmot & Wilkinson, 2001; Raphael, 2006, 2016; Raphael et al., 2020; Tarlov, 1996; WHO, 1986; Wilkinson & Marmot 2003). Currently, the most recent SDOH framework is based on the Healthy People 2030 report (n.d.-c) from the American Office of Disease Prevention and Health Promotion (ODPHP). This framework describes the SDOH as “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” (Healthy People 2030, n.d.-c, para 1). The current SDOH are grouped into
five domains: (1) economic stability; (2) education access and quality; (3) health care access and quality; (4) neighbourhood and built environment; and (5) social and community context (Health People 2030, n.d.-c, see Figure 1.1).

**Figure 1.1**

*Social determinants of health (SDOH)*

In Wellesley Institute's study of Canadian perceptions of the SDOH, it was found that the SDOH are not always highly considered by citizens due to the dominant individualistic approach to wellness and health, overriding a broader community view (Snyder et al., 2016). Their scoping review highlighted that Canadians “seem to understand the relationship between health and the downstream factors (like lifestyle choices), better than upstream factors (such as housing and income)” (Snyder et al., 2016, p. 9). As incorporated in the Wellesley Institute’s examination from 2016, a discovery from the Canadian Institute for Health Information revealed that when questioned “70% of Canadians believed they had excellent/good knowledge of health issues when prompted” (Snyder et al., 2016, p. 4). Only a third of respondents indicated that elements such as housing, a supportive community, and income, which pertain to the broader economic and social conditions, impacted the health of the Canadian population. Raphael (2006) underscored that if communities only focus on the market, a holistic consideration of health, its
determinants, and wellness is overlooked. Therefore, this study utilized the SDOH to facilitate an examination on how to improve family wellness holistically. Although Raphael (2006) noted the SDOH had theoretical shortcomings and obstacles, such as the omission of Canadian "political, economic, and social forces influencing the quality of these health determinants" (p. 654), he also emphasized the significance of the framework in granting access to distinctive, insightful, and rich sources of inquiry. This, in turn, contributes to the enhancement of health and wellness through political and social action.

As a complement to the five domains of SDOH (WHO, 2008; Healthy People 2030, n.d.-c), Swarbrick and Yudof’s (2015) eight dimensions of wellness or the wellness inventory-r, will also provide a theoretical framework for this thesis (see Figure 1.2). Swarbrick and Yudof (2015) embrace the following eight wellness dimensions in their model: (1) emotional; (2) social; (3) physical; (4) occupational; (5) financial; (6) intellectual; (7) environmental; and (8) spiritual.

**Figure 1.2**

*Eight dimensions of wellness or Wellness inventory-r*

![Image of Wellness Model](image)


The eight dimensions of wellness (Swarbrick & Yudof, 2015) is a framework established by Swarbrick (1997). Swarbrick (1997) discussed incorporating two fundamental frameworks
into her concept of wellness: 1) Johnson's (1986) definition, which acknowledged three aspects of wellness (spiritual, physical, and emotional), and 2) Dossey et al.'s (1989) five dimensions of wellness, which expanded on Johnson’s (1986) three dimensions to also include social and environmental. Upon examining Dossey et al.'s (1989) work on wellness, it appeared that five of Swarbrick and Yudof's (2015) eight dimensions were exemplified. Dossey et al. (1989) identified that wellness is “movement toward wholeness or to make whole on all levels — physical, mental (intellectual), emotional, social, and spiritual' (p. 41). Johnson’s (1986) wellness definition nor Dossey et al.’s (1989) five-dimensional wellness framework were cited by other wellness researchers discussed in this thesis. However, Swarbrick (1997) notably recognized the significance of Johnson’s (1986) and Dossey et al.’s (1989) influence on their work. As an American substance use and mental health advocate, Swarbrick (1997) has moved the deficit-based medical model approach forward to further encompass wellness as multidimensional and holistic. By 2006, Swarbrick (2006) cited that there were eight important wellness dimensions, adding occupational, financial, and intellectual dimensions to the mix, with their purpose to shift an individual’s attention away from a label of illness or disease to their empowering abilities, self-management skills, and interests.

Each of the five SDOH domains can be related to Swarbrick and Yudof's (2015) wellness inventory-r (listed in parentheses) as follows (see Figure 1.3): economic stability (financial wellness), education access and quality (intellectual, occupational wellness), health care access and quality (physical wellness), neighbourhood and built environment (environmental wellness), and social and community context (social, emotional, and spiritual wellness).
1.3 Purpose of Study

The purpose of the study was to investigate family physical wellness among a sample of Canadian families with children 2 to 8 years old. The eight dimensions of wellness model proposed by Swarbrick and Yudof (2015) and the five domains of social determinants of health (SDOH) (WHO, 2008; Healthy People 2030, n.d.-c) helped to inform how Canadian caregivers defined, related to, and perceived physical wellness for themselves and their children. This study also facilitated a deeper insight into family physical wellness in Canada. In addition, through the lens of the caregiver, this study specifically examined how a family perceived, understood, reflected on, and interacted with physical wellness and how this understanding and perception extended to play, outdoor spaces, and physical activity during a pandemic.

1.3.1 Research Question

This study used a qualitative, semi-structured interview approach to explore Canadian family wellness, specifically physical wellness. The research question guiding this study was:

What are caregivers’ perceptions and experiences of family physical wellness in the context of play, outdoor interactions, and physical activity?
1.4 Significance of the Study

The results of this study increased our understanding of how to support family wellness, and how it is perceived by Canadian families, with the potential to positively impact educators, family members, and Canadian communities. The extensive study of wellness from a variety of disciplines has resulted in a literature base flooded with conflicting results and entangled with misinformation (Fasone, 2017; Jensen & Allen, 1993; Miller & Foster, 2010). However, few studies to date have examined wellness in a familial context, and no existing psychometrically sound measures of family wellness have been published. Supporting this assertion, a study on family wellbeing study conducted in the United Kingdom by Wollny et al. (2010) stated that there is “no well-established consensus about the best way to measure” family wellness (p. 5). The result of this research has the potential to inform educational and social programming that will contribute to enhancing familial physical wellness through establishing significance, which in turn will contribute to health promotion policy at the municipal, provincial, and national levels.

1.5 Positionality Statement

In the context of the current social and political contexts, I find relevancy in exploring the interrelationship between personal and familial wellness, specifically physical wellness. My curiosity and consideration for this interrelationship cannot be traced back to a specific origin as I have remained fascinated in this exploration ever since I can remember. However, amid the pandemic, like many, I became increasingly aware of my own limitations and abilities to be physically well. Furthermore, the intrapersonal relationship now looks and feels different, at least to me. In reflecting on how I intend to explore intrapersonal and interpersonal relationships (see definitions section), I am also reminded of my privilege, particularly having space and time to contemplate these inquiries. As a White, educated, heterosexual and partnered, able-bodied and athletic, Canadian, female, master’s student, I have an ability to illuminate voices that many others may not experience.

I have often struggled with whether or not it is relevant for my voice to be heard, questioning if I am the right one to be speaking up? Self-advocating has previously provided me with a greater sense of safety, acceptance, and connectivity than not. As well, I am aware of the importance of connectivity in wellness. Therefore, the fear of expressing my findings, for example in research, is rooted in previous negative experiences and thinking patterns of
disconnection. With intention, throughout the writing process and this study, I sought to interrogate my values, beliefs, and cognitive dissonance. Cognitive dissonance, or the psychological conflict or discomfort experienced when trying to balance contradictory feelings, thoughts, and values arose when trying to write my thesis (Dilakshini & Kumar, 2020). My beliefs and values were at times in contradiction to my actions and during the writing process, I frequently felt misaligned. Consistently, the pull or desire to express something I knew or believed to be valuable and true was there. However, the action of sitting down to write and capture those true and valuable feelings, thoughts, and beliefs at times seemed like an excruciating task and impossibly intimidating. As Tolentino (2020) pointed out, the act of writing either sheds or develops self-delusion. This continuous tension of ability, to write or not to write, led me to realize: if I am not the right person to write, share, or be heard on this work, who was? I aimed to learn more about a voice, or the voices I shared, and to better utilize my own voice, the one that evolved alongside this research. The emerging voices that I shared through the interview process might not always be analogous and certainly participant voices may or may not echo my own voice and experiences. Taking the risk of sharing my voice in vulnerability is a natural impulse for me. Even when I was unaware of how my words would be received or if my intended message would be understood, I appreciated the opportunity and privilege to reflect together.

My physical location, as well as many aspects in my life, changed over the course of my graduate studies. As I write this statement, I'm living in Calgary, Alberta. In addition to being a master’s student in educational psychology at the University of Saskatchewan, I am a research assistant with the University of Winnipeg and a crisis centre manager, community resource specialist, child caregiver, and a wellness advocate in the community of Calgary. Throughout my work and volunteer experiences, I have provided support to and learned from children, teenagers, and families from various backgrounds and local and global communities. I have learned that families undergo many challenging situations in which strain and overwhelm a family’s capacity to achieve and maintain wellness. As a result of the pandemic, family wellness was further complicated. Thus, supporting a family is something I have actively sought to understand. Therefore, this bias in working from a humanist- and family-centered position impacts how I look for this interrelationship among participants. Ultimately, I must stay focused and aware of how this bias will impact the data collection and analysis.
1.6 Definitions

The following terms will be utilized throughout this study and have been included to provide clarity.

1.6.1 Wellness

The Constitution of the World Health Organization (WHO) defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (WHO, 1948, p. 2; WHO, 2020) and wellness as “the optimal state of health of individuals and groups” expressed as a “positive approach to living” (Smith, Tang, & Nutbeam, 2006, p. 344). The Global Wellness Institute (GWI) defines wellness as “pursuit of activities, choices and lifestyles that lead to a state of holistic health” (GWI, 2017, p. iii).

1.6.2 Physical wellness

As per Swarbrick and Yudof’s (2015) definition, physical wellness “involves the maintenance of a healthy body, good physical health habits, nutrition, and exercise, and obtaining appropriate health care” (p. 4). Building upon Swarbrick and Yudof's (2015) characterization of physical wellness, which primarily encompasses nutrition and exercise, this study within the Canadian family context refined its investigation to four specific dimensions: exercise, healthy eating, time away from TV and screens, and sleep.

1.6.3 Emotional wellness

As defined by Swarbrick and Yudof (2015), emotional wellness “involves the ability to express feelings, enjoy life, adjust to emotional challenges, and cope with stress and traumatic life experiences” (p. 14).

1.6.4 Social wellness

Social wellness, as characterized by Swarbrick and Yudof (2015), “involves having relationships with friends, family, and the community, and having an interest in and concern for the needs of others and humankind” (p. 12).

1.6.5 Financial wellness

According to Swarbrick and Yudof (2015), financial wellness “involves the ability to have financial resources to meet practical needs, and a sense of control and knowledge about personal finances” (p. 16).
1.6.6 **Occupational wellness**

As specified by Swarbrick and Yudof (2015), occupational wellness “involves participating in activities that provide meaning and purpose, including employment” (p. 18).

1.6.7 **Environmental wellness**

Swarbrick and Yudof (2015) defined environmental wellness as involving “being and feeling physically safe, in safe and clean surroundings, and being able to access clean air, food, and water. Includes both our microenvironment (the places where we live, learn, work, etc.) and our macro-environment (our communities, country, and whole planet)” (p. 8).

1.6.8 **Intellectual wellness**

Intellectual wellness, as stated by Swarbrick and Yudof (2015), “involves lifelong learning, application of knowledge learned, and sharing knowledge” (p. 6).

1.6.9 **Spiritual wellness**

Spiritual wellness, in accordance with Swarbrick and Yudof’s (2015) definition, “involves having meaning and purpose and a sense of balance and peace” (p. 10).

1.6.10 **Wellbeing**

Wellbeing is “the support, confidence, and resources to thrive in contexts of secure and healthy relationships, realizing their full potential and rights” (Ross et al., 2020, p. 473).

1.6.11 **Eight dimensions of wellness**

For use within my context and study, the eight specific and interconnected dimensions identified by Swarbrick and Yudof (2015) and endorsed by Substance Use and Mental Health Services Administration (SAMSHA), are emotional, spiritual, intellectual, physical, environmental, financial, occupational, and social.

1.6.12 **Five domains of Social Determinants of Health (SDOH)**

Additionally, another theoretical framework was used in the study, the five domains of the social determinants of health (SDOH) (WHO, 2008; Healthy People 2030, n.d.-c): (1) economic stability; (2) education access and quality; (3) health care access and quality; (4) neighbourhood and built environment; and (5) social and community context.

1.6.13 **Family wellness**

“Family wellness is not the “absence of discord” (Prilleltensky & Nelson, 2000, p. 87) but rather family wellness is the expression of support and affection that nurtures the collective wellbeing of the entire family. Prilleltensky and Nelson (2000) emphasized that family wellness
programs need to “adopt a model of social responsibility to replace the dominant paradigm of individual responsibility” (p. 99).

1.6.15 Interpersonal and intrapersonal relationships

Uskul, Cross, and Günsoy (2023) illuminate that the connections “occurring between individuals” falls under the category of interpersonal, while intrapersonal pertains to processes transpiring “within an individual's own mind” (p. 2).

1.6.16 Caregiver(s)

Coalition for Diversity and Inclusion in Scholarly Communications referred to caregivers as “people providing care” and to “avoid the assumption that a woman is the primary caregiver in any situation” (p. 17). Similarly, a caregiver, guardian, or extended family member in this research was defined as someone consistently addressing a child's basic needs and served as “a secure base from which to explore and, when necessary, as a haven of safety and a source of comfort” (Benoit, 2004, p. 541).

1.6.17 Play

As Koeners and Francis (2020) eloquently defined play, (citing Burghardt, 2005; Caillois, 2001; Huizinga, 1949) it is “easy to recognize…an activity or expression that is fun, enjoyable, voluntary and non-serious…and involves an in-the-now-attitude” (p. 144).

1.6.18 Physical activity

Physical activity, as defined by Caspersen, Powell, and Christenson (1985), is “any bodily movement produced by skeletal muscles that results in energy expenditure” (p. 127). Additionally, Humbert et al. (2006) defined physical activity utilizing an ecological model and stated that “one must address the characteristics of physical activity at multiple levels and consider the integration and interaction of the factors within each of the three domains,” intrapersonal, social, and environmental (p. 468).

1.6.19 Exercise

Exercise, as defined by Caspersen, Powell, and Christenson (1985), “has been used interchangeably with physical activity and…both have a number of common elements…” (p. 128). However, exercise is “subcategory of physical activity” and “is planned, structured, repetitive, and purposive” (p. 128).
1.6.20 Fitness

Unlike physical activity, which pertains to the actions and movements that individuals engage in, Caspersen, Powell, and Christenson (1985) defined fitness as the “set of attributes that people have or achieve” (p. 128).

1.6.21 Health

As mentioned previously in the wellness definition (p. 19 of this thesis), health is “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1948, p. 2; WHO, 2020). Callahan (1973) defined health as not merely a choice but “the golden key” (p. 83) or remedy for human suffering, determinant to our survival. Callahan detailed that health “is not just a term to be defined” but “something we seek and value” (p. 84). Health encompasses play, exercise, physical activity, fitness, wellness, and numerous other concepts expanded upon within this thesis.

1.6.22 Participant understanding of definitions

It's important to acknowledge that physical family wellness participants might not adhere strictly to these distinctions, potentially utilizing the terms and definitions interchangeably or in a non-academic way.

1.7 Chapter Organization

The thesis progresses to include information on family physical wellness and caregiver perceptions and experiences of physical wellness. Chapter two begins with a literature review related to wellness globally and in the Canadian context. Then follows a discussion on the historical development as well as the theoretical and empirical conceptualizations of wellness, how wellness and family wellness is defined, how caregivers perceive physical wellness, as well as a critical analysis of research that most closely relates to family physical wellness. The third chapter outlines the qualitative methodology and provides an overview of the selection of participants, data collection and analysis, and ethical considerations. In chapter four, a description of the results and key findings is detailed. Finally, in chapter five, a findings summary, an evaluation of the study’s limitations and strengths, along with future suggestions for research is included.
2.0 Chapter 2: Literature Review

This chapter provides an overview of the context and importance of wellness including why wellness is thought to be vital for human beings and the consequences of not having wellness. Global perspectives on wellness including prevalence and statistics are then provided before an overview of the Canadian context. A historical overview of how wellness has been theoretically and empirically conceptualized over time follows prior to specific discussions about how family wellness is defined, and how caregivers perceive physical wellness. This chapter concludes with a description and critical analysis of the research completed to date that most closely relates to family physical wellness.

2.1 Defining Wellness

Defining wellness is complicated due to the overlap and breadth of the terms such as wellness, wellbeing, happiness, quality of life, health, and others. Wellness definitions and models have changed over time (see Table 2.1). According to Dodge et al. (2012), the definition and measurement of wellness, as well as the understanding of how wellness, wellbeing, happiness, quality of life, health, and other synonymous terms relate and differ from each other, remains largely unresolved. A starting point for many researchers in the field is utilizing the World Health Organization’s 1948 definition of health: “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1948, p. 2; WHO, 2020). Similarly, the Global Wellness Institute (GWI) defined wellness as a “pursuit of activities, choices and lifestyles that lead to a state of holistic health” (GWI, 2017, p. iii).
Table 2.1
Components of Wellness Theory Models Over Time

Components of Wellness Theory Models
(based on Swarbrick & Yudof’s (2015) Eight Dimensions of Wellness)

<table>
<thead>
<tr>
<th>Author</th>
<th>Emotional</th>
<th>Spiritual</th>
<th>Intellectual</th>
<th>Physical</th>
<th>Financial</th>
<th>Environmental</th>
<th>Occupational</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Health Organization (WHO), 1948</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dunn, 1959</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travis, 1972</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hettler, 1980</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arndt, 1982</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travis, 1981</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dossey, Keegan, Guzzetta, 1989</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sweeney &amp; Witmer, 1991</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swarbrick, 1997</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witmer, Sweeney, &amp; Myers, 1998</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eckstein, 2001</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myers &amp; Sweeney, 2004</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ellis &amp; De la Rey, 2006</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Granatello, 2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swarbrick &amp; Yudof, 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melnyk &amp; Neale, 2018∗</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Melnyk & Neale introduced a 9th dimension, creative wellness

Note. The colours of the dimensions reflect Swarbrick and Yudof’s (2015) eight-dimensional wellness model. The filled cells indicate how each model source relates to Swarbrick’s eight dimensions of wellness (Swarbrick & Yudof, 2015).

Not always does each source name their dimensions the way Swarbrick does. For example, Travis (1981) included a feeling dimension in their model which would be categorized as the emotional dimension based on Swarbrick and Yudof’s (2015) model. Additionally, Melnyk and Neale (2018) included a ninth dimension of wellness, creative wellness, that Swarbrick did not (Swarbrick & Yudof, 2015).

North America began to adopt a more balanced, holistic, and harmonious view of wellness and recognized the relationship between mind, body, and spirit, around the 19th century (Leguizamon, 2005). This philosophy originated from ayurvedic eastern healing and holistic medicinal practices (Eckstein, 2001; Svalastog et al., 2017), which prioritized wellness to focus on balancing the body, mind, and spirit. In Canada, the biomedical approach, rooted in settler
colonialism, disregarded Indigenous health knowledge and healing practices perpetuating the impact of intergenerational trauma, systemic racism, colonialism, and cultural oppression (Allen et al., 2020). While not the primary focus of this thesis, it’s central to highlight that Native Wellness shaped the wellness movement in Canada (Fiedeldey-Van Dijk et al., 2017). As cited in McCornery and Dumont (2010), “Native Wellness is a whole, and healthy person expressed through a balance of spirit, heart, mind, and body” (Fiedeldey-Van Dijk et al., 2017, p. 4). Accordingly, a holistic wellness approach emerged in the 1950s (Dukes, 2016). This approach encouraged people to choose healthy, supportive lifestyles and move beyond the dichotomous wellness definition of sickness vs. health (Dunn, 1959; Jensen & Allen, 1994). Today, the wellness definition in North America tends to focus on the personalization of wellness and the promotion of self-care, self-optimization, self-tracking, and lifelogging (Lupton, 2017). A brief wellness timeline includes some key speakers from the 50s to today (see Figure 2.1).

**Figure 2.1**

*Wellness Timeline*

*Note.* This timeline includes the major key speakers on wellness (not everyone) across a wide array of disciplines of education, medicine, nursing, counselling, mental health, and substance use.
Throughout this study, wellness will be synonymous and used interchangeably with terms such as wellbeing, health, happiness, quality of life, vitality, and optimal living (e.g., Burckhardt & Anderson, 2003; Edlin & Golanty, 2015; Lambert et al., 2015; Renger et al., 2000). Wellness is multi-dimensional (Corbin & Pangrazi, 2001). Although there is a variety or range of wellness sub-dimensions, from two (physical and mental) to more than nine dimensions, as suggested by Melnyk and Neale (2018), it is important to understand the inter-relatedness of the dimensions and that each dimension influences the other dimensions. Wellness is frequently considered a sub-component of health that focuses on disease prevention and is a condition, quality, and ongoing state of existence for an individual (Travis, 1988). Wellness is “a zest and enthusiasm for life…[incorporating]…the whole person throughout the totality of the life span” (Myers, 1991, p. 2).

Even though “we are prone to instinctively focus(ing) on the easily discernable physical components of wellness” (Fasone, 2017, p. 29), wellness is not limited to physical fitness/activity or how fit or well an individual believes they are. Among the limitations of emphasizing a biomedical focus on wellness is the sole focus on an individual's physical health, lack of disease, and body performance (Fasone, 2017). Taking this approach ignores the various dimensions of wellness that exist within an individual (Fasone, 2017). This perspective is in direct alignment with what Corbin and Pangrazi (2001) put forth regarding how having a clear, uniform, and holistic definition of wellness is imperative “rather than having competing definitions” (p. 6). Corbin and Pangrazi (2001) emphasize that wellness programs can only be considered genuinely qualified if they encompass all wellness dimensions, extending beyond the confines of the physical dimension alone. Additionally, “any and all lifestyles that contribute to wellness must be included not just physical activity” (Corbin and Pangrazi, 2001, p. 6).

2.1.1 How Families are living in Canada

According to Statista Research Department (2023), approximately 94.84 million families reside in North America, including 10.61 million in Canada and 84.23 million in the U.S. In Canada, the typical nuclear family consists of about three members, while Senegal holds the distinction for the largest global family size, averaging about 10 members per household (Statista, 2024). The number of families living in Canada has grown 16% over the last 15 years, from 9.06 million in 2006 to 10.61 million in 2022 (Statista, 2022). Currently, the life expectancy in Canada is roughly 82 years (Bushnik et al., 2018), As families continue to grow
larger and live longer, understanding family wellness from the caregiver's perspective is more critical than ever to ensure global health and wellness.

It is crucial to consider the alarming health costs associated with varying levels of wellness and health among families since a continuum of wellness exists. For instance, the Canadian Institute for Health Information’s (CIHI, 2023) latest report of the 38 OECD countries demonstrated that Canada's health care expenditure was one of the highest internationally. In 2020, Canada’s spending per capita ranked 4th at CA$7,507, behind the top-ranked United States ($15,275) and second and third ranked Germany ($8,938) and Netherlands ($7,973; CIHI, 2023). In 2022, health care costs represented 13% of the GDP, or about $331 billion annually with half of the health budget going to hospitals (25%), drugs (14%), and physicians (13%) (Canadian Medical Association, 2022).

As Knibb-Lamouche (2012) pointed out in their study, Canadian health promotion and medicine often tackle health, illness, and disease symptomatically which neglects to treat individuals holistically. Knibb-Lamouche (2012) also highlighted that:

- commonly, people from a nehiyawak (People of the Four Direction; Plains Cree) community in northeastern Alberta would recall their experiences of accessing health care in the area by saying, ‘They only go there [a hospital] to die, not to get better’ (p. 65).

Alongside Knibb-Lamouche’s (2012) advocacy for a cultural, holistic, and multi-dimensional view of one’s wellness, Canadian health organizations (such as Public Health Agency of Canada, Canadian Mental Health Association, Wellness Together Canada, Mental Health Commission of Canada etc.) have illustrated the need to improve on health services as oftentimes they are fragmented, inaccessible, inconsistent in quality, and poorly coordinated (Dhalla & Tepper, 2018). Family members and communities are also affected by individual health problems and illnesses, according to Pearson (2015). Pearson (2015) stated that one third of those with a loved one(s) impacted by health concerns, specifically mental health, also reported experiencing disruptions in their own wellness dimensions (e.g., intellectual, financial, emotional, spiritual, social, etc.). Even though Canada provides comprehensive education and prevention-based wellness programming, a lack of incentivizing citizens to attend proceeds as well as many other factors. Low attendance in Canadian wellness programming might be due to 15% of Canadians not having access to a family doctor and uncomfortably long wait times to see a medical
professional (Wert, 2020). Raphael and colleagues (2020) raised a compelling query about the consequences received when individuals don’t have adequate support in their pursuit of wellness: “what good does it do to treat people’s illnesses, to then send them back to the conditions that made them sick?” (Raphael et al., 2020, p. 8). In an era of growing demands on the health care system, it is imperative to provide care that is comprehensive, person-centered, and family-centered to understand and address wellness concerns before sickness and hospitalization (Kokorelias et al., 2019).

2.1.2 Global Insights

A recent report by Schneider et al. (2021) from The Commonwealth Fund compares the health care systems across 11 high-income nations using “indicators available across five domains: access to care, care process, administrative efficiency, equity, and health care outcomes” (p. 3). According to The Commonwealth Fund research team, Canada ranked as 10th and the United States as 11th worst in healthcare performance (Schneider et al., 2021). Interestingly, American and Canadian patients also reported greater income inequity than in other countries, which was a contributing factor (Schneider et al., 2021). Among the top countries, Norway, the Netherlands, and Australia, the achievement of equitable health outcomes was related to the lowering of cost barriers, the development of accessible-to-all primary care networks, and the reduction of discrimination and unequal treatment (Schneider et al., 2021). Additionally, the top countries avoided strain on their healthcare systems by investing in education and childcare (Schneider et al., 2021). To improve healthcare systems worldwide, health outcomes such as these will be vital to every family’s wellness.

Wellness needs to be prioritized globally because of the growing number of aging populations, chronic diseases such as diabetes, heart disease, respiratory infections, cancer, obesity, physical inactivity, substance abuse, deaths by suicide, and a rise in stress, depression, anxiety, and other mental health concerns (WHO, 2019; GWI, 2019). The Global Wellness Institute stated that one in six persons globally are experiencing mental health or substance use concerns, with anxiety ranking as number one (GWI, 2019). Over the past two decades (1990 to 2019), a noticeable rise in the global occurrence of reported depression and anxiety has occurred (Dattani et al., 2023). According to the Global Burden of Disease Study 2020 findings, the global impact of the COVID-19 pandemic resulted in a 25-27% surge in instances of anxiety and depression (WHO, 2022). Moreover, there has been no apparent reduction in anxiety and
depression's burden and prevalence since 1990 despite significant global efforts and interventions (Santomauro et al., 2021).

According to WHO (2021), ischaemic heart disease was the top cause of death of noncommunicable disease globally and other noncommunicable diseases such as Alzheimer's disease and diabetes have become more prevalent. In terms of communicable diseases, HIV/AIDS and tuberculosis have fallen off the top 10 list (WHO, 2019), while respiratory infections topped the list. Noncommunicable diseases, including heart disease, stroke, cancer, diabetes, and chronic lung disease, are collectively responsible for 41 million people dying annually (WHO, 2023). In Canada, the top three causes of death for young children (ages 1 to 4) in 2019 was congenital anomalies, road injury, and drowning. For the same year (2019), all ages (ages 0 to 85+) experienced the following top causes of death: ischaemic heart disease, Alzheimer’s disease and other dementias, and trachea, bronchus, and lung cancers (WHO, 2019).

Concerns about the political, global, economic, and environmental landscapes present daily obstacles to an individual’s wellness. (Baudon & Jachens, 2021; Buchanan et al., 2021; GWI, 2019; Korn Ferry Institute, 2021; Vercio et al., 2021; Wert, 2020). As highlighted by Robino (2019) in their study on global compassion fatigue, among counsellors before the pandemic, they noted “all humans are susceptible to experiencing fatigue as a result of high exposure to global issues through media” (p. 277). Due to the pandemic, burnout and compassion fatigue are commonplace. Eco-anxiety, eco-grief, climate depression, and other emotional descriptions are required now to articulate people’s experiences interwoven with environmental stress (Albrecht, 2019; Clayton et al., 2017). Since the 1990s, stress at work has spiked in Canada by 20% (Korn Ferry Institute, 2021). Technology advancements and social media exposure have led to doom-scrolling and information overload (Buchanan et al., 2021). Recent studies also showed that caregivers who faced financial strain or unemployment during the pandemic were more susceptible to engaging in child maltreatment (Brown et al., 2020; Gadermann et al., 2021; Thomson et al., 2021) adding to familial distress or unwellness.

Movement or exercise is medicine (Hippocrates, 460-370 BCE, as cited in Tipton, 2014, p. 109). This understanding that activity contributes to health and wellness is underscored by data from a recent survey of Canadians, revealing that 85% of Canadians who reported very good to excellent physical health also reported having very good to excellent mental health (Canadian Internet Registration Authority, 2020). However, based on hip-worn accelerometry data, the
average duration of sedentary behavior for Canadian adults was 9.8 hours per day (Colley et al., 2022). The wellness challenges families are currently facing are multi-dimensional and exist globally.

2.2 Canadian Context of Wellness

2.2.1 Challenges to Workplace Wellness

A study by Wert (2020) examined workplace wellness programs in North America and “found that about 80% of Canadians… have one or more of five major modifiable health risks such as hypertension, tobacco use, overweight, diabetes, and inactivity” (p. 6). In Wert’s (2020) study, presenteeism is described as the lost productivity in a workplace due to employees showing up present for work but not fully functioning and/or distracted by other matters. In a report by Mercer Canada (2018), mental health issues cause Canadian companies to incur losses of about $16.6 billion in productivity each year from employees calling in sick, or absenteeism. On average, stress has “caused one in four workers to leave their employer” and “disability strikes one in five Canadians” each year (Mercer Canada, 2018, p. 3). This prevalence makes psychological concerns the leading contributor to disability, resulting in an annual economic burden of 20 billion dollars (Mercer Canada, 2018). Mercer Canada (2018) and Wert (2020) both recommended promoting wellness programs and increasing health and wellness benefits in the workplace to reduce presenteeism and absenteeism. Wert (2020) addressed that five dimensions of wellness are to be emphasized within wellness programs: intellectual, financial, physical, occupational (or academic), and social.

2.2.2 Defining Wellbeing

The Canadian Index of Wellbeing (CIW), established in 1994, features 64 indicators spread across eight domains, utilizing a systemic approach to gauge the various aspects that impact Canadians (CIW, 2016). The eight domains are as follows: “community vitality, democratic engagement, education, environment, healthy populations, leisure and culture, living standards, and time use.” (Canadian Index of Wellbeing, 2016, p. 2).

Although wellbeing and wellness are used interchangeably (McCallum & Price, 2016), wellness is distinct from wellbeing. Wellness, as emphasized by Carter and Anderson (2023), represents the cumulative effect of proactive measures taken to realize a state of wellbeing (Carter & Andersen, 2023). This viewpoint is reinforced by Holdsworth (2019) who also recognized a nuanced distinction between wellbeing and wellness, underscoring a hierarchical
relationship. Holdsworth (2019) acknowledged that health serves as the overarching term, followed by wellbeing, and then wellness. Consistent with wellness research, wellbeing is also multi-dimensional and sometimes includes other facets such as sustainability, education, social justice, diversity, and inclusion. (Diener et al., 2002). Simons and Baldwin (2021) stated that “wellness differs from wellbeing in being an active noun, whereas wellbeing is passive” (p. 986).

### 2.2.3 Caregiver Relationship to Family Physical Wellness

Considering only one dimension of family physical wellness, physical activity, Fredricks and Eccles (2004) emphasized that children's physical activity participation is largely influenced by their caregivers since they spend most of their free time with them. Mol and Buysse (2008) observed that children and caregivers possess agency, and through a reciprocal, bidirectional connection, they can mutually influence and contribute to each other's physical wellness equally. However, caregiving has an evident emotional and physical impact on the caregiver (Mol & Buysee, 2008). The Family Caregiver Alliance National Center on Caregiving (FCA) estimates that caregivers of adults with disabilities experience lower physical wellness as they are less likely to participate in self-care and health-enhancing activities due to lack of time and burnout (Lutz, 2010). Griffith (2022) agreed that caregivers of young children might face social isolation, limited physical activity, and excessive work demands. According to Blair and Perry (2017), who studied compassion fatigue experienced by family caregivers, several wellness dimensions suffer due to stress such as emotional, social, financial, and physical. In addition to compassion fatigue, family caregivers often report experiencing psychological and physical fatigue, self-neglect, disturbed sleep patterns, high blood pressure, and difficulty regulating their weight (Blair & Perry, 2017; Day et al., 2014; Meyer et al., 2015; Perry et al., 2010; Ward-Griffin et al., 2011). In a recent Canadian scoping review on family-centered care models, Kokorelias et al. (2019), found that “family members may experience a negative impact on their own wellbeing as part of the ongoing demands of caregiving” (p. 6). Thus, caregivers may be considered experts in family wellness.

### 2.3 Theoretical Foundation: Wellness Instruments and Models

This section provides a historical perspective to the development of wellness instruments and models. The following models were included in this review because each model and/or theorist
focused on wellness as a holistic and multidimensional construct, even though the individual dimensions or domains constituting the constructs were defined differently.

The WHO defines wellness as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 1948, p. 2; WHO, 2020). The WHO's 1948 definition of wellness was cherished by the four founding fathers (Grénman, 2019, p. 25) of the modern wellness movement: Halbert L. Dunn, John Travis, Don Ardell, and Bill Hettler. Dunn’s 1959 four quadrant model of high-level wellness was one of the first recorded wellness models utilized in the wellness movement in North America (see Figure 2.2).

**Figure 2.2**

*Four quadrant model of high-level wellness (Dunn, 1959)*

Adopting the WHO’s 1948 definition, Dunn emphasized the importance of a holistic and integrated approach to wellness as well as the significance of environmental wellness and outside influences playing a role in overall wellness (Das, 2015; Grénman, 2019; Kennedy, 2014; Prescott et al., 2019; Roscoe, 2009). Prescott et al. (2019) described Dunn’s wellness definition to be calling for “a universal philosophy of living … a lifestyle which involved a sense of purpose and meaning” (p. 5). Dunn's model remains a theoretical model discussed today across many disciplines. Despite its expansion of wellness beyond disease and its role in enhancing how wellness is understood, it lacks empirical validation (Kennedy, 2014).
In accordance with Dunn, Travis (1972) presented an illness-wellness continuum to understand the experience of wellness beyond disease. He envisioned wellness to be fluctuating and dynamic, with death (figured here as illness) at one end of the continuum, high-level wellness (wellness) at the other end of the continuum, and varying degrees of wellness in between (see Figure 2.3).

**Figure 2.3**

*Illness-wellness continuum (Travis, 1972)*

![Illness-wellness continuum](image)


In the model’s two paradigms, treatment and wellness, Travis (1972) noted that the absence of disability, symptoms, and signs of illness (treatment) would lead an individual to a neutral point (Travis, 1981). Dunn had already emphasized the importance of individuals caring for their own wellness rather than relying on professionals and Travis’ (1972) illness-wellness continuum model further articulated this idea (Travis & Ryan, 2004). They both highlighted self-responsibility, awareness, education, and growth as fundamental to leading individuals from neutral to high levels of wellness (Witmer, 2012).

Together Travis and Ryan (1981, 1988, 2004) developed two additional models from Travis’ original (1972) illness-wellness continuum: (1) the iceberg model (Travis & Ryan, 1981; see Figure 2.4); and (2) the wellness energy system (Travis & Ryan, 2004; see Figure 2.5). In their most recent wellness workbook edition, Travis and Ryan (2004) encouraged readers to maintain wellness by “master(ing) the three keys” (p. xxxv): the illness/wellness continuum, the iceberg model, and the wellness energy system.

The iceberg model of health and disease characterizes wellness as a concept that may be deeper than first thought and layered in ways that are not always visible or obvious (Travis &
Ryan, 2004; see Figure 2.4). In this model, *state of health* (wellness or illness) is visible and has three specific, *unseen* layers underneath the surface: 1) lifestyle/behavioural level; 2) psychological/motivational level; and 3) spiritual/being/meaning realm. Travis and Ryan (2004) described the third below-the-surface layer as a *realm* because of its unclear boundaries that pervade the layers above and impact one’s overall *state of health* and contemplation of life’s meaning. Travis and Ryan (2004) described this realm as:

the real meaning of life... the way in which you address these questions and the answers you choose, underlie and permeate all of the layers above. Ultimately this realm determines whether the tip of the iceberg, representing your state of health, is one of disease or wellness. (p. xxi)

This model is frequently used today to illustrate the complexity of wellness.

**Figure 2.4**

*Iceberg model of health (modified from Travis & Ryan, 2004, p. 4)*

---


The wellness energy system (Travis & Ryan, 1981) explored wellness as a system of three major inputs and nine outputs transformed from the input energy (see Figure 2.5). Based on the wellness energy system model, a person’s wellness suffered if they had insufficient inputs (breathing, sensing, and eating) or outputs (moving, feeling, thinking, playing and working,
communicating, intimacy, finding meaning, transcending, and self-responsibility and love). Distortions in a balanced wellness energy system, including inadequate, contaminated, or blocked energy (Travis & Ryan, 1981), arise when individuals strive to harmonize their own energy while simultaneously seeking to balance the energy systems of others.

**Figure 2.5**

*The wellness energy system (modified from Travis & Ryan, 2004, p.xxv)*

![Diagram of wellness energy system](image)


Understanding the energy system was challenging due to its visual complexity. Consequently, Travis and Ryan (2004) crafted a more simplified representation, called the wellness wheel, to illustrate the equilibrium within the wellness energy system. The wellness wheel had twelve dimensions and attained completeness as individuals answered the wellness index questionnaire. The wellness index questionnaire had 334 (1981) to 430 (2004) questions and when completed, the wellness wheel indicated the areas of life that needed improvement. Travis and Ryan's (1981, 1988, 2004) models contributed to the understanding of wellness but were not paired with supporting empirical evidence.

Don Ardell (1977) presented a wellness model with five dimensions which was greatly influenced by both Dunn and Travis. The primary component added to the previous models was
self-responsibility. While Travis and Ryan (2004) included *self-responsibility and love* as the first dimension of their wellness wheel, Ardell (1977) described *self-responsibility* as being central to achieving wellness. In Ardell’s (1982) book, *14 Days to High Level Wellness*, he emphasized the remaining dimensions of wellness in a diagram and included the four dimensions that are influenced by self-responsibility as: "physical fitness, stress awareness and management, environmental sensitivity, and nutritional awareness” (p.18).

Ardell's model (1982) closely corresponded to the two dimensions outlined in the WHO's 1948 definition: physical and mental. While Ardell’s doesn’t explicitly outline his model in either of his 1977 or 1982 publications, Grénman (2019) provided an interpretation of his three domains of wellness. Grénman’s (2019) “circular model of wellness by Ardell” (p. 30) demonstrated Ardell’s wellness domains to be expanded into 14 skill areas which were as follows: 1) the physical domain consisted of exercise and fitness, nutrition, appearance, adaptations/challenges, lifestyle habits; 2) the mental domain consisted of emotional intelligence, effective decisions, stress management, factual knowledge, and mental health and 3) the meaning and purpose domain consisted of meaning and purpose, relationships, humour, and play. Ardell’s current wellness philosophy of R.E.A.L. wellness (Reason, Exuberance, Athleticism, and Liberty) created in 2011 (Ardell, 2011) and newest book, *Freedom from Religion in 30 Days* (2022), are evidence of Ardell's focus on physical, intellectual, and social wellness. Dunn (1959), Travis (1972), and Ardell (1977) all shared the idea of taking individual responsibility for one’s wellness. The rejection of spiritual wellness was Ardell's main difference from his two mentors, labelling his work as controversial (Miller, 2005). While Ardell's models contributed to the wellness discussion, his models have also not been empirically tested.

Hettler’s 1980 model of wellness is linked to Ardell’s 1977 previous conceptualization of wellness with an emphasis on physical wellness (see Figure 2.6).
Founded in 1976 by three faculty members at the University of Wisconsin-Stevens Point, the Institute for Lifestyle Improvement became the National Wellness Institute (NWI) in 1985 (National Wellness Institute, n.d.). Bill Hettler (1980), a member of the NWI, proposed Hettler's Hexagon, a six-dimensional wellness model that was characterized by emotional, spiritual, intellectual, social, physical, and occupational wellness domains. Drawing on Fuller's (1969) discussion which highlighted the essential nature of all six edges for a tetrahedron's stability, Hettler (1980) asserted that “the stability of the human depends on the integrity of [every] dimension of wellness” (p. 79). Many acknowledge Hettler as the founding figure or “father of the modern wellness movement.” (Myers et al., 2008, p. 483). He informed the creation of two wellness instruments for NWI: The Lifestyle Assessment Questionnaire (LAQ) and Testwell (Das, 2015). Although Hettler's six-dimensional model lacks empirical evidence, Palombi's (1992) investigation of the 100-item LAQ ($\alpha = .93$) and Owen's (1999) psychometric report on
the 100-item TWI instrument ($\alpha = .92$) have demonstrated evidence of internal consistency and reliability for both subsequent measures (Das, 2015).

In the 1990s, the Wheel of Wellness was developed in response to two researchers, Sweeney and Witmer, searching for valid and reliable measures of wellness (Beckwith, 2018; Kennedy, 2014; Knapp, 2016). Alfred Adler, an individual psychologist in the 1930s, informed Sweeny and Witmer's focus on the ebb and flow of a person's existence and development (Myers & Sweeney, 2004). Initially, five life tasks were included in their model (Sweeney & Witmer, 1991) with spirituality at its core, self-regulation next and work, friendship, and love surrounding them. There is a dynamic interaction between the life tasks and forces such as family and government (see Myers & Sweeney, 2004 for initial image of wheel of wellness). Globalized events are depicted as outside of all the concentric circles as they influence and interact with the surrounding life tasks and forces (Sweeney & Witmer, 1991). Informed by Adler's individualistic psychology, this strength-based model was later renamed based on factor analyses of over 3,000 participants' scores using the Wellness Evaluation of Lifestyle (WEL) instrument (Myers et al., 2000). Before the re-labelling and after the use of the WEL instrument in research, a couple of changes were made (see Figure 2.7) and a second version was published by Myers, Sweeney, and Witmer (1998). In the similar but updated version, the umbrella life task term 'self-regulation' was renamed to describe self-direction, the subtasks were expanded from seven to twelve subtasks, and “the life task of work was subdivided into the two tasks of work and leisure” (Myers et al., 2000, p. 254).
Figure 2.7

*The Wheel of Wellness (Witmer et al., 1998)*

According to Myers and Sweeney (2004), Hattie et al.’s (2004) investigation of the WEL instrument and scores demonstrated that some of the original theoretical components of the Wheel of Wellness' 17 tasks were not supported (five life tasks (love, friendship, work, etc.) and 12 subtasks (humour, nutrition, self-care, etc.). Therefore, the Indivisible Self wellness model (IS-Wel) was developed (see Figure 2.8).
The Indivisible Self (IS-Wel; Sweeney & Myers, 2004)

![Diagram of the Indivisible Self (IS-Wel)](image)


The Indivisible Self (IS-Wel) included the following subtasks in each of the five second-order factors: 1) the Essential Self (4): spirituality, gender identity, cultural identity, self-care; 2) the Creative Self (5): thinking, emotions, control, work, positive humor; 3) the Coping Self (5): leisure, stress-management, self-worth, realistic beliefs; 4) the Social Self (2): friendship, love; and 5) the Physical Self (2): exercise, nutrition (Myers & Sweeney, 2004; Shannonhouse et al., 2016). The IS-Wel model differed from Wheel of Wellness because it clustered the twelve subtasks into five second-order factors, added five new subtasks, and spirituality was removed from the model’s core (Shannonhouse et al., 2016). Kennedy (2014)’s review of wellness models asserts that the IS-Wel is a strong, empirically supported, and holistic wellness model because the models that have followed “have not been empirically tested” (p. 39).

Founded on the Indivisible Self model (IS-WEL), three versions of the five-factor wellness inventory (5F-WEL or FFWEL) were developed: children (3rd grade reading level, 5F-
Wel-E or FFWEL-E), adolescents (6th grade, 5F-Wel-T or FFWEL-T), and teenagers and adults (9th grade, 5F-Wel-A or FFWEL-A). Typically, each self-administered subscale assessment instrument can be completed within 20-25 minutes (Myers & Sweeney, 2008). The inventory, although not a publicly released, measures the IS-WEL constructs, “five second-order factors containing 17 discrete scales” (or subtasks), and has 91-97 items, assessing the same five areas as the IS-WEL (Myers & Sweeney, 2005a). A recent assessment conducted by Shannonhouse et al. (2020) analyzing the psychometric outcomes of the 5F-Wel through factor analyses suggested that this instrument “yields structurally valid scores, the factor structure of the 5F-Wel is robust, and useful in describing adult client responses” (p.101).

The 5F-Wel was revised, providing a briefer measure of wellness using only 56 items, constituting a new measure called the 4F-Wel (Bart et al., 2018). This instrument was re-developed because of some criticism that the 5F-Wel lacked evidence of validity and reliability (Myers, Luecht, & Sweeney, 2004). The content areas were reduced and newly created to reflect four second-order factors: physical, relational, spiritual, and cognitive-emotional wellness (Bart et al., 2018). Future research needs to verify that the 4F-WEL as well as the 5F-WEL are applicable to the population a researcher is working with (Myers, Luecht, & Sweeney, 2004).

Working independently, Eckstein (2001) prioritized five dimensions of wellness (physical, mental, spiritual, emotional, and social), and developed a 6-dimensional F.A.M.I.L.Y. Self-Care Assessment Inventory. This self-behavior assessment tool served as an aid in creating an action plan for improving one's personal and family wellness. The F.A.M.I.L.Y. acronym outlined Eckstein’s (2001) scale comprising of six factors: motivation, moving through loss, adaptability, independence, fitness strategies, and longevity (see Eckstein, 2001, p. 334 for the F.A.M.I.L.Y. self-care assessment inventory). In line with Sweeny and Witmer’s (1991) work, Eckstein (2001) captured a holistic approach to wellness and was influenced by Adler's (1958) notion that the body and mind are reciprocally related. To date, this scale remains unique, with no empirical testing or presence in any other studies.

Much like Eckstein (2001), Margaret (Peggy) Swarbrick appeared to develop her wellness models outside of the work of other theorists (Swarbrick, 1997, 2006, 2010, 2012, 2019, 2023). During the late 1990s, Swarbrick (1997) adopted a mental health and psychiatric perspective to create a dual-component psychoeducational wellness model known as 'The ABCs of Wellness' (1997) and 'Wellness Dimensions' (1997). These models were designed to address
the psychiatric care unit population she was working with (Swarbrick, 1997). Although Swarbrick (1997) did not identify other wellness model developers specifically, she referenced Dossey et al. (1989) who are known for the book *Holistic Health Promotion: A Guide for Practice*. Dossey et al.’s (1989) wellness self-assessment tool initially defined wellness as the *circle of human potential* and encompassed six wellness dimensions: “physical, mental, emotions, spirit, relationships, and choices” (McElligot et al., 2018, p. 375). According to Dossey et al. (1989), the circular model of *wholeness* placed spirituality at the outer circle emphasizing that spirit transcends all dimensions and maximizes human potential (see Dossey, Keegan, Kolkmeier, and Guzzetta’s (1989) book, *Holistic Health Promotion: A Guide for Practice* for a more detailed review of the model).

Swarbrick (1997) explored how a wellness-oriented care model, a medical model supported by “peer-support, whole-health specialists and wellness coaches can play an important role in integrated care” (Swarbrick, 2013, p.723). This approach seemed to inform her later eight-dimensional wellness model, endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA; Swarbrick & Yudof, 2015) (see Figure 2.9), inclusive of the following eight dimensions: physical, emotional, spiritual, intellectual, social, occupational, financial, and environmental.

**Figure 2.9**

*Eight dimensions of wellness (Swarbrick & Yudof, 2015)*

In a study that investigated the empirical evidence of Swarbrick and Yudof’s (2015) model of wellness, Das (2015) suggested that “the model maintain[ed] an integrative characterization of overall wellness, specifically, as ‘the presence of purpose in life, active involvement in satisfying work and play, joyful relationships, a healthy body and living environment, and happiness’” (p.9). Das (2015) explained that the wellness model corresponds nicely to the WHO's 1948 triad of physical, mental, and social wellbeing. Swarbrick and Yudof’s (2015) eight dimensions of wellness model can be related to the iceberg model as well (Travis & Ryan, 2004). The first level below the surface is the lifestyle/behavioural level (Travis & Ryan, 2004), or what might be described as physical and emotional wellness (Swarbrick & Yudof, 2015). The secondary level is the cultural/psychological/motivational level (Travis & Ryan, 2004), which might represent the environmental, social, financial, intellectual, and occupational wellness dimensions in Swarbrick and Yudof’s (2015) model. Finally, the third level or the spirituality/being/meaning realm (Travis & Ryan, 2004) might indicate spiritual wellness (Swarbrick & Yudof, 2015).

2.4 Theoretical Framework Selection Rationale: Swarbrick and SDOH

Wellness has been conceptualized in different ways although the existing models have some similarities (Holdsworth, 20919). Wellness is multi-dimensional, complex, and the WHO (1948) triad of physical, mental, and social wellness is foundational for most models and theories of wellness (Adams et al., 1997; Ardell, 1977; Corbin & Pangrazi, 2001; Dossey et al., 1989; Dunn, 1959; Eckstein, 2001; Fullen, 2016; Granello, 2013; Greenberg, 1985; Grénman, 2019; Hettler, 1980; Knez et al., 2020; Knibb-Lamouche, 2012; Melnyk & Neale, 2018; Myers & Sweeney, 2006; Myers et al., 2000; Roscoe, 2009; Renger et al., 2000; Swarbrick, 1997; Travis, 1972; Walker et al., 1987; Witmer & Sweeney, 1992). An individual's wellness can be categorized as a dynamic process, a lifestyle, or both and is placed on a continuum (Adams et al., 1997; Dunn, 1959; Travis, 1972; Myers & Sweeney, 2006). The internal components of wellness can include self-awareness as well as the external can include the impact of relationships such as from community and family wellness (Ardell, 1977; Hettler, 1980). Though there is some similarity between existing models, wellness has been conceptualized and defined differently, blurring the boundaries of what wellness is (Corbin & Pangrazi, 2001). Often, it’s hard to make
sense of the literature as wellness and wellbeing are utilized interchangeably but might be defined uniquely and in different ways (Carter & Andersen, 2023; Dodge et al., 2012; Holdsworth, 2019). However, when examining the existing wellness models, it is apparent that most are theoretical and lack empirical evidence (Das, 2015; Kennedy, 2014; Knapp, 2016; Myers, Luecht, & Sweeney, 2004; Palombi, 1992; Roscoe, 2009).

When searching for a model to focus on family wellness, it was important to consider multiple factors. Having accessible models to evaluate family wellness was essential. Given the fulfillment of thesis requirements through this study, access to funding was limited. Some instruments may have had more empirical evidence but came at a financial cost or weren’t able to be found through the cited works/cited reference lists (Kennedy, 2014; Knapp, 2016; Myers, Luecht, & Sweeney, 2004; Palombi, 1992; Roscoe, 2009). As well, it is not uncommon for families to avoid or be limited in participating in studies and activities that cost money (Largent & Lynch, 2018). It was also critical to consider a model that was broad enough and supported the idea that wellness is multi-dimensional and complex (Corbin & Pangrazi, 2001; Fullen, 2016; Knez et al., 2020). Many of the existing models focused on ‘individual wellness’ and we needed to capture more than the caregiver perspective. For example, a mother’s physical wellness may or may not serve as an accurate measure of a family’s overall wellness. Thus, it is important to have a model where modifications could be made to support overall family wellness and capture all perspectives.

In summary, the eight dimensions of wellness (Swarbrick & Yudof, 2015) is likely the most empirically supported holistic model (Das, 2015). Swarbrick and Yudof”s (2015) model is in alignment with the social determinants of health (SDOH) (WHO, 2008), which has been used extensively in the past. The eight dimensions of wellness (Swarbrick & Yudof, 2015) is the ideal model to use when considering family wellness from the perspective of caregivers.

2.5 Wellness Defined

2.5.1 Measuring Wellness

A review of six instruments aimed at measuring wellness by Roscoe (2009) concluded that the current measures available are not suitable for evaluating theoretical wellness concepts empirically.

Swarbrick (2006), a mental health professional and researcher, defines wellness as "a conscious, deliberate process that requires a person to become aware of and make choices for a
more satisfying lifestyle" (p. 311). To better understand how to support people's wellness needs in the United States of America, especially individuals struggling with mental health, substance abuse, and addiction, Swarbrick and Yudof (2015) developed an eight-dimensional model of wellness. In Canada, mental illness is estimated to cost the national economy over $50 billion every year (CAMH, n.d.). In the most recent Public Health Agency of Canada’s (2018) report on the economic burden of illness, Canada’s health expenditures totalled $183.1 billion. Using Swarbrick and Yudof’s (2015) eight-dimensional wellness model will help to better understand and serve Canadians' wellness needs.

Swarbrick and Yudof’s (2015) eight dimensions of wellness model has been primarily tested in populations in the United States and there are limited citations of utilizing this measurement of wellness (Swarbrick 2023). Originally, the dimensions were designed to help American individuals experiencing substance abuse, addiction, and/or mental health issues (Swarbrick, 1997). Accordingly, investigating how Canadians find relevancy in each of the wellness dimensions is important. Wellness in some global contexts is undergoing a defined shift, with a reduced focus on physical wellness and a renewed emphasis on relational and emotional dimensions (Hooker, 2020). Therefore, analyzing the psychometric properties of Swarbrick and Yudof’s eight dimensions of wellness model (2015) strengthens our understanding of wellness, its relevancy, and its measurement. The eight dimensions include: physical, social, emotional, intellectual, financial, occupational, spiritual, and environmental. In expanding on Swarbrick and Yudof's model (2015), I provided more detail on the model’s physical wellness dimension and what aspects were explored in this study. I explored family wellness through the lens of caregivers. Using the five domains of social determinants of health (SDOH) (WHO, 2008; Healthy People 2030, n.d.-c) as a theoretical framework, I also considered the physical wellness experiences of caregivers in Canada.

2.5.2 Physical Wellness

There are several components of physical wellness, including but not limited to sleep, healthy eating, time away from TV and screens, exercise, play, and spending time outdoors. Children and youth are stimulated by learning from oneself, their own lived experiences, as well as their interactions with others. Peter Gray (2013), an educational and play psychologist and author of the book Free to Learn, used the title of their book to suggest that young individuals will experience greater happiness, increased self-reliance, and enhanced lifelong learning.
opportunities if they have the freedom to engage in play and movement. Gray’s (2013) work coincides with the age-old fitness-focused adages, that are not very well or definitively documented: movement or *exercise is medicine* (Hippocrates, 460-370 BCE as cited in Tipton, 2014, p. 109), *motion is lotion*, and the famous quotation by Plato, “lack of activity destroys the good condition of every human being, while movement and methodical physical exercise save it and preserve it” (Diamond & Byrd, 2020, p. 233). Promoting physical activity as a vital necessity to living a healthy and long life, although not novel to health promotion work, is particularly important at this current time (Rollo et al., 2023).

Often, family wellness is not well defined, although there have been attempts to define the term (Prilleltensky & Nelson, 2000; Wollny et al., 2010). It hasn’t been well-researched and is lacking a Canadian context. Similarly, family physical wellness has not been researched in depth from the perspective of the caregiver. A vital aspect of individual caregiver or family physical wellness has not been developed in the way this study has proposed to explore it, encompassing a wide range of factors such as: sleep, healthy eating, time away from TV and screens, exercise, and spending time outdoors. There are studies on the perceptions of how caregivers influence their child’s physical activity (Lim & Biddle, 2012; Tucker et al. 2011) or how there is interplay between child and caregiver (Sleddens et al., 2017). After a review of the existing literature, a gap emerged, one this study aims to fill, exploring caregiver perceptions and experiences of their family’s physical wellness (see Table 2.2).
Table 2.2

*Family Physical Wellness Research Findings*

<table>
<thead>
<tr>
<th>AUTHORS</th>
<th>FOCUS OF STUDY</th>
<th>PRESCHOOL AGE</th>
<th>SWARBRICK’S THEORETICAL FRAMEWORK</th>
<th>FAMILY</th>
<th>COUNTRIES</th>
<th>PHYSICAL WELLNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thompson et al., (2010)</td>
<td>Family-based interventions to address complex needs, busy lives, provide affordable diverse activities</td>
<td></td>
<td></td>
<td></td>
<td>U.K.</td>
<td></td>
</tr>
<tr>
<td>Columna et al., (2017)</td>
<td>Stemmed from previous 2013 study that overlooked parental perceptions, how to support families getting active with children with VI</td>
<td></td>
<td></td>
<td></td>
<td>U.S.A.</td>
<td></td>
</tr>
<tr>
<td>Linville et al., (2018)</td>
<td>Intervention to address family nutrition and exercise to enhance family connection and quality time.</td>
<td></td>
<td></td>
<td></td>
<td>U.S.A.</td>
<td></td>
</tr>
<tr>
<td>Lopez-Aymes et al., (2021)</td>
<td>Lived experiences during COVID-19, physical activity impacts child’s intellectual and emotional wellness</td>
<td></td>
<td></td>
<td></td>
<td>Argentina, Chile, Colombia, Panamá, Mexico, and Spain</td>
<td></td>
</tr>
</tbody>
</table>

Note. This table of the five studies includes relevant studies on family physical wellness and no studies to date have been found using Swarbrick and Yudof’s (2015) 8-dimensional wellness model.

In Thompson et al.’s (2010) exploration of the frequency and mode of family time spent together, caregiver perceptions of physical activity for the family were captured. A semi-structured interview process was used to gather preferences and perceptions for physical activity from 30 caregivers, with one to seven children in their family unit (ages 10 to 11), in the United Kingdom. In the interviews, caregivers shared that family time together was imperative, “whether the activity [was] physical or sedentary was not seen to be of great importance” (Thompson et al., 2010, p. 270). In this study, physical activity was recognized by caregivers as a tool to enhance overall family wellness. Participants described improved family wellness outcomes, such as mental health, weight management, physical fitness, more enjoyable time...
spent together, and better communication and engagement. Thompson et al. (2010) highlighted how children, or the family, participated in activity and did not necessarily reflect on their own personal level of physical wellness. Children's varying ages and interests and the busyness of daily lives were two of the most common reported barriers to family physical activity. Additionally, physical activity may have been further prevented due to demanding schedules, numerous and sometimes conflicting interests, and mixed ages of adults and children, along with insufficient finances, transportation, unfavourable weather conditions, and accessible facilities. Physical wellness was limited to only physical activity, or exercise and was not inclusive of other dimensions such as nutrition, sleep, time away from TVs and screens, and time outdoors. Thompson et al. (2010) reported a lack of diversity in their study participation sample, suggesting that the results may not be representative of caregivers who place a low value on physical activity. A future research direction identified by Thompson et al. (2010) was to promote “family-based interventions …that accommodate the demands and needs of two-caregiver and single-caregiver families and provide affordable and diverse activities that appeal to a wide range of interests” (p. 272). To address family wellness needs, it’s imperative to better understand the types of activities and programs that can assist families in overcoming barriers.

In an American study conducted by Columna et al. (2017), the researchers focused on caregivers of children with visual impairments and assessed perceptions of their family’s physical activity (PA). Eleven caregivers (10 families) of children (ages 4 to 12) with visual impairments participated in semi-structured interviews. This study primarily focused on family physical activity together and how caregivers could motivate their children with visual impairments to participate in physical activity. Accordingly, caregivers “articulated that physical activity provides an opportunity to build their children’s confidence” (Columna et al., 2017, p.98). In addition, there were perceptions shared by caregivers about their own participation in physical activity. Taking a modelling approach, caregivers stated that they attempted empowering their children to be physically active “by being active themselves” (Columna et al., 2017, p. 93). Participating caregivers reported positive wellness benefits, including weight maintenance and weight loss, which positively benefited the entire family (Columna et al., 2017). Furthermore, they understood how limited their own participation in physical activity was due to obstacles such as lack of time, finances, knowledge, or external support (Columna et al., 2017). Consequently, the physical wellness of the entire family was
restricted by these obstacles that the caregiver faced. The findings of Columna et al. (2017) demonstrated that physical wellness is important to the wellbeing of the entire family, despite the fact the researchers did not explicitly use the terms *physical wellness* or *family wellness*. The authors also used *parents* to describe the population that this study refers to as *caregivers*. Researchers examined a diverse family population with children with visual impairments using a sample size of 10 families.

In a study Columna co-authored, Perkins et al. (2013) focused on how children with visual impairment participated in physical activity but overlooked caregiver perceptions. The recognition of a gap in caregiver wellness perceptions, as noted by Perkins et al. (2013), directed the researchers' attention towards this specific area of investigation in their 2017 study (see paragraph above). The 2013 study examined the perceptions of caregivers about the physical activity of their children with visual impairments but did not address the perceptions of caregivers themselves. More research is needed to better understand strategies and programming that will enable all families, not just those of children with visual impairments, to overcome barriers and be physically active and well together.

To expand on caregiver’s experiences of physical wellness, Linville et al. (2018) conducted a phenomenological qualitative research study. This study explored perspectives of caregivers with children (ages 3 to 5), and healthcare providers who were involved in *Healthy Balance*, an intervention program aimed at enhancing family’s healthy lifestyle choices (Linville et al., 2018). The primary goal of the eight-session *Healthy Balance* group program was to promote family physical wellness and to prevent obesity. *Healthy Balance* participants were encouraged as a family to reflect on and develop ways to "make small healthy changes" (Linville et al., 2018, p. 255). These changes included increasing physical activity, reducing sedentary behavior, and improving the family diet. In Linville et al.’s (2018) study, 19 participants from the *Healthy Balance* project were selected to engage in face-to-face, semi-structured interviews: five healthcare providers and 14 caregivers (one married couple). Several key findings emerged. First, the study suggested that flexible definitions of health and wellness are important. Accordingly, Linville et al. (2018) stated that caregivers understand their “families seemed to realize the positive impact that family physical wellness activities could have on their relationships” (p.267). Additionally, Linville et al. (2018) expressed that if families could come together as a collective to enhance their literacy on health and wellness, this union “may also
improve family functioning in other important domains, such as communication, cohesion, and intimacy.” (p. 269). This study was limited by the lack of longitudinal data as only one qualitative interview (per participant) took place after the intervention (Linville et al., 2018). Perceptions may be biased towards a very specific population (i.e. Latinx families) and a small sample of individuals (19 participants). Linville et al.’s (2018) intervention was also specifically designed to develop and implement a successful obesity-prevention program. The researchers have identified a need for a more comprehensive, integrated, culturally relevant, and family-centered approach that meets families where they are at (Linville et al., 2018).

As stated by Zovko et al. (2021), “[caregivers] serve as role models for their children and have a major influence on their physical activity” (p. 2). Using accelerometry as an assessment tool, Zovko et al. (2021) investigated family-child physical activity and sedentary behaviour of 174 children (ages 11 to 14) and their families (225 caregivers and 52 grandparents) across Slovenia. Their quantitative approach tried to use reliable and objective methods. Using an accelerometer, a method that was indicated to have high reliability (89.2%) as per Yao and Rhodes (2015), Zovko et al. demonstrated that “[caregiver]-child physical activity correlates were greater with objective measurement than with self-reported questionnaires” (2021, p. 4). The results indicated that caregiver physical activity and maternal support significantly influenced a child's physical activity (p < 0.05). It was noted that since this was the first study to examine how three-generational families experience physical activity and sedentary behaviour, more research is needed. This study also suggests that to gain more insight into how caregivers perceive family physical wellness, further research is essential on including a more diverse population sample, not just active families. Zovko et al. (2021) stated that their study did not control for “external factors that could influence physical activity and sedentary behaviour such as family problems, friendship problems, dietary habits and changes of environment/school, socioeconomic status” (p. 5). By conducting research with a qualitative approach, these perceptions of external variables and variations in physical activity, such as links to physical activity and weather or seasonal changes for example, can be captured (Padulo et al., 2018).

Adding to the discussion of considering the impact of the pandemic on family wellness, López-Aymes et al.’s (2021) mixed methods research was closely linked to this study’s exploration on the caregiver perceptions of family physical wellness during COVID-19. The research team investigated physical activity perceptions and knowledge (for caregivers and their
children), its importance, and the (potentially stressful) lived experiences across several Spanish-speaking countries (Argentina, Chile, Colombia, Panamá, Mexico, and Spain). López-Aymes et al., (2021) invited 234 caregivers, with one or more children (ages 8 to 17), to take a survey with two measures: (1) an 18-item, closed and open-ended, questionnaire, designed by the researchers and (2) a 27-item quality of life scale called KIDSCREEN (Ravens-Sieberer et al., 2005). In this study, caregivers perceived that their child may have had sufficient activity, but the activities performed may have been insufficient. It was indicated that the “relationship between physical space…to exercise is related to the satisfaction or dissatisfaction with the physical activity performed” (López-Aymes et al., 2021, p. 10). According to the authors' perspective, a children's self-report measure is essential as well as highlighting physical wellness, specifically this study mentions physical activity, and its impact on a child's intellectual and emotional wellness. There was no caregiver self-report collected on family physical activity. Instead, caregiver perceptions of family physical wellness are limited to only physical activity, not the other dimensions of physical wellness, and only children, not caregivers. Therefore, it would be necessary to re-examine the research question in the future to include caregiver perceptions of both caregiver and child.

Although most of the selected studies were not based in Canada, they were globalized, sharing a perspective that the importance family physical wellness exists outside of North America (López-Aymes et al., 2021; Thompson et al, 2010; Zovko, 2021). No study examined the 2 to 8 years old age group. No study used the term caregiver although caregivers was almost always used to describe the participants. Only one of the selected five studies talked about COVID-19 (López-Aymes et al., 2021). Only one study discussed wellness definitions (Linville et al., 2018). All five studies focused on one singular aspect of family physical wellness, physical activity. This differs from how the TOYBOX is examining family physical wellness. The barriers caregivers faced in engaging in family physical activity echoed across the majority of the studies and they were as follows: busy lives, lack of resources, knowledge, time, transportation, weather, external supports, and financial stability (Columna et al., 2017; Linville et al., 2018; Perkins et al., 2013; Thompson et al., 2010; Zovko et al., 2021). The selected participant sample size was usually smaller than originally hoped for and lacked longitudinal evidence. An emerging future direction from all studies was to continue efforts towards understanding the
types of activities used in family wellness programming as well as recruiting a larger, more diverse participant pool.

Together, these studies suggested that additional research on how the caregiver perceives their family wellness is imperative to determine how to improve family wellness. Although other studies came close to including an examination of caregiver perceptions of physical wellness with children between 2 and 8 years old, one has yet to be found. A close example was Pratt et al. (2017)’s study reviewing mother’s perspectives of physical activity, feeding dynamics, and nutrition which looked at pre-school aged children ages 2 to 5 years old. Few relevant studies are Canadian. A popularized discussion and at least seven of the original studies found centred on obesity prevention (Burdette et al., 2004; Haines, et al., 2018; Hennessy et al., 2020; Moreno et al., 2011; O’Kane et al., 2017; Po'e, et al., 2013; Pratt et al., 2017; Uijtdewilligen, 2017). When reviewing some of the obesity intervention studies, Hennessy et al. (2020)’s study stood out because they were trying to gather caregiver perceptions of sedentary behaviour and physical activity for the family. Upon closer inspection, the participants in Hennessy et al.’s (2020) research were found to be Irish rather than Canadian and the discussion included families with infants regarding their growth and development, (instead of children ages 2 to 8 years old). Koltz et al. (2021) proposed the PACES model of student wellbeing (as first described by Nelson et al., 2015) as the model to examine family wellbeing. The American-based PACES model was a theoretical proposal of how to examine five dimensions of wellness: cognitive, physical, affective, social, and economic and has yet to be used with any population in research. A separate investigation that brought awareness to family-wellness, and not disease-prevention, was authored by Rotheram-Borus, Swendeman, and Flannery (2009). The research team cited statistics from WHO and discussed how to manage health challenges, like HIV, while promoting family wellness throughout their study. However, they did not recruit participants and so their suggestions remain theoretical. A fascinating study in Nunavut, Canada spotlighted Arviarmiut mothers’ perceptions of wellness and provided recommendations for the development and implementation of a culturally responsive wellness model to support Inuit family and child wellness (Johnston et al., 2022). This study fell outside of the in-depth critique as their primary focus was on child welfare and child apprehension, and although physical wellness of caregivers and children would have been impacted, it wasn’t described. A semi-structured qualitative approach was actioned, however, and not just mothers were interviewed. In addition to mothers,
twelve key informants and three Elders were interviewed, broadening the participation to something different than the inclusion criteria for this study. Finally, there have not been many independent applications of Swarbrick and Yudof’s (2015) eight dimensions of wellness model in the literature. There are a couple of theses that explored the model. However, no study using Swarbrick and Yudof’s (2015) model aligned with the topic of caregiver’s perceptions of family physical wellness. For instance, Das (2015)’s thesis assessed an empirical test of validity and expanded on Swarbrick and Yudof’s (2015) eight dimensions of wellness model by suggesting a ninth dimension of wellness be added, community resources.

As seen in this chapter, wellness is fundamental and the search for a unified definition has continued throughout time (Corbin & Pangrazi, 2001; Fullen, 2016; Knez et al., 2020). Significant repercussions extend beyond the individual to encompass the surrounding communities and contexts with which the individual interacts when something, such as wellness, lacks clear structure or definition for understanding (Corbin & Pangrazi, 2001). One major barrier in developing a comprehensive and sustainable wellness strategy is the complexity of holistic wellness. Although there is consensus regarding the multidimensional nature of the construct (Adams et al., 1997; Hettler, 1980; Renger et al., 2000; Walker et al., 1987), disagreement persists surrounding the total number and naming of the dimensions that together comprise holistic wellness.

2.6 Summary

Historically, wellness and more specifically family wellness lacks a clear, concise, relevant definition (Prilleltensky & Nelson, 2000; Wollny et al., 2010). In this chapter, a global perspective on wellness, including the prevalence of mental and physical health conditions and statistics, was provided before an overview of the Canadian context. A gap in the research was highlighted on how caregivers perceive their physical wellness. This chapter concluded with a critical analysis on the current literature that is most closely associated to exploring family physical wellness. In the next chapter, the methodologies employed to investigate caregiver perspectives on wellness and the TOYBOX intervention will be explored. A reiteration of the research question and qualitative methodology rationale, design, sampling methods, and semi-structured interviews will occur. The procedure of thematic analysis and any ethical considerations required will be discussed as well. Hence, it is imperative to further explore how
Canadian families currently perceive wellness and specifically, in an unexplored context of family physical wellness from the proxy of the caregiver.
3.0 Chapter 3: Methodology

This methodology chapter, consisting of five sections describes the processes used to gather information to understand family physical wellness and the TOYBOX intervention from the caregiver perspective. The first section includes the research question, a rationale for the use of qualitative methodology, and the research design. The second section outlines the sampling methods used including participant recruitment, selection, and criteria for participant inclusion. Next, the method of data generation, and the use of semi-structured interviews, is described. Qualitative thematic analysis procedures are identified in the fourth section. Finally, trustworthiness and ethical considerations required for this study are addressed. It's important to note that physical family wellness participants might not adhere strictly to the distinctions of family physical wellness, potentially utilizing terms and definitions interchangeably or in a non-academic way.

3.1 Research Questions and Design

In the current investigation, Canadian families were interviewed to understand their perceptions of family physical wellness. As Braun and Clarke (2021) pointed out, one of the ten key elements to good qualitative research is having sharp, focused research questions that can also evolve. Therefore, the primary research question that oriented this study was: What are caregivers' perceptions and experiences of family physical wellness in the context of play, outdoor interactions, and physical activity? This study also examined the relevance of utilizing the five domains of social determinants of health (SDOH) (WHO, 2008; Healthy People 2030, n.d.-c) and Swarbrick's eight dimensions of wellness (Swarbrick & Yudof, 2015) as a basis for understanding the intersections between public health and psychology, as well as the contributing factors to Canadian family wellness.

According to Merriam (2002), qualitative research involves “the search for meaning and understanding, the researcher as the primary instrument of data collection and analysis... and a richly descriptive end product” (p. 6). Qualitative researchers ask open-ended, exploratory questions to discover how people interpret the world, and aiming to convey their perceptions about the research in a "rich, complex, nuanced, and detailed" way (Braun & Clarke, 2021, p. 27). Additionally, qualitative research helps to describe the participant voice. While trying to gain a comprehensive understanding, exploratory efforts from the researcher require flexibility and a willingness to learn the value of uncertainty and subjectivity. Braun and Clarke (2021)
describe this as avoiding the "positivism creep" (p. 7), or the gradual seep of searching for absolute, objective, unbiased, and singular truth, an aim of quantitative research. Although the researcher is the primary instrument for the data collection and analysis, researcher acknowledgement toward the lenses and positionality they uphold must be presented. Braun and Clarke (2021) emphasized how qualitative research is enhanced by reflexivity and subjectivity in facilitating meaningful examination and towards the end of this chapter, a discussion around data trustworthiness will occur.

Ngulube (2015) asserted that the focus of qualitative research “is on the meaning of events and actions, rather than statistical significance and relationships between variables” (p. 3). Quantitative research values finding an explanation or a cause-and-effect relationship and setting out to test hypotheses. Research has not yet focused on how the caregiver perceives and experiences family physical wellness (Miller & Foster, 2010). Further, no studies have explored the relationship and experience of family wellness to Swarbrick and Yudof’s (2015) eight dimensions of wellness. Due to qualitative research focusing on how questions and its ability to provide interpersonal insights that quantitative research cannot offer (Creswell & Poth, 2016; Olmos-Vega et al., 2023); a qualitative approach was chosen as the best option for investigating the research question on family wellness.

This study took place as part of a larger quasi-intervention study, the TOYBOX Friends research project. The Canadian families that participated in the TOYBOX Friends research project were encouraged to participate in the University of Winnipeg’s larger TOYBOX initiative for six weeks. The TOYBOX, a cost-free project, provided interested families with age and developmentally appropriate activities promoting learning in three areas including literacy, numeracy, and wellness. Each week, participating families received a TOYBOX email with three activities, one activity for each of wellness, literacy, and numeracy (see 3.3 Data Generation for more details on how the study was structured).

A semi-structured, in-depth interview was a massive component of this study and was conducted with one caregiver from each of the participating families. This occurred before and after a six-week pilot study. Considering family wellness, a semi-structured interview method was chosen to capture family perceptions, opinions, and interpretations about family physical wellness. With semi-structured interviews, it is possible to record meaningful, diverse, rich descriptions and expressions, enabling the researcher to focus on what's important to the
participant (Cridland et al. 2015). As a qualitative method, semi-structured interviews were used to develop a deeper understanding of participant’s lived experiences of family physical wellness both prior to and following the pilot study.

3.2 Participants

Upon receipt of University of Saskatchewan Ethics Board of Approval, 24 families were recruited through snowball sampling to participate in the TOYBOX Friends research project. A snowball sampling or “chain-referral” technique where “data [is] accumulated through existing social structures” (Roberts, 2014, p.4) was employed to recruit 24 caregivers interested in family wellness. Due to the challenges presented by the ongoing pandemic, when this project was initiated, participant recruitment occurred through email and social media. As a means of mitigating “the biases associated with snowball sampling” (Trust et al., 2016, p.18), recruitment letters and posters were made available on various online platforms including email, Instagram, and Facebook.

Before any research was conducted, an informed consent form and a pre-survey were completed. All participants, families with one or more children, were required to complete a consent form, follow-up surveys, and two video interviews using Zoom (on a computer, cell phone, or device with internet and/or data capabilities). The inclusion criteria for this study encompassed the following conditions: being a Canadian citizen, serving as a caregiver in a family with children ages 2 to 8, and have the capacity to provide written informed consent. Participation was open to individuals of all genders, races, and ages. Conversely, families with child(ren) falling outside the recommended age range (2 to 8) were excluded. As well, the developmental and educational aspects of the pilot study activities were thought to be unsuitable for children outside of the recommended age range. Participants were required to complete both the interview and the survey components. Therefore, despite the initial recruitment of 24 families, the study encountered several factors leading to a reduced participant count of 19. One participant chose to decline their participation after receiving details during the consent form and pre-survey phase. Additionally, two participants were unable to participate as they were not Canadian citizens and lived internationally (USA and Colombia). Another participant’s disclosure of dishonesty during their interview responses rendered them ineligible to be considered for data analysis. Lastly, one individual did not complete the full study and opted out.
of participating in a follow-up interview. As a result, the current study incorporated a total of 19 participants.

Participants had the opportunity to share information, stories, and lived experiences about their health and wellness. Caregivers reflected on their wellness prior to March 2020 through to their current state of wellness during the pre-interview at the beginning of February 2022 and again at a later follow-up interview that took place towards the end of March 2022. In the context of this study, a child referred to a family member aged 2 to 8 years. Similarly, a caregiver, guardian, or extended family member in this research was defined as someone consistently addressing a child's basic needs and served as “a secure base from which to explore and, when necessary, as a haven of safety and a source of comfort” (Benoit, 2004, p. 541). There was no specific request for a primary caregiver interview, as households acknowledged shared roles and responsibilities in caregiving (co-caregiving), with both partners equally contributing to fulfilling the child's needs. This study focused on the results of only the qualitative pre-interview.

3.3 Data Generation

Each week the 19 participating families, in the TOYBOX friends project, received a TOYBOX email with three activities, one activity for each of wellness, one on literacy, and one on numeracy. Caregivers engaged in a pre- and post- survey (60-70 minutes total), weekly feedback surveys (1-2 minutes), as well as a pre- and follow-up online Zoom interview (60-90 minutes total). The activities included tips at various levels (basic, intermediate, advanced) and focused on numeracy. The wellness activities, designed by the larger TOYBOX project, supported families to engage in active and passive rest and included movement or resting. For example, one of the weekly activities that caregivers participated in for wellness was named Dance It Out (ToyBox, 2023b), which encouraged families to express themselves creatively by moving to music. The literacy and numeracy activities were designed to support families in their children’s skills development. A literacy activity example, titled Alphabet Bowling! (ToyBox, 2023a), prompted families to build on their comprehension of letters and phonetic attributes instrumental to developing strong reading skills. An example of a numeracy activity was called Jump Rope, Number-Line (ToyBox, 2023c) which had caregivers use a number line to develop an understanding in how numbers relate to one another. Families were encouraged to try the TOYBOX strategies or activities each week. Initial recruitment occurred via email to friends and colleagues by the wellness research committee. In addition to email (see Appendix C), Facebook
and Instagram were used as tools for engaging a broader audience. As mentioned in the previous section, the study began with participants completing an informed consent form and a pre-survey.

The in-depth, semi-structured web-based interviews helped deepen and expand our understanding of how caregivers support their personal and family wellness. The videoconferencing platform, Zoom, was utilized to record the interviews. Transcription occurred with the support of the application Otter.ai (2021), offering an immediate speech-to-text transcription which saved time and money (Otter.ai, 2021). In a second review of the transcripts, the TOYBOX research assistant team at the University of Winnipeg aimed to confirm the accuracy of Otter.ai’s (2021) transcription. An inclusive virtual setting and space were provided to aid participants in their introspection, reflecting on interactions with others, the familial environment, their children, and themselves.

Caregivers responded to a total of 53 multi-part questions between the two interviews, describing their family’s relationship to wellness. For example, questions/statements participants responded to included: “Over the course of the pandemic, would you say that overall, your physical wellness has: improved, worsened, or stayed the same?”, “How would you define wellness?”, and “What kinds of wellness do you think needs improvement in your life?”. Each question allowed for deeper discussions on how caregivers see themselves and their families in terms of wellness. I journalled and met with the research team and committee throughout the study. Journaling and the meetings were conducted to record the thoughts, feelings, or insights of research team members discovered during the data collection process.

3.4 Data Analysis

The current study analyzed participant data using thematic analysis (TA). Thematic analysis is a method of data analysis that aims to identify, analyze, and record patterns (themes) across data sets that were associated with a specific research question (Braun & Clarke, 2006). Braun & Clarke (2021) outlined that TA shares “an interest in patterns of meaning” (p. 4) and guides a researcher on a journey of discovering and learning how to do their own style of data analysis rather than following a set of linear rules or steps.

Initially, I began the task of examining both pre- and post-semi-structured interview time points to thoroughly delve into caregiver perceptions and experiences regarding family physical wellness. However, given the expansive volume of data involved, particularly in the context of
this being a master’s thesis project, I found it imperative to restructure the scope of my analysis to ensure manageability and focus. This thesis project also occurred amidst the COVID-19 pandemic, with provinces implementing different restrictions. However, I made efforts to remove the COVID focus as it was not part of my research question.

**Figure 3.1**

*Thesis Project Timeline*

![Thesis Project Timeline](image)

*Note.* This project took place during COVID-19 pandemic.

Throughout the analysis process, Braun and Clarke (2021) described moving through six effective phases. The initial phase of thematic analysis, *familiarizing yourself with the dataset*, included immersing myself within the data (Braun & Clarke, 2021). By repeatedly reviewing, listening to, and transcribing the semi-structured interviews, ideas were noted during the interview process. Otter.ai's (2021) assistance helped to capture meticulous transcriptions. With Otter.ai (2021), time spent typing was reduced which increased time spent attentively listening to and accurately recording participants' words and ideas. The Otter.ai application is only a technical tool, so it wasn’t relied upon exclusively. To ensure precision, I relistened and reread all participant interviews repeatedly.

The second phase involved coding (Braun & Clarke, 2021). In developing preliminary codes, I created an excel spreadsheet and noted responses to various questions. This further immersed me within the data, providing a space for me to critically engage and identify codes. When I began to document the codes from participant interview responses, I maintained an open mind and focused on clarity, relevance, and depth (Braun & Clarke, 2021). In keeping an open mind, I explored potential relationships between codes. For example, I randomly selected a smaller group of participants (approximately three) to learn more about what each participant was initially discussing about their family’s relationship to physical wellness. I observed how this smaller group compared and differed from one another and noticed reoccurring codes such
as a sense of belonging was important to caregivers. A crucial aspect of coding involved clearly
defining and accurately representing the data through codes that were easily distinguishable from
one another. For example, a participant combined discussions about their neighbourhood and the
weather in a single sentence. I immediately identified the presence of at least two distinct codes
that I could assign, anticipating their potential contribution to new and distinct themes, such as
the impact of weather and location matters. I selected codes that were pertinent to my research
question ensuring their relevance and direct connection to the specific inquiry. For relevance, I
noticed, for example, that participants discussed swimming as a nurturing activity for family
wellness. Although this only one code amongst an extensive list, I recalled its importance in
relating to part of my research question in capturing caregiver’s experience of family physical
wellness. In maintaining depth, I delved into aspects such as how each caregiver defined
wellness or how wellness was perceived and what their relationship to the dimensions of
physical wellness would be, such as healthy eating, exercise, time away from TV and screens,
and sleep. Understanding individual caregiver perspectives throughout the coding process
revealed a variation in habits, preferences, and challenges that families experienced which
contributed to a more comprehensive understanding. I organized codes with supporting evidence,
such as direct quotations and a line number within Microsoft Excel. For instance, most
caregivers spoke on seasonal activities and so I included line items of where seasonal activities
were mentioned. To further illustrate this, Helen talked about seasonal activities at six different
times throughout her interview (37-40, 149-166, 254-258, 500-502, 573-578, and 613-619).

In the third phase, generating initial themes (Braun & Clarke, 2021), I searched for
patterns and began arranging the data into themes by actively and creatively generating similar
and potential themes across the dataset. During this phase, consistent with Braun and Clarke’s
(2021) description of theming as a journey involving moments of discover and uncertainty, I
certainly navigated “find(ing) [my] way again…” and “hiccups and backtracking” (p. 79). I
stumbled my way through multiple conversations with my supervisor about where I was keeping
myself and my data singular, focusing on the granularity and not wanting to part with any
participant voice or code. In my thoughts at the time, every aspect held significance and
exhibited some connection to one another. I initiated the identification of some commonalities
among the codes, leading to the emergence of initial themes which was very time-consuming.
These initial themes were subsequently re-examined and defined as sub-themes. For example,
codes such as temperature, seasonal activities, conditions, and settings initially related to a broader theme and were labelled as the theme “impact of weather.” Later this transformed into a sub-theme of a larger category named “location matters.” I explored the patterned meanings and considered how broad clustered ideas told a story and addressed my research question.

The fourth phase involved developing and reviewing the themes (Braun & Clarke, 2021). This was conducted by re-engaging with the meaningful idea clusterings created in phase three. In this phase, I examined each theme to observe if an expansion or narrowing was required. I aimed to provide viable, focused, rich, “distinctive… not merg(ing) into each other” themes (Braun & Clarke, 2021, p. 97). Building on the example provided in phase three, “impact of weather” became a smaller sub-theme of the overarching theme “location matters” during this phase. It was in this phase that four major key themes identified: 1) environmental wellness; (2) physical wellness; (3) play; and (4) self-care. I actively utilized thematic mapping as a tool. I initiated the process with a single map and iteratively adjusted it to encompass the evolving themes more comprehensively and how they also related to two theoretical frameworks. I linked the generated data to broader theoretical concepts, developing a connection to (1) the five domains of social determinants of health (SDOH) (WHO, 2008; Healthy People 2030, n.d.-c); and (2) Swarbrick’s eight dimensions of wellness, or the wellness inventory-r (Swarbrick & Yudof, 2015). It was crucial to investigate the contribution this research had on new insights as well as to how it was in alignment with previous research in the field.

The fifth phase, involved refining, defining, and naming themes (Braun & Clarke, 2021), pushed theme development one step further and “blends into the final phase of TA - writing up” (Braun & Clarke, 2021, p.108). My aim in this phase was to identify what was unique and relevant, to define and name each theme with precision, and to demonstrate how the themes aligned with the overall analysis. I portrayed relationships between possible themes and subthemes and there was lots of movement between one theme to another. I focused on detailing the interconnections between potential themes and subthemes, often navigating fluidly between other themes. At times, certain sub subthemes were omitted to streamline the granularity of the findings, facilitating a clearer understanding of the defined themes and sub-subthemes. This process facilitated coherent and meaningful narratives that encapsulated the essence of the data.

Finally in phase six, writing up (Braun & Clarke, 2021), I transitioned my writing from informal and just for myself to a more detailed, clear, and formal presentation of writing for
publication or professional audience. Using this style of writing might help me publish or present to a professional audience in the future. Several refinements were made to the overall analysis, linking it to the research question, the literature review, and other sections of the thesis. Multiple iterations of developing figures to illustrate how the themes were identified and were related as well as continuous dialogue with committee members helped to refine the writing up process.

3.4.1 Trustworthiness

McGinley et al. (2021)’s latest study, exploring how to improve trustworthiness in qualitative research, outlined the importance of starting with Lincoln and Guba’s (1985) four factors using them “as a checklist to determine whether additional measures are needed to establish trustworthiness” in qualitative research (p. 15). Data trustworthiness was achieved by following Lincoln and Guba’s (1985) four criterion of trustworthiness framework: credibility, transferability, dependability, and confirmability.

Credibility. In the context of this current study, credibility was practiced by exploring participant voice through a pre-interview. Although the findings of the follow-up interview were outside of the boundaries of this thesis study, it provided an opportunity to double-check and validate participant voice as I was the main interviewer of both. The first interview provided the participants and I with a collaborative space to discuss how family wellness is experienced through the lens of the caregiver. Following the pre interview, the follow-up interview assisted more dialogue on if there were changes to family wellness during the six weeks between the two interviews. This further allowed for participants to understand and perceive how their family was experiencing family wellness. The pre interviews were around 36 minutes in length, which gave participants an uninterrupted freedom to express and detail their family wellness experiences. Throughout the interviews, I consulted the wellness research committee (see data generation) to verify the study's findings through multiple perspectives.

Transferability. Transferability in qualitative research is where findings can be applied to other contexts and settings (Lincoln & Guba, 1985). Most importantly, the applicability aspect of trustworthiness in research enables “the reader to assess whether your findings are transferable to their own setting” is critical (Korstjens & Moster, 2018, p. 122). In this study, due to the evolving and contextual nature of different family sizes, different geographical locations, and employment statuses, everyone’s experience was a little different. There were definite parallels that arose as well. All families had young children, families had two caregivers, and the
participant served as a caregiver to their families. By discerning these distinctions, I was able to recognize commonalities among the participants as well, facilitating an opportunity to connect participants and their stories together. Capturing experiences in a rich and detailed way aided in understanding the factors that appear to influence, strengthen, and deteriorate Canadian family wellness. I have yet to have biological children of my own, but I have experience serving as a caregiver in various settings including working both full-time and part-time in daycare facilities, providing childcare to my cousin’s family and her two children, as well as caregiving and offering support to my friends and their children. In this step, there was a need for qualitative researcher reflexivity, or humbly acknowledging situatedness, while also developing a “vicarious experience” (Compton-Lilly, 2013, p. 60). Thus, I tried to support, learn from, and stay connected to the stories and voices of the participants. Being mindful of engaging the audience (Lincoln & Guba, 1985; Korstjens & Moster, 2018), I provided the reader with descriptions of a participant’s background, characteristics, and whenever possible described participant voice utilizing direct quotations.

**Dependability.** McGinley et al. (2021) detailed dependability or consistency as to how a study can be replicated or used to establish future studies. In this study, a wellness research committee supported the data collection process and was closely involved in the examination of the data analysis and results to determine whether the thematic findings accurately described the participant experiences. I spent a large amount of time reviewing participants’ voice, notes that were recorded throughout the study that captured my thoughts and reflections. These notes were recorded on sticky notes and in a journal and at times at strong personal connections to other parts of my life as the researcher. With sticky notes, I was able to move and reorganize my thoughts quite quickly and I was able to use different colour pens and papers to gain a deeper insight to how the data was interconnected. Visualizing the data in this way and maintaining a thorough documentation of my thought and analytic processes ensured the accurate analysis of participant voice. I was able to add, remove, and combine notes through a continuous observation of (re)interpretation of my notes. Notes that were reflexive in nature demonstrated my “subjective responses to the setting and the relationship with the interviewees” (Korstjens & Moster, 2018, p. 123).

**Confirmability.** Finally, confirmability refers to the neutrality and accuracy of the data (Korstjens & Moster, 2018; Tobin & Begley, 2004) and suggests that the data be “free from bias,
function solely of the informants and conditions of the research and not of other biases, motivations, and perspectives” (McGinley et al., 2021, p. 11). Throughout the research process and study, a journal documenting my reflections and reactions was kept. By doing this, independence from the participants was maintained and bias was avoided. Although bias and subjectiveness cannot be eliminated from the data collection and interpretation process, Merriam (2002) emphasized the importance of identifying and monitoring personal bias. Braun and Clarke (2021) showcased the importance of keeping “a reflective or reflexive journal… [and] documenting or storing thoughts for subsequent reflection, interrogation, and meaning-making” (p. 19). With referring to my notes throughout the research process, I was able to continuously reflect on and (re)organize my thoughts which led me to finalize and understand my decisions. For example, I had originally only jotted down two major themes as umbrella terms in capturing my thoughts on the subthemes and sub subthemes that I identified. I realized through an iterative process that there were two additional major themes, and I would have missed these additional themes, had I not immersed myself and repetitively revisited the data within my journaled notes.

3.5 Ethics

The larger TOYBOX project received ethical approval from The University of Winnipeg under the supervision of Dr. Sheri-Lynn Skwarchuk. However, I was required to notify and seek approval from the University of Saskatchewan's Research Ethics Board due to human participation in this study. The University of Saskatchewan approved my participation in this project (REB File #: Beh ID 3357).

The participants were provided with informed consent forms at the beginning of the pilot project, before participating in the survey or pre-interview session. Those who choose to participate were given the opportunity to ask questions and raise concerns as well as ample time to fully understand the implications of their involvement in the study.

The outline of the informed consent and confidentiality forms was as follows: purpose and information about the study; a detailed procedure about the requested participation; benefits and risks associated with participation; how data was collected and how data arising from the project might be used in the future; a confidentiality agreement; and the right to withdraw. Participants were informed that participation was completely voluntary, their information would be kept strictly confidential, and any identifiable information, such as their names, would not be associated with the data. Participants could have stopped participating at any time. If participants
had any further questions or concerns, my contact information was shared. Participants were also able to participate in a free debriefing session with Sheri-Lynn Skwarchuk, R. Psych, a member of the wellness research team. Sheri-Lynn’s contact information was also provided. That way, those who participated in the interviews could feel supported if any information discussed was triggering or if there were further questions and concerns. In accordance with the guidelines and regulations of the University of Saskatchewan, a copy of the participant data related to my specific study will be stored in the office of Dr. Laureen McIntyre within the Department of Educational Psychology and Special Education for five years. Upon completion, a research project report is filed with the University of Winnipeg REB, and a copy will be directed to the University of Saskatchewan Research Ethics Office

3.6 Summary

The third chapter described the methodology used for this qualitative research study on exploring caregivers’ experiences and perceptions of Canadian physical wellness. How participants were recruited, how data was checked for trustworthiness, and how the data was collected and analyzed was described.
4.0 Chapter 4: Findings

This chapter introduces the voices of the 19 caregivers who participated in sharing their perceptions and experiences in the context of family physical wellness related to the research question: What are caregivers’ perceptions and experiences of family physical wellness in the context of play, outdoor interactions, and physical activity? This chapter begins with an introduction of the participants in the study. Following the description of these participants, the findings of the thematic analysis are presented and organized by theme.

4.1 Participants

Nineteen caregivers participated in this Canadian family physical wellness study. To maintain confidentiality, each participant was assigned a pseudonym. To protect confidentiality, enhance clarity, and provide an articulated voice, quotes from participants were edited. Alterations or omissions of specific words (i.e., names, locations, organizations) and incidences of verbal disfluency (i.e., like, umm, so, you know, etc.) or the “temporary suspension of speech flow through filled pauses, silence, repetitions or new utterances” (Kosmala et al., 2019, p. 1) were addressed accordingly. It is important to acknowledge that the participants in this study may have used terms such as “health”, physical activity”, or “exercise” in a manner that may not align with or adhere to the academic definitions originally presented. Such colloquial quotes were maintained as presented in order to share the true voices of participants.

Originally, 24 participants were recruited for the study. However, five participants were excluded from data analysis for various reasons: (1) two participants lived outside of Canada, with one relocating shortly before the interviews commenced; (2) one participant expressed disinterest and did not complete the initial consent form or pre-interview survey; (3) another participant admitted to providing false information due to social desirability reasons after the interview was completed; and (4) one participant chose not to participate in the post-interview, resulting in the exclusion of their pre-interview data.

Each of the 19 participants identified as male or female adults with diverse educational and occupational backgrounds, predominantly engaging in professional or trades settings. Each caregiver was in a partnership, with approximately seven caregivers on maternity leave at the time of the interviews. Moreover, all participants were caregivers to children aged between 2 and 8 years old. One caregiver from each family engaged in an interview to explore the perceptions and experiences of family physical wellness in Canada. Although geographic location was not a
studied factor, some participants lived in smaller cities (e.g., Fernie, BC) while others resided in larger cities (e.g., Ottawa, ON). Although most participants were living in urban settings, one participant specifically identified living in a rural setting. The following table presents a summary of the characteristics of the nineteen participants (see Table 4.1).

Table 4.1

Demographic Details for the Study Participants (n=19)

<table>
<thead>
<tr>
<th>Pseudonym and Gender</th>
<th>Province</th>
<th>Household Income</th>
<th>Highest Level of Education</th>
<th>Number of Children (ages)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chris; Male</td>
<td>AB</td>
<td>50 to 75</td>
<td>Undergraduate</td>
<td>1 dau.(^a) (2)</td>
</tr>
<tr>
<td>Julia; Female</td>
<td>AB</td>
<td>&gt; 100</td>
<td>Undergraduate</td>
<td>1 dau.(^a) (2)</td>
</tr>
<tr>
<td>Paula; Female</td>
<td>BC</td>
<td>&gt; 100</td>
<td>Undergraduate</td>
<td>1 dau.(^a) (2)</td>
</tr>
<tr>
<td>Isla; Female</td>
<td>AB</td>
<td>&gt; 100</td>
<td>College Diploma</td>
<td>1 son (5)</td>
</tr>
<tr>
<td>Maya; Female</td>
<td>AB</td>
<td>&gt; 100</td>
<td>Graduate</td>
<td>1 son (5)</td>
</tr>
<tr>
<td>Bonnie; Female</td>
<td>AB</td>
<td>&gt; 100</td>
<td>Graduate</td>
<td>1 son (3)</td>
</tr>
<tr>
<td>Gema; Female</td>
<td>AB</td>
<td>75 to 100</td>
<td>Undergraduate</td>
<td>1 son (7)</td>
</tr>
<tr>
<td>Kara; Female</td>
<td>MB</td>
<td>&gt; 100</td>
<td>High School</td>
<td>1 son, 1 dau.(^a) (4, 2)</td>
</tr>
<tr>
<td>Olivia; Female</td>
<td>ON</td>
<td>&gt; 100</td>
<td>Undergraduate</td>
<td>1 son, 1 dau.(^a) (5, 2)</td>
</tr>
<tr>
<td>Farah; Female</td>
<td>AB</td>
<td>&gt; 100</td>
<td>Graduate</td>
<td>1 son, 1 dau.(^a) (5, 3)</td>
</tr>
<tr>
<td>Adam; Male</td>
<td>SK</td>
<td>&gt; 100</td>
<td>Graduate</td>
<td>1 son, 1 dau.(^a) (7, 4mos)</td>
</tr>
<tr>
<td>Mike; Male</td>
<td>ON</td>
<td>&gt; 100</td>
<td>N/A</td>
<td>2 dau.(^a) (3, 11mos)</td>
</tr>
<tr>
<td>Demi; Female</td>
<td>AB</td>
<td>&gt; 100</td>
<td>Graduate</td>
<td>2 dau.(^a) (4, 8)</td>
</tr>
<tr>
<td>Erica; Female</td>
<td>ON</td>
<td>&gt; 100</td>
<td>College Diploma</td>
<td>2 dau.(^a) (5, 7mos)</td>
</tr>
<tr>
<td>Nina; Female</td>
<td>AB</td>
<td>N/A</td>
<td>College Diploma</td>
<td>2 dau.(^a) (6, 8)</td>
</tr>
<tr>
<td>Quin; Female</td>
<td>SK</td>
<td>&gt; 100</td>
<td>Undergraduate</td>
<td>2 dau.(^a) (7, 2)</td>
</tr>
<tr>
<td>Alexis; Female</td>
<td>AB</td>
<td>&gt; 100</td>
<td>Graduate</td>
<td>2 sons (4, 2)</td>
</tr>
<tr>
<td>Helen; Female</td>
<td>MB</td>
<td>50 to 75</td>
<td>High School</td>
<td>3 children: 1 son (5), 2 dau.(^a) (3, 1.5)</td>
</tr>
<tr>
<td>Lisa; Female</td>
<td>AB</td>
<td>&gt; 100</td>
<td>Graduate</td>
<td>3 dau.(^a) (10, 6, 11mos)</td>
</tr>
</tbody>
</table>
Note. The provinces were abbreviated and are as follows: Alberta (AB), British Colombia (BC), Manitoba (MB), Saskatchewan (SK), Ontario (ON).
Daughter(s) was abbreviated to dau.

4.1.1 Wellness Defined by the Families

In a family-focused study on the experiences and perceptions of physical wellness, 19 participants shared their diverse definitions of wellness, and in doing so supported the understanding that wellness is indeed multi-dimensional. For some participants, wellness entailed a delicate balance between physical (physical wellness) and mental health (emotional wellness), considering both aspects as equally crucial. Although the primary emphasis of this study was on the experiences and perceptions of physical wellness, participants notably expressed the importance of emotional wellness. Some participants defined wellness differently for their children, emphasizing practical factors like sleep, nutrition, and exercise illustrating a distinct familial approach to defining wellness. Comprehensive definitions of wellness also surfaced, with participants expressing the belief that wellness encompasses the broader notions of health and happiness. For instance, according to Adam, family wellness is encapsulated in the notion of being "healthy and happy." Julia echoed a similar sentiment to Adam in her definition by emphasizing that "experiencing happy moments throughout the seasons of your life" is foundational to wellness.

Overall, participants revealed a range of perspectives, with the majority of participants conceptualizing wellness as holistic and inclusive of many of Swarbrick’s eight dimensions of wellness (Swarbrick & Yudof, 2015), despite the participants’ lack of familiarity with a specific theoretical wellness framework or model. Family-centric views emphasized the significance of shared activities such as exercise, healthy eating, taking care of each other, and quality time spent together. Additionally, several participants noted “finding joy” and “a balance” as part of wellness. Overall, participant insights reflected a holistic and comprehensive understanding of family wellness, highlighting the need to assist and support families in a multi-dimensional way.

4.2 Analyzing Themes

Following the analysis of each interview transcript through the theoretical frameworks of the eight dimensions of wellness (Swarbrick & Yudof, 2015) and the five domains of the social determinants of health (SDOH) (WHO, 2008; Healthy People 2030, n.d.-c), four major themes were intentionally fashioned: (1) Environmental Wellness; (2) Physical Wellness; (3) Self-care;
and (4) Play (see Figure 4.1). Further elaboration on these themes is provided in the remainder of the chapter, connecting the themes through insightful subthemes and sub subthemes and highlighting participant voice through quotes from the participants.

Figure 4.1

Themes and Subthemes
4.3 Environmental Wellness

The first theme highlighted in the study environmental wellness (see Figure 4.2) which included three subthemes: (a) location matters; (b) impact of weather; (c) outdoor interactions and included several sub subthemes. The 19 participants focused on micro and macro environmental factors, highlighting the importance of safe spaces; supportive and intentional environments chosen for learning, recreation, play, and employment; and a sense of belonging that encouraged overall wellness within this theme.

Figure 4.2
Environmental Wellness Theme

- Location Matters
  - Sense of Belonging
  - Intentional Location
  - Supportive Environments

- Impact of Weather

- Outdoor Interactions
  - Mind-Body-Nature Connection
  - Planned Time Outside
  - Swimming

Relating to the theoretical frameworks utilized in this study, Swarbrick and Yudof’s (2015) definition of environmental wellness describes “feeling physically safe … being able to access clean air, food, and water, [and]…includes both micro-…and… macro-environments” (p. 8). Within the neighbourhood and built environment domain of the five domains of SDOH (Healthy People 2030, n.d.-a), the objective of the domain describes enhancing “health and safety in the places where people are born, live, learn, work, play, worship, and age.” (Healthy People 2030, n.d.-a). In this study, caregivers did not address the accessibility of clean air, food, and water, as outlined by both the theoretical frameworks, as the caregiver demographic consisted of families less prone to lacking these essentials. Nonetheless, families spoke to the
importance of safe spaces, gathering areas, supportive environments for education, recreation, play, and employment. The 19 participants focused on micro and macro environmental factors. As well, caregivers mentioned that specific locations fostered a sense of belonging and promoted activity that supported overall wellness.

4.3.1 Location Matters

Caregivers expressed a sense of belonging and the importance of living somewhere with intention. Participants also noted several gathering spaces that felt like a second home and supportive to the entire family. Therefore, this subtheme location matters included three subthemes: (a) sense of belonging; (b) intentional location; and (c) supportive environments.

Sense of Belonging. All 19 participants talked about a sense of belonging or desire to be around others in relation to their environmental wellness. As Swarbrick and Yudof (2015) defined environmental wellness as the need for a safe space, safe “communities, country, and whole planet” (p. 8), several participants referred to this aspect. For example, Helen, a rural community resident, observed that community and a sense of belonging to her community and the environmental surroundings she’s a part of was vital:

Oh, community, community, community! Building relationships… I’ve advocated for this many times. I'll see my girlfriend in the city. She’s like “I’m having such a hard time” [I say]… come out here, bring your own food, [and] we'll have a picnic outside. You can do your thing and I can do my thing. But just get out in the country…. It's amazing watching the sun come up and not having to worry.

Additionally, when Adam discussed their family’s environmental wellness ranking, he expressed that “it’s very subjective” and “it depends on where you have your child.” Adam went on to mention that larger communities in Canada offered more people, diverse environments to interact with, and greater opportunities to get involved and establish connections. Based on the theoretical frameworks, connecting at a macro-environmental level and attunement to community dynamics is linked to environmental wellness. Uniquely, Gema was the only participant to provide reference to a land acknowledgment:

…we reside on the lands of treaty seven, and we are in [a city] in Alberta. We live in a condo that we own in [a neighbourhood that is] … very close to the core (downtown), which for many reasons, is very ingrained in us by now.
In discussing sense of belonging in connection with nature, Erica and Alexis stood out among the participants and specifically highlighted the importance of living close to natural, green spaces and parks. Erica expressed that her sense of belonging encompassed both schools and green spaces, noting, “there’s one catholic elementary and two public [schools]. There’s a …natural park we walk through… nice neighbourhood, quiet.” Alexis mentioned there’s “a really big backyard which we love and mature trees, apple trees…very close to a green strip, …school, …[and] lots of parks.” Many participants, including Nina, referred to the significance of school proximity being an important aspect of a family’s sense of belonging. Nina shared that, “[we] live in a single-family home…and my kids go to the public school.” In addition, Demi stated that “we are quite involved in our neighbourhood association… we’ve had connections in the neighbourhood, and we know quite a few people who live around [us].” Gema’s acknowledgment of the broader context of the land and community where they lived, as well as Erica, Alexis, Nina, and Demi’s conversations about the places they lived, learned, worked, and played in emphasized family awareness of their microenvironments, a concept addressed by the theoretical frameworks.

In terms of fostering intergenerational connections, Mike articulated his desire for his family to live closer, as both sets of grandparents currently reside two hours away. He mentioned many caregivers of his age “strategize where they buy their house” specifically to be closer to their own caregivers for support. Julia cemented the notion that families and stated, “we are living with my parents and so (my daughter) is very connected to her grandparents right now.” Isla also expressed gratitude for living in “the same neighbourhood within…four or five blocks” of her and her caregivers, her children’s grandparents. Being near to grandparents and having familial support promoted the need caregivers had for a safe space, which also directly aligned to Swarbrick and Yudof’s (2015) definition of environmental wellness.

**Intentional Location.** All but six participants strongly expressed their intentions to reside in a purposeful location. Participants who lived in a location that felt desirable and meaningful chose to do so for environmental or social reasons. Considering connection to microenvironments, a concept explored by both theoretical frameworks, caregivers explored their intention of living where they do. For example, when questioned about how their wellness had changed over the years, Maya’s response demonstrated her connection to her surroundings:
I think some of it is location… When we first got married, we moved to Vancouver Island and so we were outside all the time… Whether it was …walking on the beach with the dog, hiking or… doing all sorts of stuff …And then here, I don't know if it's having a kid… but we've noticed that we don't do as many activities outside.

Quin described their residence in a “pretty inner-city neighborhood, very walkable… about three blocks away from the school that I went to as a child, both me and my husband have lived here pretty much our whole lives and grew up here.” Quin’s comment highlighted her deep connection to the place where she and her family live, fostering a strong sense of social connectedness. In addition, the location is an environment that resonated with them and encouraged physical activity through walking. Both Maya and Quin demonstrated their desire to reside in an intentional location, one that is situated in micro and macro environments.

Six participants (i.e., Kara, Farah, Chris, Olivia, Bonnie, Lisa) did not directly comment on the positive aspects of their surroundings or expressed explicit satisfaction or happiness about their neighbourhood, or how “good” it was, for example. However, indirectly five of the six participants still conveyed their intentions to live in a meaningful location. For instance, Kara mentioned that “a lot of people want to be here because the schools are very good” but didn’t share directly why the family had chosen their current location. Farah briefly mentioned the Albertan neighbourhood where they resided and emphasized the forest school that she enrolled her children in was crucial to their family’s wellness. Although it can be inferred Farah and her family selected the neighbourhood due to its proximity to the desired school, Farah didn’t elaborate on the reasons for choosing her current location. Hence, Farah’s perception and experience of their location may not have been a significant consideration to how she perceived their overall family wellness.

On the other hand, this subset of caregivers was aware and discussed their location and its impact on family wellness. Chris revealed that he was surrounded by the population he desired to be around by stating; “we live in suburbia, the cookie cutter outskirts where young families typically live.” Similarly, two participants who recently moved to the same city shared different experiences of their new home location. Paula mentioned “there's so many opportunities to get outside and be active….and then there's so many other people that are outside and active. So, it's definitely a place that's conducive to [an outdoor lifestyle]”. Olivia noted her family’s experience relaying that “right now, …we don't do much … we just moved here a year and a half ago.” Similarly, Bonnie did not mention her location but commented on
how she “would like to spend more time with (her) side of the family”, who live internationally. Lisa was the only participant of this subgroup of six that did not mention her neighbourhood or intentions for the situated location. For the family participants, living in a location with intention and experiencing health and safety, especially in the surroundings that people live, was emphasized by SDOH’s built neighbourhood and environment domain (Healthy People 2030, n.d.-a) and Swarbrick and Yudof’s (2015) environmental dimension of wellness.

**Supportive Environments.** In exploring the sub subtheme of families and their connection to supportive environments and communities, participants shared insights that underscored the significance of building meaningful connections. Helen, for instance, highlighted the establishment of a genuine community where mutual support was integrated into daily life. She mentioned, "we've created our own real community out here... if they (friends) need childcare, I'm at home four days a week so they can always drop off the kids." Although Alexis differed from Helen by taking her children to daycare, she reflected on her children’s supportive daycare environment sharing that, “they get a lot of great learning, creative play, and social interaction, they really do love it. And the caregivers are really loving and kind.” Helen and Alexis presented differing views on childcare. Nonetheless, both emphasized the significance of a nurturing microenvironment, supported by the theoretical frameworks examined in this study.

Chris echoed a sense of wellness emerging from a connection to each other as a young, loving family, stating, "so, now that we're in our 30s with a kid, wellness comes from wanting and having a young family, a young loving family with the dog." However, Chris also acknowledged the challenges in building like-minded connections with other young families for shared activities such as hiking or swimming, saying, "as much as we offer... it's extremely difficult to find a connection." Paula mirrored Chris recognizing the challenges of building community at times. While reflecting on her interactions within community, Paula expressed a sense of depth and connectedness within her community of mom groups, stating, "I've met moms through my kid and their kids through mom groups but have never really had in-depth conversations with other moms in the community." Paula and Chris appreciated the importance of a wrap-around community for their family’s wellness, which is supported by the theoretical frameworks.
Erica emphasized the joy derived from simple shared experiences with her family and the community, stating, "we have a really good time just being together and playing outside and eating good food and drinking wine for the parents." Gema agreed with Erica in the sense that community is for the entire family. She brought attention to the role of a community being more important than the activity itself sometimes by sharing, "it's not only about going to the climbing gym, it's actually more about the community [where] we can see all our friends... our (son) [too]." Similar to Gema, Quin felt empowered by the trust and connection she felt for her community and shared that she encouraged her children to “be independent within our community.” Erica, Gema, and Quin all perceived a profound connection to their microenvironments (gatherings at friend’s and family’s homes, meeting up at the climbing gym, fostering independence in their children to explore environments that feel safe and clean) as well as their macroenvironments (establishing a deeper sense of support through community connections). This notion is in direct alignment to the theoretical frameworks. The family narratives collectively illuminated the intricate dynamics between families and their communities, emphasizing the value of connection, belonging, and shared experiences, especially when it came to wellness.

Within the subtheme of environmental wellness, location matters, all participants highlighted the significance of a sense of belonging, and many expressed their intention to live in a purposeful and supportive location.

4.3.2 Impact of Weather

The second major theme identified within the broad theme of environmental wellness was impact of weather. Extreme weather conditions can pose risks to physical safety and environmental cleanliness. Participants' awareness of Canadian weather and its impact on their family's wellness reflected their concern for maintaining a safe and clean environment, which is a fundamental aspect of Swarbrick’s and Yudof’s (2015) environmental wellness dimension. The impact of Canadian weather on family wellness demonstrated how macroenvironmental factors like climate can significantly affect individual and family wellness, as outlined by SDOH’s neighbourhood and environment domain (Healthy People 2030, n.d.-a). Within the subtheme of environmental wellness, participants exemplified the significance of Canadian weather and their awareness of its impact on their family’s wellness.
Caregivers conveyed how weather influenced their entire family’s wellness, especially linked to their environmental wellness. Participants tended to organize their perceptions and experiences around temperature, seasonal activities, and specific weather conditions. While the theoretical frameworks do not explicitly address weather, they both discuss the significance of reducing health and safety risks to enhance overall wellness.

All but one participant stated that the Canadian temperatures impact a person’s wellness. Interestingly, Gema did not comment on temperature directly. However, she did talk about her family’s newer relationship with indoor time commenting, “I didn't use to go to the pool with (my son) as much [or spend time] inside [in] winter… we're doing more…unplanned stuff that we plan with other parents.” Adam, living in SK, stated that:

weather is an important factor in Canada, especially in the prairies. [Recently] we had that arctic air [that stayed] for about two weeks and the whole two weeks it didn't get warmer than minus 23 without windchill. So we couldn't go out, that was difficult.

In contrast, Quin, also in SK, recognized the impact of weather when talking about her community and where she lives, pointing out that it’s important to embrace winter:

It's a winter city… our recreational … endeavours are often impacted by weather more than other places. But we try to embrace it as much as much as possible… We're pretty wintery people just out of necessity, not out of desire.

Chris, living in AB, offered a different perspective, given the notably different weather patterns experienced during the same timeframe as Adam and Quin. Chris noted that, “I found the weather pattern of the last two to three years has been a whole lot more supportive… Today is double-digit temperatures for January and I just finished barbecuing some burgers outside without a jacket on.” Chris also mentioned that he goes swimming with his daughter as “it’s the perfect break from the…bite of winter.” Chris stated that weather doesn't hinder his lifestyle; he enjoys barbecuing outdoors even in winter and opts for swimming despite harsh winter winds.

Two participants emphasized their agreeableness to enjoying summer activities with their family and didn’t mention much about winter activities. Bonnie stated “if it's the summer[time] then we are out all the time… We are always going to either parks or maybe to a lake…we are always outside enjoying summer.” Alexis furthered the notion of enjoying summertime activity by sharing:
we do [go swimming]. We just got an RV last summer, so we do a lot of camping…, hiking, exploring nature. We went to Callaway (amusement park in Calgary, AB) quite a few times last year… [and we] play out in our backyard. Alexis mentioned that her family can get bundled up for outdoor wintertime activities but it’s not enjoyable emphasizing that “yesterday for about half an hour [we went out] but (my younger son) cried the whole time so it’s not super fun.” Maya was one of several participants that shared experiences of seasonal affective disorder for themselves and potentially their partner(s) and explained:
I would say I definitely have seasonal affective disorder and my husband has recognized that he might be impacted by less light as well. We do try to make more … of a conscious effort to get outside in the winter months. So today after we're done this meeting we will try and do a … bike ride just to get outside and get some fresh air because we’ve been stuck in the house [and] it’s exhausting.
Olivia echoed Maya’s difficulty with wintertime activity by sharing that “with my kids, I try to encourage outside time [but] it’s hard right now because it’s winter.” Demi declared the impact of weather conditions on their family’s environmental wellness:
It can be incredibly windy sometimes. If it's minus 25 or minus 30 I feel like I should limit how much time is spent outside … Then we get the chinooks, [and] everything melts and turns to mud and slush. So, it's messy to be outside and clothing gets soaked very easily. And you can't really play on things because there's a piles of mud underneath them. But it's not warm enough [yet], it’s not summer mud, it's still winter mud… sometimes the weather can be a bit precarious.
In the context of environmental wellness, participants demonstrated the importance of Canadian weather and their acknowledgment of its influence on family physical wellness.

### 4.3.3 Outdoor Interactions

The third subtheme identified within the theme Environmental Wellness was Outdoor Interactions which included three sub subthemes: (a) mind-body-nature connection; (b) planned time outside; and (c) swimming. Almost all caregiver participants discussed nature and its defining role in their family’s wellness, emphasizing that getting outside is necessary.

**Mind-Body-Nature Connection.** All 19 participants emphasized a profound connection between mind, body, and nature, particularly in the context of getting outside. Quin illustrated
the positive impact of outdoor activities on her family’s wellness, by sharing that if her kids “got outside” and “did something active, it was just better.” Alexis echoed that “it gets so mundane…when you can’t go outside,” noting that “parents struggle psychologically…it’s tough not to let that seep into your ability to parent.” Echoing Alexis, Farah felt guilty staying inside and was “always trying to give (my kids) different things to do… lots of nature” activities “like hiking…exploring… going to the zoo.” She shared that integrating nature was vital for her and her children, “I try to spend time with my kids in nature as much as possible, I think nature is healing for me.” She also shared about the forest school where her kids attended, “it’s 100% outdoors and it kind of saves us, our wellness.” Farah was able to “connect with other moms and get outside.”

Gema, Adam, and Chris detailed the importance of disconnecting and “going to the mountains” as “a prerequisite” for wellness. Gema explained that “if we don’t have” outdoor time, “I wouldn’t have my feet under my body right now.” Chris shared his love for hiking repeatedly, emphasizing that his family were “outdoors people.” Adam expressed his family’s commitment to staying active by also sharing “we love mountains and we love hiking.” Paula shared how “getting outside and being active has been huge… for staying …positive.” When asking Paula how she maintained a family wellness balance, she explained: “I think us getting outside and playing outside is sort of a big part of it as we do it all together… to play… and just enjoy being outdoors.” Julia highlighted “the value of getting outside into fresh air” as something they’d do to support their daughter. Bonnie expressed a desire to “try to get (her family) out more…” and to be “more outdoorsy” when asked about how she would try to improve family wellness, if given an opportunity to do so.

Helen spoke about the importance of living in a rural setting, “creating an environment” that aligns with her values. She explained a list of activities that her family engaged in while living on an acreage in a rural setting, “chase the cats, climb the snow hills, …garden, water the plants, pull weeds… go see how our trees are growing, …run up and down the driveway, ride bikes… ride ponies… and walk the yard.” Helen shared a similar sentiment to Chris, “we’re outside people.” Similarly, Isla described a mix of outdoor adventures including walks, swimming, camping, and hiking. When Demi was asked how she maintains family wellness balance, she replied that:
I don't know that I've ever really thought of what we consciously do. But balanced meals, balanced snacks, opportunities for unstructured play, independent play, family times spent together, individual time with the kids when I can, reading, and time in nature. Demi also acknowledged the challenges of outdoor activities and extreme weather, “if it's minus 25 or 30, I feel like I should limit how much time is spent outside.” Maya similarly concurred with Julia’s comments about fresh air and stated her family needs to “just to get outside and get some fresh air” because when “stuck in the house, it’s exhausting.” In response to the question about what wellness practices would be pursued if there were no constraints, Maya envisioned individual and shared outdoor activities, “whether that is hiking or just being outside.”

Participants appreciated the benefits of outdoor engagement, reflecting that wellness is connected to one’s perception of the environmental wellness dimension. In turn, a positive impact was observed in one’s environmental wellness, as well as their physical and emotional wellness dimensions. As mentioned, every participant in the study acknowledged the positive relationship between outdoor engagement and the wellness of their families.

**Planned Time Outside.** Almost all caregivers prioritized intentionally planned outdoor time as a family. Caregivers seemed to take the lead in getting outside as a family. Those caregivers who commented on getting outside with their family aimed to do so daily. If daily wasn’t a possibility, typically due to weather conditions or busy schedules, they tried to ensure it happened at least weekly. Paula emphasized the collective experience of frequent outdoor play, describing it as a significant component of their family’s wellness, stating, "us getting outside and playing outside is sort of a big part of [family wellness] as we do it all together." Farah delved into her deep connection with nature, as her children attend forest school and she actively sought out opportunities for outdoor exploration in a planned and structured-like way. She explained “I try to spend time with my kids in nature as much as possible.” With her children attending forest school, it helped mom she discussed “connecting with other moms and getting outside” frequently as a result. At least “once a month, we do big hikes,” she elaborated. Farah had to have nature time scheduled because if she went “days without going for a walk in the woods,” she would feel anxious.

Some caregivers stuck to a structured routine. For example, Mike emphasized the significance of planned outdoor time in his family’s routine, aiming for “getting outside twice” a day at least “for a morning and afternoon activity” during the week and for additional time on the
weekends. Helen also shared Mike’s approach of trying to “get the kids out at least once sometimes twice” daily. She also elaborated on her frequency by sharing that they “really are outside a lot.” Bonnie’s weekend plans for her family included trying “to go outside with (son)…[and] get to the mountains as much as we can.” A few participants commented on providing their partner with planned time outside. Demi mentioned her “partner’s a runner… has his regular run” outside. Adam prioritized his wife’s walking time, “if she wants to go out for a walk for 20-30 minutes, I will just do everything… so that she can go out.”

While the majority commented on an unstructured planned amount of time outside. As one participant (Mike) captured it, most caregivers spent time outside with their little ones to “frolic around” and explore in an unstructured sort of way. Nina mentioned “we like to get outside a lot.” Julia shared that they “get outside into fresh air…” by getting to the playground near their house. Olivia also valued playground time “encouraging outside time” as much as possible. Demi shared her children spent time “outside playing” on playgrounds and she attempted “to get to parks” often.

Caregivers tended to adjust their outdoor time to accommodate various circumstances, including changes in weather, seasons, or busy schedules. Kara mentioned “I don’t take the kids outside when it gets cold, and Maya agreeing stated that they have to make “a conscious effort to get outside in the winter months.” Nevertheless, many found ways to incorporate outdoor time into their routines, even if it meant adjusting plans. Several caregivers commented on increasing their frequency of time spent outside, especially if they noticed spending too much time indoors. For instance, Erica underscored the significance of breaking away from indoor routines, advocating for at least an hour of outdoor time weekly, stating that getting them outside and “outside of their heads for an hour… even an hour a week is so important.” Similarly, Alexis acknowledged the “mundane” side of indoor life and the need for variety, saying, "we get them outside everyday… we’ve gone down to the river bottom a lot recently." Paula integrated outdoor activities into her family’s daily routine, highlighting its now habitual, striving to “get outside and get moving even a little bit. And it's become a habit." Considering the extent to which caregivers went to ensuring their families spent time outdoors, Quin discussed her efforts to plan outside time for when her children visited their grandparents. She expressed her preference for engaging them in “something active” and emphasized the importance of getting outside during their time together. Her sentiment indicated the value that families placed on
intentional, planned outside time spent together. Overall, these comments illustrated how some prioritizing outdoor time, in a sometimes planned, frequent, and structured way, supported family wellness.

**Swimming.** Over half of the participants (12/19) mentioned swimming as important to their family’s wellness. A priority to focus on swimming connects Canadian caregivers and their families to a water environment. Although caregivers did not explore access to safe drinking water, swimming aligns with the Swarbrick and Yudof’s (2015) emphasis on physical safety and access to clean water as participating in swimming activities requires a safe and clean aquatic environment. The recognition of swimming’s importance suggested that caregivers prioritized access to water environments, meeting Swarbrick and Yudof’s (2015) environmental wellness definition of being in safe and clean surroundings. The acknowledgment of swimming’s significance reflects the SDOH framework (Healthy People 2030, n.d.-a), as creating safe environments that support health and wellness is emphasized.

In exploring water as essential to family wellness, Chris elaborated on his and his daughter’s “consistent” and “regular” activity, highlighting their strong connection to swimming and wellness:

> As a family wellness consideration, I would call swimming probably our most [consistent activity]. One of my most favourite activities because I want her to be comfortable with water and not nervous, … the familiarity of it and being comfortable with it… We go to the wave pools and... [spend time] in the kiddie pool and of course she loves the hot water…the hot tub... Even in the summertime, there’s splash parks and the lake.

A few participants provided examples of how swimming was a part of their family wellness. Lisa had her children participate in a competitive “swim club in the mornings.” Kara mentioned enrolling both her children in swimming lessons every season. Nina identified two primary activities that her family enjoys, biking and swimming. She highlighted the challenges her family faced when they were unable to engage in swimming, “it sucked not to be able to go swimming.” Even though all three participants are in landlocked provinces (Lisa and Nina in Alberta; Kara in Manitoba), going swimming was valued. Erica, residing in Ontario, stated how going to the beach is a central summertime activity for her family, aligning with their geographical location in the country. Adam, in Saskatchewan, described the prairies as flat and not offering much. However, he specifically noted the beauty and accessibility of the nearby
lakes for swimming in the summer and ice fishing and skating in the winter, “it’s beautiful, we can go to so many lakes.” Alexis, in Alberta, mentioned the enjoyment of “the Y so that we can take them [the children] swimming” and “going down to the river bottom”, enjoying the outdoor bodies of water whenever possible. In summary, the participants' experiences and perspectives, including Chris's detailed account, showcased the integral role of swimming in fostering family physical wellness across diverse geographical locations in Canada.

In summary, the participant voices collectively support the value of environmental wellness for Canadian families. Three subthemes emerged: locational embodiment, intentional belonging, and reliance on environment as a wellness support. Participants recognized the importance of enjoying nature through outdoor interactions and swimming as a core family value. However, they expressed dismay of Canadian weather (in particular, extreme cold and mud were mentioned; the interviews took place during winter months) as a deterrence to environmental wellness. The subthemes and sub subthemes of environmental wellness mentioned herein related to both theoretical frameworks emphasizing safe and supportive environments, in the context of micro- and macro-environmental factors. These findings collectively emphasize the multifaceted nature of environmental wellness and its influence on family wellness.

4.4 Physical Wellness

The second theme, the physical wellness theme, explored the participants' perspectives on caregiver wellness and the relationship between caregivers' physical activity and their family’s wellness. This discussion was a significant portion of the overall interview. Caregivers were asked direct questions, and several subsequent questions, about their physical wellness and how it impacted their family and abilities to provide care for their children. This led to the identification of four subordinate subthemes including: (1) Exercise; (2) Healthy Eating; (3) Time Away from TV and Screens; and (4) Sleep. Several sub subthemes were identified. Exercise consisted of three subthemes: (a) Movement is Vital (activities and the wellness dimensions); (b) Emotional Regulation; (c) Streaming Wellness. Healthy Eating included two subthemes: (a) You Are What You Eat (b) Selective Eating. Time Away from TV And Screens was characterized by two subthemes: (a) Reducing Sedentary Behaviour and (b) Navigating Screen Time Challenges. Sleep consisted of the three subthemes: (a) The Importance of Shut Eye, (b) The Benefits of Sleep – Refresh, Reset, and Regenerate, (c) Rituals and Coping
Strategies (see Figure 4.3). These themes will be discussed in detail to show how they support the physical wellness of families.

**Figure 4.3**

*Physical Wellness Theme*

4.4.1 Exercise

A review of the family narratives led to the development of three subthemes within the exercise theme: (a) movement is vital (activities and the wellness dimensions); (b) emotional regulation; and (c) streaming wellness. Additionally, participants described various activities they engage in to support both their personal and family’s physical wellness. This section includes an exploration of how each caregiver relates to their own exercise habits and their family’s exercise approaches, and the overall impact on physical wellness.

**Movement is Vital.** Kara exemplified the subtheme of Movement is Vital with her statement, “Your body is designed to move. If you stop moving it, it forgets how to be physically active.” Participants consistently emphasized the role of movement in maintaining physical wellness, highlighting that for these Canadian families, movement was necessary and impactful. Erica emphasized the importance of physical activity in her wellness definition, defining wellness as “exercise.” She disclosed that she engaged in activities like going to the gym to do spin or yoga frequently for her own wellness and commented that when “your body gets
stronger, you feel good. You're stronger and you feel better overall.” She emphasized the importance of movement stating that “if I haven’t done anything physical…my brain doesn’t shut off to sleep…”

Alexis spoke to the benefits of movement as well, “if you're up doing other things, you're moving around, walking, or even things like household activities, you're getting exercise in.” She also observed that she’s “less restless if (she’s) had a hard workout.” Caregivers were mindful of tracking fitness and Alexis made specific mention of “tracking on my Fitbit,” noting her resting heart rate and observing a relationship to a lower heart rate if she worked out on a regular basis. Resembling Erica’s response, Alexis remarked on her body’s strength and stated that “if I’ve had a hard workout, I’ll get better sleep” and that she would feel “stronger, can play with my kids longer, and have more energy in general, it's really linked.”

Adam shared that he and his partner used to be more active but having children, especially having a newborn earlier in the year, changed the family’s fitness dynamic. Adam indicated, “I haven’t been doing anything, like zero, but we try and keep (our son) as active as possible.” He elaborated and stated that “for myself and my wife, I think we need more physical activity.” He also remarked on the impact that lack of exercise has on his sleep, “if I'm not doing enough exercise. I have trouble going to sleep. I stay asleep for a shorter amount of time which causes exhaustion the following day. I think physical activity is more important, …keeps you sharp.”

Quin also highlighted the importance of being physically active by expressing that it encourages her and her family to “do things (they) hadn’t done” before. This suggested that movement is a catalyst for exploration and adventure. Quin briefly named the link between physical activity and diet changes, “actually as far as diet, things have changed too.” Mike shared his intentional efforts to engage in activity, especially outdoors by saying “currently, we're trying to get outside twice for like a morning and an afternoon activity.” Olivia shared “when we do exercise, we're in a better mind space.”

**Activities within Wellness Dimensions.** Caregivers talked about many different activities they used to be active with their families. These activities included formal and informal participation, either on their own as an individual caregiver, with their partner excluding their children, or as a family inclusive of their children. Formal activities included structured exercise classes or gym workouts (such as yoga, spin, crossfit, dance, etc.), swimming lessons, and
organized sports (e.g., soccer, basketball, hockey, karate etc.). Informal activities included unstructured and more casual activities such as backyard activities, neighborhood or mall walks, dance parties around the house, biking and hiking, and exploring nature. Caregivers commented on engaging in both organized, structured activities as well as unscheduled, spontaneous, more flexible activities. Although some caregivers shared that they enjoyed activities alone at times, other caregivers emphasized and valued shared experiences with one another, from cooking as a family to playing outside together. Participants showcased a shared desire to build on family cohesion. A variation of activities existed that families, both solo and together, engaged in and prioritized. The activities can be categorized in many unique ways and perhaps the most intentional would be relating the activities to Swarbrick and Yudof’s eight dimensions of wellness.

**Physical dimension of wellness.** For more moderate to higher intensity activities, caregivers took actions to nurture their physical wellness, cardiovascular health, and strength in both indoor and outdoor settings. They participated in indoor activities like dance, gymnastics, and yoga while outdoor pursuits included biking, running, kayaking, and sports like soccer and hockey. Caregivers shared the outdoor and seasonal activities. Winter activities for some families included sledding, ice skating, cross-country skiing while summer activities included kayaking, golfing, camping, and biking.

The significance of physical activity for caregivers and their families cannot be overstated. As described in this section, the range of physical activities was not only extensive and varied but intricately addressed multiple dimensions of wellness. There were some unique and very individualized family activities and hobbies mentioned, that span across dimensions of wellness, such as shopping, chores, shovelling, gardening, growing food, yard work, fishing, playing with playdough, colouring, twirling, listening to podcasts, furniture refinishing, riding horses, and studying the bible. For the majority of the families, physical activities were discussed as an immense support to their diverse, well-rounded, and balanced lifestyles.

**Other dimensions of wellness.** Although the focus of this thesis was on physical wellness, some of the activities identified by caregivers as impacting family wellness also related to other areas of wellness such as intellectual, emotional, spiritual, and social wellness.

Varying levels of intensity existed between the categories of activity too. Families described some intellectual wellness activities that linked to low-intensity activities such as
reading, doing puzzles, and playing board games and cards fostered mental wellness. Olivia commented on her family’s relationship to reading and although she didn’t engage with reading much personally, her husband and children did. Personality differences within families may have influenced or contributed to how different families engaged in lower-intensity activities. Olivia highlighted this differentiation by mentioning “my husband reads and is more… introverted which is good for him.”

Family emotional wellness was supported through creative outlets for self-expression such as activities like art, painting, sewing, meditation, and yoga. Additionally, cooking and baking served as both creative and practical emotional activities that both caregivers and kids were included in. Alexis’ point of “having to get creative with working out” stood out as how most caregivers spoke to their personal physical wellness.

Spiritual wellness overlapped with some activities that were also identified in of the sub subtheme of family’s emotional wellness. There was interconnectedness and families engaged in activities like bible study, spiritual classes, yoga, and breathing/meditation. Mike mentioned that his wife leads their children through “breathing exercises and (they) take to those.” These engagements promoted a sense of overall purpose and connection to one another within the family context, as well as extended to a broader connection to the world around them.

Social wellness was accentuated through group activities like team sports (skate club, karate, hockey, etc.), walking with the dog (i.e., more than five participants mentioned this activity specifically), and attending classes together (yoga, dance, Girl Guides, marriage classes, etc.), encouraging social bonds and a sense of community. Zoom calls with family and friends or the child’s friends were also part of the family’s socialization.

**Emotional Regulation.** Caregivers provided insightful perspectives on the connection between physical wellness activities and emotional regulation. Quin aptly pointed out that “exercise is always good,” linking the positive impact of physical activity on one’s emotional wellness. For Quin’s family, there was a tangible observation of movement on her family’s wellness. Quin shared, “I see my kids are way, way better …if we get out there first.” Quin also shared in the Mind-Body-Nature Connection subtheme (see Environmental Wellness theme), that playing outdoors influences and improves the flexibility, positivity, and emotional regulation of her children. Alexis further touched on the emotional benefit of exercise, using it as a tool for her own emotional regulation, “I go to the gym…especially when I’m frustrated.”
Alexis noticed that it’s difficult if she doesn’t get movement in. She said she’ll have a “rough day, people can feel that vibe.” She commented on her shortness with her husband, that she’s “more closed off with my kids, then they'll get more clingly and want my attention more.” and things just get difficult. She shared she was more engaged, attentive, and creative with her kids if she has worked out physically.

Lisa drew attention to the negative impact of excessive screen time and how it “very much leads to some form of dysregulation.” She shared that by observing her kids, she recognized that “we're not moving our body and we're not paying attention to how we are feeling.” Mike further supported this perspective and stated his children were “more irritable, in more of a fog…” after a prolonged time spent online and/or in front of screens. Demi used similar wording when describing how her emotional state was impacted if she didn’t prioritize physical activity: “irritable”, “snappiness”, “less willingness to do things with the kids.”

Adam shared that “physical activity is more important…keeps you sharp, takes away stress and anxiety, it’s a tension releaser.” Similarly, Gema discussed how important it was to adapt and balance physical activity routines with rest. She recognized her child’s oscillating needs between doing activity and staying at home, and she tried to honour her son’s energy levels. She reflected that, “I know (my son) is at a desk all week. Sometimes he feels like moving, sometimes he doesn’t, and I let him dictate that because I don't have a set schedule”.

Gema linked physical activity to mental clarity. She emphasized that for her family physical activity improved their quality of sleep, sharing that being in the mountains and engaging in physical exertion led to a “good tired.” She further explained, “when we’re in the mountains, we definitely sleep better as a whole. You feel tired, a good kind of tired. You've worked physically, you've cleared your head mentally, and you can sleep better”. Paula confirmed the idea that exercise and movement are crucial to her and shared; “Exercise is my go-to top priority. If I am not feeling great and can manage to motivate myself, it’s my easy fix”.

Mike shared that:

We're just beginning to have a little bit more depth in conversation with our older (daughter), …she’s more emotionally driven. So my wife has been pretty good at breathing exercises with her, she takes to those. And we always try and provide her, her choice now. We strategically give her choice to steer her in a way that we want her to go.
Caregivers illuminated the profound connection between physical wellness activities and emotional regulation, recognizing the positive impact of movement on both themselves and their families. Encouraging children to act with autonomy and choose their own activities fostered emotional resilience and maturity, offering caregivers a sense of relief in their caregiving role. Prioritizing exercise resulted in enhanced emotional wellness, leading to more engaged and attentive interactions with their children.

**Streaming Wellness.** Online workouts were incorporated at times for convenience, contributing to family physical wellness while accommodating busy schedules. Caregivers responded to the specific question, “Have you accessed any classes online or virtually?” and responded by sharing the various online fitness platforms they accessed (YouTube, Zoom meetings, pre-recorded materials, etc.). At times caregivers faced challenges. For example, Julia pointed out that she tried “prenatal yoga online… but the classes were just not that motivating…” Inclusive of the lack of motivation, Julia also mentioned the specific challenges that she faced was due to scheduling conflicts and the absence of childcare as well. Despite having access to fitness recordings, Julia emphasized the importance of accessibility and practicality in determining her level of physical activity. Bonnie echoed Julia in saying that if she’s unable to take an in-person fitness class, she won’t exercise from home as she’s “not a fan of doing classes on Zoom.” Olivia shared that she “always sees stuff online and then never follows through and does it.” Paula also shared that she struggled with “scheduled” workouts but sometimes used online workouts on her “own time”, especially if it was for a fitness “challenge” offering. For example, she participated in “a 10-day yoga challenge online.”

Other participants shared that they were able to do “a lot of exercise at home” (Demi) through online activities through YouTube videos such as ‘cosmic yoga’ or dance (Erica, Alexis, Maya). Several caregivers recognized the ease, convenience, and desire to participate through online training programs such as online karate (Demi), yoga (Demi, Maya, Julia, Paula, Lisa), and exercise apps such as Peloton (Alexis, Olivia, Maya). However, some participants participated in other types of courses and learning such as online education (Mike), marriage classes (Alexis), spiritual groups (Helen), yoga teacher training (Gema), piano classes (Adam), and organized group sports or clubs including Girl Guides (Nina), and story time through the library where her children sang “songs in English and French” (Olivia).
4.4.2 Healthy Eating

Canadian caregivers in this study voiced a strong connection between ‘healthy eating’ and family physical wellness. There were two main sub themes: (a) “you are what you eat,” conveying a strong link between food and the impact it has on wellness and how the body feels and (b) selective eating, including a discussion around the financial implications of eating well. Their emphasis on these sub themes demonstrated an understanding of nutrition, food as fuel for the body, and that mindful food choices nurture physical wellness.

“You Are What You Eat” – Olivia. Caregivers were mindful of and recognized the significant impact of food choices on family physical wellness, as emphasized by Olivia’s assertion, “you are what you eat.” Although many were attentive to the importance of healthy eating, Olivia was the only participant who pointed out having “to care about childhood obesity and right now mental health…especially…not having people doing anything.” She elaborated, “if you eat healthy then you're more motivated to workout… if we eat a lot of junk food we feel sluggish…you are what you eat”. Olivia also discussed processed food and prioritizing healthy eating over processed foods. She shared that eating “relatively healthy” meals at regular, scheduled times, “making sure that (she) had food” was critical to her family’s physical wellness.

Demi indirectly elaborated on the obesity discussion by touching on body dysmorphia. Due to cultural and societal factors influencing body image and self-worth, Demi explained that “we can look at things like fatphobia or the diet industry and that dieting mentality and finding our self-worth in the way we look or in the things that we do.”

Labels such as good, right, fun, versus junk or bad foods were used and the majority of caregivers reflected on what they used to fuel their body and how they found balance in what they ate as a family. According to Adam, healthy eating was “essential,” and Bonnie also shared that it’s “probably one of the most important things” they do as a family.

Eight caregivers mentioned the importance of purposely keeping tabs on the amount of sugar or junk foods they have as a family. Olivia observed that with her first child, she did not think her child’s sugar exposure was problematic but now that there are two children, Olivia stated that “they do get more packaged foods and sugar than when (my son) was little.” Quin also reflected on wellness for her children and the concern for “what are we eating? How much sugar are we consuming?” Similarly, Demi shared that she made “sure we have balance, checking our fats and sugar” during a meal. Maya chatted about when you’re “not really
nourishing your body” you might “wake up at 2 A.M. and you're hungry for a sugar craving.” Akin to Maya, Alexis talked about the relationship to stress and sugar cravings, “if I'm stressed sitting at work for hours on end, I always crave like chocolate and sugar.” Farah mentioned that she’s an “emotional eater…if I’m feeling stressed, I reach for chocolate…” She noticed that it was an indicator for when she needed to “take care of (her) mental health…not eat (her) emotions.” Isla echoed the emotional connection to eating that it’s “comforting” and not always for “nutritional value.” She shared, in the context of COVID, that sometimes, “you’re like, screw this. I am eating chips at 9pm because it's the pandemic and I don't give a shit.”

A few caregivers discussed an appeal for balance. Isla strived for her son to get “a balance of fun foods that he actually wants to eat and healthy food.” Julia admitted healthy eating is important to her family even though she humorously added, it’s “not my forte” and it “doesn’t stop me from eating all the French fries.” Julia carried onto share that she cooks “healthy meals or tries to…and (my spouse) and I are pretty happy to swap…tag team” so that they can feel more balanced and less overwhelmed. Farah echoed the overwhelm and shared that she often thinks that her family “needs to eat healthier but sometimes I feel overwhelmed because there’s so much to do.” She continued saying “cooking, it’s not something that I enjoy. I do it because I need to.”

Gema expressed the opposite by sharing she “loves to eat good food…it’s easy…for me… and for us…food is really primordial.” She noted that they often share meals after a big day of activities such as skiing and a marked “craving for good food” afterward. Gema and her spouse aim for “meals together” as a family and trade off cooking “because of (their) work schedules.” Helen emphasized the desire for good food and that “getting processed food is not really quick or accessible for us.” She shared that food is a self-care strategy for her friends and invited them to come out and enjoy, “bring your own food…to have a picnic outside.” She emphasized the benefits of growing her own food and that if her family eats well the “body’s good…if they’re gonna eat crappy food, they’re more irritable and harder to deal with.”

In line with Helen, Quin highlighted the shared belief in their household that consuming unhealthy food, even on rare occasions like road trips for example, led to a negative impact on her family’s physical wellness. Quin tried to promote eating healthy as an overall daily choice and lifestyle as she witnessed for her family that “eating crappy, makes us feel crappy.” Like Quin, Mike recognized that “eating like crap” affects his family’s physical wellness. He also
shared that “when you eat, especially how you eat, drastically makes your gut feel good or bad.”
Mike also noted that he does “splurge a little bit in terms of eating foods that taste good” but overall he is “quite disciplined…focusing on eating habits.” Paula related to Mike in saying that the “enjoyment of food” was important to her family and occasionally eating items that were not “quite so healthy but having a good relationship with food” was critical.

Many participants shared about the importance of family mealtime, connection, and eating healthy foods. For Alexis, mealtime was utilized as a connection with her partner, “we try to do weekly marriage time…we'll order a nice meal…. take some time to connect.” Chris further demonstrated the importance of connection with family as he shared “we spend time as a family every single day…cooking, baking in the kitchen.” Maya too echoed the connection of making foods together at home by sharing a beloved weekend routine, “then we'll make dinner together… it's pretty relaxed.”

Nina, Kara, Adam, and Erica similarly discussed a similar link mentioned previously between healthy eating and enhanced energy levels. Nina commented on planning ahead: if you're eating healthier, you feel better physically, …you have more energy. But if you're too physical that can affect your eating and then you're not picking the best choices sometimes… if you're doing too much, you gotta sort of plan ahead and pick wisely.

Kara resonated with Nina’s commentary and highlighted the challenges of excess weight and everything “becoming infinitely more difficult, your energy levels are way down” if your body feels heavy. She continued to say that “healthy eating helps you to maintain a good weight and helps you to feel more energized and energetic.”

Nina also shared that her family tries to find a balance with eating “at home and eating out” and that they “could probably eat out less.” Adam echoed this perspective on cooking at home vs. eating out, that they strive for a balance and he stated that they eat out weekly or bi-weekly “something from restaurants, not fast food.” He clarified that they “cook everything at home” and opt for restaurant meals “not fast foods.”

Erica further solidified this link of food to energy by expressing how consuming nutritious meals provided energy and healing, “eating well so that you have the energy to continue with your exercise. It heals your body and makes you feel good.” Maya adopted an approach with open communication around food access and catered to son’s interests, “he's
allowed to go grab whenever he wants. There's a drawer in the fridge which has yogurt, apples, and stuff and he knows that if he's hungry that’s where he can go to snack.”

The 19 caregivers tried to provide a variety of healthy foods to their families as much as possible. However, for some families, this was not as easy to implement especially when a child had preferences regarding what food they put into their body to feel good. Other challenges included affordability and accessibility to healthy food options given financial limitations for the family. It is also important to note the dichotomous language participants used to describe food (good/balanced/healthy/right/real/fun versus bad/fast/junk foods) throughout. Canadian caregivers reflected a strong understanding of the role of nutrition in promoting family physical wellness.

**Selective Eating.** Two participants spoke on the challenges of selective eating. For example, Demi emphasized the pursuit of finding an equilibrium in her family’s healthy eating habits, aiming for “balanced meals, balanced snacks,… (and) opportunities for… family time spent together.” Despite her efforts, she acknowledged the difficulty to achieving the balance:

I do most of the cooking so I try to make balanced meals. Do my kids always eat them?

No! They apparently can’t like the same thing on the same day or two days in a row. So that's frustrating, but I do my best there.

Olivia concurred with a similar expression, “if I could have fresh meals delivered to me or something like that would be very helpful. I think if we weren't so picky too.”

Although many caregivers stated that healthy eating is necessary for their wellness, these two caregivers recognized the complexities of catering to individual preferences while striving to maintain a healthy and balanced diet for their families. Demi tried to promote a healthy relationship to foods for her children to perceive as well, by “not being too restrictive …or talking about foods in terms of whether they're good or bad.”

Lisa and Chris strived to select “healthier choices with food,” illustrating a shared concern about the financial implications of prioritizing nutrient-dense meals for their families. Chris emphasized the importance of consuming nutritious foods for energy and overall wellness, suggesting that neglecting proper nutrition can lead to feeling like “a big potato bag” and “a downward spiral real fast.” He also admitted further that “the whole spiral” is a challenge for families, stemming from a lack of financial wellness. Lisa agreed with Chris sharing that the “affordability of food bores” her and to “buy groceries…it seems that if you want to eat healthy,
it actually costs you more than not.” Furthermore, these financial considerations may contribute to the selective eating habits mentioned by other participants, such as Demi and Olivia, who discussed the challenges of achieving a balance and trying to overcome picky eating behaviors within the family.

Caregivers emphasized the belief that choosing nutritious, wholesome good, right, and fun foods massively contributes to better energy levels, mood, and overall family physical wellness. Consistent consumption of unhealthy or bad, junk, foods was discussed as having negative effects on family’s physical wellness.

4.4.3 Time Away from TV and Screens

Screens have persistently seeped into daily life, becoming an inescapable part of how families spend time and engage with one another. As families navigate the digital landscape in Canada, participants commented on the challenges of managing time spent on screens as well as preserving quality family time. The two subthemes within time away from TV and screens were: (a) reducing sedentary behaviour and (b) navigating screen time challenges.

Reducing Sedentary Behaviour. For caregivers the pervasive influence of technology and screen time was alarming. Mike, expressed apprehension, noting the unsettling rise in screen time and therefore, the disconnectedness to self and “disassociation with people around you.” Lisa echoed Mike’s sentiments and shared that with “a reliance on technology…people don't understand the immense negative impact that it has.” Many caregivers resonated with this shared perspective and delved into the profound impact of technology on physical wellness.

The overarching theme centered on the challenge of balancing screen engagement with physical activity. Nina vividly conveyed that "screen time is a major time suck," encapsulating the idea that the hours devoted to engaging with TVs and screens tend to consume you. She went on to say, “when you get into it, you don’t wanna stop and do the physical activity that you really should be doing.” She furthered that the less engagement you have with screen time, the “more physically active you’re going to be.” Alexis pointed out the ease of succumbing to a sedentary lifestyle facilitated by screens, leading to mindless habits, “it’s so easy to continuously sit, numb out, eat more,… and you’re not mindful….we spend our whole life…on screens…sitting.” Corresponding to Alexis, Adam spotted the connection to screen time and harm of excessive sitting that “kids and adults spend a lot of time sitting by the screen eating anything …and even veggies will accumulate a lot of carbs over time… so it’s not good.”
Caregivers emphasized the challenge of diverting attention from screens to engaging in physical activities. Adam shared a screen time limit strategy, “when two hours pass, we do something else, we try to fill the time for him.” The priority for Adam to participate in this study was to learn “additional ideas on how to keep him busy and away from the screen.” Farah agreed too that “I’m trying to limit it to two to three hours, max.” Olivia also detailed enforcing screen time limits for her children with even more of a minimal boundary set up getting “two 20-minute time slots a day to do screen time.” She aimed to prevent “big bursts of energy that they need to have released”, trying to find “a balance” in her family’s approach to screen use.

Farah recognized generational and cultural differences in TV consumption “when we were growing up in Brazil, it’s not like Canada where you can grow up not afraid. So, we are the generation that watches a lot of TV and we’re doing just fine.”

Quin led her daughter through an experiment in limiting screen time after she observed that her daughter’s consumption of TV was linked to her “meltdowns, grouchiness” and “her emotional regulatory behaviours” being “out the window.” Although Quin explained that “it was one of the hardest weeks ever because… I didn't have my TV babysitter,” her child’s mood and behaviours improved greatly. She also considered that “screen time activates your brain but your body's not doing anything” and “I don't know why it's different from reading a book… [screens are] a weird thing.” Quin also shared that she struggled to set screen time limits, “I find that I'm always pushing this is too much TV but my husband doesn't necessarily support that all the time.” Farah also noted partner differences on limiting screens, “it's something that my husband sometimes tells me ‘(Farah) you’re too strict, don't stress about it.’”

All but one caregiver remarked on reducing screen time to be the priority in relationship to physical wellness. Isla offered a contrasting perspective stating “it should be” important to have time away from TV and screens but expressed gratitude for the convenience of iPads, “I don't know how people parented before there was such a thing as iPads, they’re a godsend. How did people get things done before there were iPads for children? I do not know.”

As caregivers voiced their concerns, the struggle to navigate screen time and its impact on physical wellness surfaced. From setting screen time limits to acknowledging the generational shift in TV consumption, these caregivers grappled with observing technology’s influence on their families. The desire to redirect attention from screens to activity was revealed as a shared value, and various strategies, challenges, and co-caregiving in managing screen time unfolded.
Amidst the concerns, one participant offered a unique perspective, expressing gratitude for the convenience of iPads while recognizing the importance of time away from screens. Together, the participants sparked a reflective conversation about the role of technology in caregiving.

Navigating Screen Time Challenges. Julia acknowledged the invasiveness of screens, specifically social media:

It's one of those things where intellectually, I know I should be having less screen time. And if I can notice when screens are starting to make me anxious or what I'm ingesting on social media, that sort of thing. But that's definitely one area where I wish I had better, self-control or boundaries.

Julia spotlighted the aspiration to be more disciplined in reducing time on screens and building self-awareness and control. Mike spoke to when his job transitioned temporarily to solely online, “we're getting eight to nine hours of screen time, which I know is not good … but a large majority of that was out of our control and we had to be doing it.” Maya shared that “when the screens are gone and not keeping us in one place, then we are more likely to actually move.” Additionally, Helen stressed that “it’s really, really important” to stay off screens, and Paula echoed this sentiment by describing screen time as “sneaky” and getting time away “makes a really big difference” for her family.

On the note of social media, Demi shared the struggles for people, herself included, finding “it hard to disengage” with devices. Demi critiqued the “quick entertainment” and dopamine release provided by screens and that tech time hinders more than it contributes to physical wellness. She went on to say that “we're not always getting new information or broadening our minds” due to our self-awareness being disjointed. Additionally, “there's a lot of focus on wellness for the wrong reasons too” within media.

Demi reflected on the challenges of personal discipline and obstacles with controlling phone usage and establishing a healthy sleep routine too:

My brain actually limits my ability to do things like not use my phone too much and get some sleep earlier. There's also revenge bedtime procrastination, that I’m only now understanding …[where] I want to have that time to myself to do me things and then I do them at that time. I don’t always recognize that sleep can actually be me time too.

Lisa voiced that the reason her family might not be as physically active could be attributed to “spending time sitting on TikTok or watching TV right before we go to bed.” Lisa attempted to
schedule activities for her children outside of the home to combat over-consumption of screen time.

Erica shared that physical activity keeps her family distracted “so that you're not thinking about going back to TV and the iPad.” Chris too pointed out that “we are big believers in limiting screen time and focusing on leisure and activity, it's a very high priority for (us).” Bonnie shared her individualized tech reduction strategy such as “not watching TV in the evenings anymore. This is for me as (my son) doesn’t have screen time yet.” This linked the value of less screen time allowing for one to get sleep earlier, get into a routine, and give care to their family in a more focused and present way.

Gema recognized the ease of an environment that allows her family to distract and consciously choose to be away from screens, “in the mountains, we’re not on our screens”. They spend time thoughtfully disconnecting from social interactions and having the opportunity to enjoy genuine, meaningful family time. Kara resonated with this sentiment highlighting that “if you’re outside doing a physical activity, you cannot be on screens.” In accordance, she advocated that “people can be addicted to their devices… and (taking) that break from being on the computer or anything like that is what people need.”

Overall, caregivers seemed to prioritize and actively put conscious efforts toward achieving a balance between screen time, activity, and family bonding. The overarching theme highlighted the effects of technology on wellness, encompassing the impacts of screen time limitations, prioritization of physical activities over screens, the influence of social media on wellness, the negative consequences of excessive technology use, and it’s the potential dissociation that occurs with social and personal wellness due to technology.

4.4.4 Sleep

For the Canadian family participants, sleep played a pivotal role in their physical wellness. As Demi pointed out, “sleep is a really foundational habit.” For most, sleep was the most controllable, and likely most variable, dimension of the four physical wellness dimensions that this study explored. There were three encompassing themes: (1) The Importance of Shut Eye; (2) Rituals and Coping Strategies; and (3) The Benefits of Sleep – Refresh, Reset, and Regenerate.

Caregivers recognized the connection between their own restful sleep and maintaining stability in their family’s physical wellness. For example, Helen pronounced, “I don’t sleep,”
capturing the personal struggle some caregivers faced in maintaining healthy sleep habits. In fact, sleep could be considered the fundamental aspect of physical wellness. Participants discussed sleep deprivation, the delight of a good night sleep, and the balance between sleep and caregiving responsibilities for family and personal wellness.

The Importance of Shut Eye. Participants discussed how sleep deprivation takes an emotional toll. Farah's described sleep deprivation as being “the worst thing ever,” and “when you don't sleep, it's so hard to feel good about the other aspects of your life.”

Farah was the only participant that shared a decision to co-sleep with their daughter: “I co-sleep with (my daughter) as well because (my daughter) was never a good sleeper…and now… she's sleeping great…eight hours per night… So sleep is our number one…” Farah explained that when worrying before falling asleep, caregiving capabilities were affected the next day. She noted that child's reactions may be misinterpreted when a caregiver is sleep-deprived: “when something's wrong with us, we see the kids in the reactions they have and then we take it personally.” Farah's insight showcased that a caregiver's well-rested state contributed not only to their own emotional resilience but also influenced how they perceived and responded to their children's behaviours with patience. Paula shared a commonality with Farah, observing her awareness of her children’s behaviour and speaking to the reciprocal relationship between caregiver and child sleep, “it’s undeniable what the differences in my personality are when I’m well-rested. You see the contrast when your child started sleeping through the night too.”

Quin described sleep deprivation as “it's one of those things, if you've ever been sleep deprived, you can see how your life crumbles…” Quin’s perspective recognized the “highly interconnected” nature of sleep and physical wellness, “if you're tired, your body physically can't do the things that you need to do and then that spills over onto emotional wellness and social wellness.”

Alongside Farah, Paula, and Quin, Alexis shared that, “if my sleep goes out the window my wellness is shot,” which demonstrated how significant sleep is on family functioning and wellness. Alexis stated “even if I have good intentions” showing commitment to her own sleep. Alexis spoke to the disruptions of sleep, “one kid will wake up at midnight…then the other kid was waking up at 5:30am… challenging.” The disruptions Alexis and her family faced underlined a family’s desire to have a consistent, uninterrupted sleep routine. Erica echoed the others, sharing the challenge of caregiving and sleep disruptions, “At this present moment, we
don't sleep …because of a teething baby.” The phrase *at this moment* suggested that caregivers are aware of the temporary state of sleep patterns as affected by children’s developmental stages.

Mike and Julia both highlighted the essential priority of sleep for their family’s overall emotional wellness. Mike's insight delved into the potential consequences of “chronic sleep issues…leading to depression, moodiness, and other disorders.” Julia's perspective complemented Mike's when she added a personal lens, “I really don't function if I don't sleep. I tried to make sleep a priority, especially during pregnancy because I was so tired all of the time.” She voiced the immediate effects of sleep on “cognitive functioning and your overall emotional states.” Julia asserted the need for adequate rest during a physically demanding period (pregnancy). Mike and Julia both addressed long-term impacts of inadequate sleep in their responses. While Mike and Julia detailed the long-term impacts of sleep deficiency, Lisa and Kara both added an emphasis on the daily, short-term impacts of sleeping for too little or too much. Lisa touched on the variability of sleep “if we don’t feel well or are sick, depending on what we’re battling, we might sleep too much.” Kara emphasized how sleep quality shaped how one tackled their everyday tasks, “if you're tired all the time, you're not thinking straight, you're not moving the same way, you're less ambitious to get things done throughout the day.”

**The Benefits of Sleep – Refresh, Reset, Regenerate.** Consensus among most participants including Demi, Isla, and Mike revealed that sleep is pivotal to family physical wellness. Demi underscored that with ample rest, “my time management and physical activity are better, and patience is improved.” She asserted that “because it can impact so many different areas of life, sleep is the most important.” She emphasized her beliefs about sleep being deeply impactful:

- Sleep affects physical, (intellectual), and emotional wellness…Without sleep we are likely to make less wise choices about what we eat, we're looking for extra energy to compensate for being tired, it's harder to emotionally regulate when you're not well rested…

Isla agreed that sleeping is the most essential sharing about her family’s relationship to sleep, “we all love to sleep… sleep is how your body regenerates…and resets itself, it’s huge.” Mike agreed: “the research is out there in terms of your body's ability to rest and feel refreshed the next day.” Mike acknowledged that both caregivers need sleep and have a commendable sleep routine, “sleep definitely, (it’s) our number one. We both need our sleep personally… Our
kids have been quite good at sleeping, not the greatest at naptime but they…give us 11-12 hours of sleep, a blessing.”

Discussed in the previous section limiting screen time, Demi was concerned the challenges of limiting screen time. She expressed the legitimacy of “revenge bedtime procrastination…and wanting to have time to myself… to be doing me things…” A transformative realization was captured by Demi, “I don’t always recognize it, but sleep can actually be me time too.”

In conversation around sleep, caregivers shared another benefit, sleep provided an enhancement in quality time spent with their partners. The impact of sleep extended beyond the individual to also include partnerships and family life. Alexis, for instance, highlighted the importance of post-bedtime conversations with her husband, “we will talk about our day at the end of the day after the kids have gone to sleep, and just take some time to connect.” She admitted that adequate sleep and rest translated into a more harmonious household and more engagement with her children and husband, “I'll play more with them, I'm not snapping at my husband, we're a better unit.” Mike affirmed the positive benefits of “being a good sleeper” and that their “first born allowed us nights together” as a couple. This emphasized that sufficient rest impacted partnerships.

Although Adam did not explicitly discuss time with his partner, he gave an example of supporting his wife in achieving space and time for her own physical wellness goals. Adam’s commitment to accommodating his wife’s needs within their family structure exhibited practical actions:

I try to be accommodating as much as I can. So if (my wife) wants to go shopping, I try to keep the baby in the car, drive around, do loops of the mall so that (our baby) stays asleep while she can do some shopping.

In this way, caregivers acknowledged the impact of sleep, ie. this family’s child needed sleep likely for growth and development as well as the caregivers needed their child to sleep and rest so that they too could take care of themselves. Caregivers also highlighted the role in supporting caregiving partnerships and needs, contributing to a cohesive family unit.

Caregivers contemplated the advantage of participating in physical activity with the goal to provide their families with a deeper, more quality sleep. Maya revealed, “we are all bears if we don't sleep. Sleep is …top [priority].” She commented on a deliberate strategy to move her
body consistently in order “to sleep better” in “creating … a sleep deficit where (she) physically needs rest.” This proposed the purposeful intention of physical fatigue and exhaustion from activity to enhance her personal sleep readiness.

Nina, Adam, and Erica voiced in unison what Maya shared, the critical impact of getting enough activity on sleep. Nina expressed, “you sleep better if you've had a more active day.” Adam expanded “I’m not a huge sleeper and if I’m not doing enough exercise, I have trouble going to sleep and I stay asleep for shorter amounts of time.” Erica contributed, “if I haven’t done anything physical then my brain doesn't shut off for enough time to sleep.”

Sometimes families picked activities that encouraged children to nap or rest. Paula shared that as a family they used to “do a really long walk and she would fall asleep in the backpack.” Many Canadian caregivers displayed the resilience and adaptability required to navigate the complexities of maintaining their own wellness amid changing sleep circumstances.

**Rituals and Coping Strategies.** Within caregiving, families shared a wide range of sleep rituals and strategies to support fluctuations in family physical wellness. Evening routines, such as bedtime rituals, were highlighted through Julia's experience with her daughter. Julia shared the nightly adventure of her daughter “wanting to fight sleep, sing songs, and have a little party time in her crib.” Despite the evening escapades, caregivers like Julia ensured that children “had access to naps and lots of sleep.” Paula, who didn’t explicitly discuss a bedtime routine or schedule, emphasized the blessing of naptime for her too, sharing that “if I’m exhausted, I’ll definitely take her nap to sleep too.” This showcased a flexible caregiving strategy in maintain a balance between rest and caregiving.

Mornings served as a space for caregivers, like Gema and Helen, to create moments of connection and solitude. Gema's early rising allowed her to achieve time to herself, “with a sitting meditation on my own, it's my only time of complete silence in the house.” A few caregivers commented on the importance of conversations with their children, specifically in the morning. For Gema’s family they “usually talked about how (her son’s) sleep went and (she) started [the day] by making coffee.” Comforting rituals like making coffee reflected as an anchor for this caregiver’s morning ritual. Helen, too, found solace in the early hours, relishing the beauty of a sunrise, “it’s amazing to watch the sun come up,” and immersing herself in “reading a book.” These morning rituals seemed to help caregivers embark on their daily journey.
Caregivers also employed various approaches to tackle family sleep challenges. Demi noted: “if you only have time and energy to focus on one thing to work on, (sleep) is a really great place to start.” Bonnie emphasized the significance of prioritizing sleep by implementing a deliberate routine of limiting screen time before bed to “sleep earlier and better.” Chris’ strategy of prioritizing one’s physical wellness holistically had positive impacts on his family’s sleep patterns. He stated “the more sleep you get, the more well you are…when you sleep well, you want to eat and feel better” too. From co-sleeping, as illustrated by Farah above, to prioritizing sleep as embraced by Demi, Bonnie, and Chris, adaptability was required to meet the unique needs of their families. Olivia and Quin commented on their desire to enforce stricter sleep schedules. Olivia talked about being “very strict with sleep… they go to bed at a certain time.” Quin shared that she “pushes to go to sleep early” and that if she was the only one parenting, she would make sure her “kids were in bed by 8pm…and we would read books.” When Quin considered the perceptions of wellness for her children, a sentiment echoed by many caregivers, she posed a question “When I think about wellness for my kids, I’m curious how much sleep are they getting?” Families discussed numerous sleep rituals and strategies, serving as guiding lights to support a family's physical wellness.

Throughout the qualitative interviews, the 19 caregivers reflected on four dimensions of physical wellness, resulting in the identification of four sub subthemes: exercise, healthy eating, time away from tv and screens, and sleep and each dimension had specific sub subthemes. In the exercise subtheme, participants spoke of movement being vital, emotional regulation, and their physical wellness being closely connected to online programs, tools, and apps. For healthy the eating subtheme, caregivers pointed out that their families selected foods based on eating preferences and noticed a relationship to eating well and feeling well overall. Reducing time spent sitting and screen time engagement were most important to families when discussing the time away from tv and screens subtheme. Finally, for the sleep subtheme, caregivers spoke on the importance of resting as a form of resetting the way they provide their child and family support. Caregivers had specific ways of coping and ritually doing certain things for their sleep health. Canadian caregivers embraced diverse sleep rituals and strategies, serving as guiding lights to navigate the fluctuations in family physical wellness.
4.4.5 How Families Related to Physical Wellness

When discussing the perspectives on the four dimensions of physical wellness (exercise, healthy eating, time away from TV and screens, and sleep), it's evident that sleep was highlighted as the paramount dimension, with seven caregivers explicitly emphasizing its significance (see Table 4.2). Additionally, six participants articulated the importance of all dimensions, with three specifically sharing sleep as essential (i.e. *all; especially sleep*). Although caregivers did not share this directly, the finding that sleep was essential may have been influenced by the presence of young children and the frequency of tiredness experienced by families. Furthermore, three individuals underscored the importance of exercise, while two participants prioritized healthy eating. Lastly, one caregiver emphasized the importance of allocating time away from TV and screens.

Table 4.2

*Importance of Wellness Dimension as Perceived by the Family (n=19)*

<table>
<thead>
<tr>
<th>Pseudonym and Gender</th>
<th>Family's Ranking of the Most Important Physical Wellness Dimension</th>
<th>Family's Ranking of the Three Most Important Wellness Dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erica; Female</td>
<td>All</td>
<td>Social, financial, emotional</td>
</tr>
<tr>
<td>Paula; Female</td>
<td>All; Especially exercise</td>
<td>Emotional, physical, environmental</td>
</tr>
<tr>
<td>Gema; Female</td>
<td>All; Especially healthy eating</td>
<td>Financial, environmental, physical</td>
</tr>
<tr>
<td>Julia; Female</td>
<td>All; Especially sleep</td>
<td>Emotional, physical, financial</td>
</tr>
<tr>
<td>Olivia; Female</td>
<td>All; Especially sleep</td>
<td>Social, intellectual, physical</td>
</tr>
<tr>
<td>Quin; Female</td>
<td>All; Especially sleep &amp; time away from TV/screens</td>
<td>Emotional, social, environmental</td>
</tr>
<tr>
<td>Chris; Male</td>
<td>Exercise</td>
<td>Financial, emotional, social</td>
</tr>
<tr>
<td>Kara; Female</td>
<td>Exercise</td>
<td>Physical, emotional, intellectual</td>
</tr>
<tr>
<td>Nina; Female</td>
<td>Exercise</td>
<td>Emotional, physical, social</td>
</tr>
<tr>
<td>Bonnie; Female</td>
<td>Healthy eating</td>
<td>Emotional, financial, spiritual</td>
</tr>
<tr>
<td>Helen; Female</td>
<td>Healthy eating</td>
<td>Spiritual, social, environmental</td>
</tr>
<tr>
<td>Alexis; Female</td>
<td>Sleep</td>
<td>Emotional, physical, social</td>
</tr>
<tr>
<td>Name</td>
<td>Gender</td>
<td>Activity</td>
</tr>
<tr>
<td>------------</td>
<td>--------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Demi</td>
<td>Female</td>
<td>Sleep</td>
</tr>
<tr>
<td>Isla</td>
<td>Female</td>
<td>Sleep</td>
</tr>
<tr>
<td>Lisa</td>
<td>Female</td>
<td>Sleep</td>
</tr>
<tr>
<td>Maya</td>
<td>Female</td>
<td>Sleep</td>
</tr>
<tr>
<td>Mike</td>
<td>Male</td>
<td>Sleep</td>
</tr>
<tr>
<td>Farah</td>
<td>Female</td>
<td>Sleep &amp; time away from TV/screens</td>
</tr>
<tr>
<td>Adam</td>
<td>Male</td>
<td>Time away from TV/screens &amp; exercise</td>
</tr>
</tbody>
</table>

Note. There are four dimensions of physical wellness: exercise, healthy eating, time away from TV and screens, and sleep. Some participants responded that all four dimensions are important. There are eight dimensions of wellness (physical, spiritual, social, emotional, intellectual, occupational, environmental, and financial).

As also seen in Table 4.2, caregivers provided a ranking of what the three top wellness dimensions from Swarbrick’s eight dimensions of wellness (including physical, spiritual, social, emotional, intellectual, occupational, environmental, and financial; Swarbrick & Yudof, 2015). This discussion question aided in the understanding of family wellness for this study. Among the 19 participants, eight emphasized the emotional dimension as the most important dimension, when listing the three top important dimensions for their family wellness. Additionally, four participants focused on the physical dimension, three participants prioritized the social dimension, three highlighted the financial dimension, and one emphasized the spiritual dimension as the most significant among the three dimensions listed for the family. None of the participants regarded the occupational dimension as their most important dimension. Moreover, the occupational dimension was not mentioned as a secondary or tertiary top dimension. This finding was a bit surprising as only seven caregivers (of the 38 caregivers in total) were on maternity leave. While no participants ranked intellectual or environmental as their top dimension, six individuals recognized the environmental dimension and three acknowledged the intellectual dimension as secondary or tertiary in importance to their families.

4.5 Self-care

Caregivers unanimously voiced the critical role of self-care in maintaining their personal and family wellness. The third theme of self-care presented two subthemes: (1) The Shoulds and
Societal Pressures and (2) Conscious Self-care Advocates with the second subtheme having three sub subthemes: (a) professional supports; (b) health habits; and (c) motivation (see Figure 4.4). One participant, Erica, emphasized the necessity of self-care, asserting that "100%, we need breaks" to feel “much better and more present” overall. Alexis agreed with Erica that wellness “starts …with the parents, they are the foundation of the family.” Adam aligned with both Alexis and Erica stating that “if the parents or the caregivers, … don't watch their wellness, they're not well so they cannot have a well and happy family. That's absolute to me.” Erica described self-care as time to “check back in on ourselves.” Paula stated that if she’s taking care of herself it gives her an opportunity “to do a better job as a mom …to be more patient and have the time to play.” Diverse perspectives were provided on what self-care meant to families and the theme of self-care developed as a crucial element for both individual and family physical wellness.

**Figure 4.4**

*Self-care Theme*

![Self-care Theme Diagram](image)

4.5.1 *Societal Pressures – “We should” Conversations*

In exploring caregivers' relationship to their physical wellness and movement, a notable 13 caregivers used a combination of wording such as *should, need to, or pressure* in their wellness narratives. This revealed a sense of obligation to meet societal expectations when tending to their physical wellness, potentially also reflecting on a sense of what a few participants specifically named as *mom guilt*. Intriguingly, it is worth highlighting that male participants in this study did not use the same specific language, possibly suggesting a distinct
approach to articulating their wellness concerns. Perhaps, male participants experienced a variation of societal expectations that I may have not picked up on or were not as explicit to me, as I am a female researcher.

Paula acknowledged the external pressures she feels as a mom, talking about caregiving experiences in a small-town, mountain-sports setting, “we have that pressure to perform especially in…a culture…where everyones go-go and doing big sports.” The pressure seemed to extend to other caregivers, as Quin noted, “taking care of yourself or being physical active…not because you want to but you should because it’s good for you.” Quin further commented on the evolving expectations of what it means to be a caregiver during these last few years compared to how she perceived caregiving in her childhood,

it draws into the whole parenting social pressure thing… because I think now more than ever, or …in the last year even parenting has changed... There’s way more of a ‘practical, put your kids in extracurricular activities and really controlled things’ and make sure they’re doing the things and competing and comparing the things with other parents… there’s pressure to regulate their schedules…there’s way more of a pressure point… whereas before, we could go and run through our neighbourhood…and no one checked on me…it was just the way it was.

In contemplating the sub subtheme of societal pressure, Quin’s narrative underscored the expectation for children’s involvement in structured activities, fostering an environment of competition and comparison among caregivers. Quin observed a shift from a more relaxed caregiving style that she grew up with to today’s prevalent approach, shaped by societal constructs and expectations, highlighting evolving pressures within the realm of caregiving. Similar to Quin, Demi shed light on the internalized pressure to portray a version of wellness to the world that doesn’t align with genuine personal and family wellness, “we put a lot of pressure on ourselves to hide. To be the Instagram mom or the Instagram dad and have happy Instagram kids and none of that …aligns with wellness for me.” Demi remarked that when life slows down, she has great appreciation for time in between the busyness as it gave her “a little more time to think about my physical wellness.”

Others made I should statements about various topics such as: getting “the physical activity that you really should be doing” (Nina), getting outside (Demi), spending time with their children, eating healthy foods (Julia), having less screen time (Isla), preparing for work (Maya)
or living to work (Gema), and adhering to medical advice (Helen). Lisa, similar to Isla echoed the guilt around TV time before bed, “watching TV right before bed when …we should be doing something else.” These reflections highlighted the societal norms that individuals feel dictate what should be prioritized. Bonnie reflected on “things I should do that make me feel good or well” regarding their family’s wellness. Julia elaborated on the good things that Bonnie brought attention to, stating that “I should be eating healthy…I should be having less screen time…” Olivia directly commented on mom guilt, a theme that other caregivers were touching on in their responses, “you get mom guilt. I should be spending time with my child as it's important.”

Julia also shared that “our society places a lot of importance on appearance” and suggested that this may lead individuals to “becoming unwell in terms of what their goals are.” The societal pressure may influence “how you're interacting with your own body and what you're fueling it with” and “tilt you in the opposite direction” in pursuit of wellness. Farah's perspective on needing “to improve this and I need to improve that” demonstrated the complexity moms have in aspiring to be better moms and subscribing to the external pressure of being a good caregiver, “a good mom is a happy mom, …same goes with dads…we need to be good humans.” This assertion suggests that self-improvement may be wrapped up in conformity and obligation to societal expectations. In comparison, Gema shared her strong resistance to societal pressures by exclaiming “I don’t feel that humans should live to work!” Her perspective advocates for a more sustainable wellness approach rejecting social and societal pressure and acknowledging the significance of physical activity, outdoor time, and time for solitude as well as family time.

With respect to the COVID-19 pandemic context, Helen mentioned the constant directive of being told what one should do, specifically in the context of wearing masks. This comment extends the discussion of should beyond personal choices, stressing the impact of external pressures imposed by societal norms, even in unforeseen circumstances. In essence, participants rallied for their own agency in the process of being or becoming physically well. Caregivers mentioned a desire of being the best version of themselves to support themselves and their families, even outside of societal pressures.

4.5.2 Conscious Self-care Advocates

Although many touched on this theme, five participants (Isla, Maya, Alexis, Farah, and Lisa), recognized the importance of self-care by employing the metaphor of a cup. Isla and Maya both said the same, “you can’t pour from an empty cup”, confirming that one cannot support
someone else effectively if their own cup is empty. Alexis mentioned “whatever fills your cup”, suggesting that any activity can contribute to personal wellness and emphasizing that self-care is individualized and what rejuvenates and nourishes one person may differ from another. Farah and Lisa conveyed a similar sentiment. Farah posed a question, “if you don’t take care of wellness in your life, how can you take care of somebody else?” Lisa emphasized the need for caregivers “to find balance and take care of themselves” and to have the capacity to “support our little people.” These perspectives framed self-care as essential for effective caregiving.

Caregivers, including Helen, Demi, Isla, Lisa, Quin, Bonnie, Farah, and Gema, all highlighted the importance of "taking care of myself" as an integral aspect of wellness. Overall, caregiver participants collectively stressed the vital role of self-care in their lives, recognizing it as a priority for personal wellness as well as a valuable example for their families. Helen stated “taking care of myself, … I'm really realizing how important that time is” and that she was alone tending to her own wellness for 30+ years of her life. Alongside Helen, Demi and Isla also conveyed that a conscious effort is needed to maintain “a life outside of being a parent” (Isla) as well as the importance of guiding their children toward the understanding that “self-care is not selfish” (Demi). Intentional actions are required to cultivate a personal identity and maintaining personal wellness, outside of caregiving. Lisa advocated for intentional self-care as well, promoting to “schedule a babysitter to watch your kids so that you can go take care of yourself.”

Finding time for oneself, away from the family, was a commonly shared value. However, many caregivers faced obstacles when prioritizing personal wellness and often, children’s wellness took precedence. Quin mentioned that “taking care of yourself or being physically active...because you almost should”, implied that self-care is obligatory. Bonnie, Farah, and Gema identified that self-care was “number one”. Gema viewed self-care as a means of “completely letting go” and that it’s not a momentary escape but rather a deliberate daily routine or choice to relinquish family responsibilities. She emphasized the importance of balance and prioritizing self-care to respect both her “family’s time as well as mine”. For Mike, it was as straightforward as simply creating opportunities to do things without the children in tow: “We still take our child into daycare to give us a bit more freedom.”

The concept of me time was a recurring theme among several participants, signifying a deliberate pursuit of personal wellness. For Quin, me time was “doing things that bring me joy” contributing to her happiness too. Helen found unique ways to incorporate me time into her daily
routine by; “getting up at five o'clock in the morning and if I got my me time first thing in the morning, my day went so much better”. The intentional early start allowed her personal rejuvenation time, setting a positive tone for the hours ahead. She also shared a conversation she had with a friend about how she used her work commute, an hour drive there each way, as me time. Isla was one of the only caregivers to state she’s “definitely good at getting me time,” a self-awareness of ensuring she had secured moments of personal fulfillment throughout her day. Nina, on the other hand, strategically used the time when her oldest child is at school as her designated me time by going “out for lunch” or having “a bath… it’s not very much but I use that time as me time.” Although limited, it sounded powerful and important for her to engage in. Olivia aligned with Quin’s perspective of doing things that brought her joy, sharing that “whether it’s doing physical activity, reading a book, or doing something …with (other) moms”, she’s “carving out me time.” Demi introduced a nuanced view by “recognizing sleep can actually be me time too.” She shared that she has a strong desire for “that opportunity to be doing me things…” but isn’t always able to do so based on personal or family time constraints.

These varied expressions of me time collectively highlighted the participants' conscious efforts to reserve moments of time and activities for themselves, amid the demands of caregiving. Ultimately this emphasized the diverse forms that self-care can take within caregiver’s lives.

Some of the benefits of engaging in self-care that families mentioned included more presence (Erica), energy and patience. (Alexis), calm (Helen), and gratitude (Gema). These counteracted the barriers that most commented on, such as “not having a ton of time to work out” (Alexis). Demi shared, “I could give equal time to wellness, if I was putting in the thought, effort, and was questioning expectations… the reality is though I do put my kids wellness ahead of mine.” This admission shed light on the common theme among families where the dedication to their children’s wellness often took precedence, an ingrained sense of responsibility and devotion to family wellness. Isla strongly pointed out the critical nature of self-care too by articulating that neglecting her own wellness could have dire consequences by stating, “if I don’t take care of myself, I’m literally not gonna be here anymore.” Acknowledging the gravity of the situation Isla talked about, it was articulated that there is an urgent need to protect caregiver’s time and space allocated to participating in self-care, specifically in support of their physical wellness.
A variety of activities existed amongst caregivers to support their personal wellness including: “escaping to the store, drinking wine with friends, taking a bath without children in the bathroom” (Alexis). Adam mentioned that he “something that I do with close friends is go out sledding together.” He elaborated that he finds it challenging to support his own personal wellness by saying he doesn’t “have that luxury at the moment” but if he did he would “go do something like kayaking or fishing.” A variety of activities were also part of family wellness maintenance Alexis “we have a really good time just being together.” Caregivers accentuated the deliberate and prioritized context of self-care as part of their physical wellness.

**Professional Supports.** Several families when asked about how they could improve on family physical wellness when facing wellness challenges shared that they often benefited from professional support. Adam emphasized the importance of financial wellness as a component of wellness, suggesting that referrals to professional counsellors and financial experts would be the most helpful. For any concerns that could be addressed “through social interaction with others, I would want to do that”, advocating for building on connection with others in one’s life. Bonnie asserted, “I always recommend therapy, I’m a big fan.” Similarly, Julia exclaimed in her interview, “Go to therapy! Number one thing you can do…to help you manage your wellness.” Lisa, Farah, Maya also agreed that therapy, or professional support like a doctor, is a powerful wellness tool. Maya recognized the perceived selfishness associated with taking time for yourself, promoting those around her to engage in self-care. Maya specifically mentioned encouraging her husband to see his own therapist for support, as she also sees one. Isla, who often played the role of a “family and friend's therapist”, stressed the importance of tailoring support depending on the specific situation or hardships faced by individuals.

The majority of families discussed engaging in socialization and bonding with each other, exploring and conversing about self-care activities that could be pursued individually or with the friend involved in the conversation. For example, Nina mentioned the value of “talking it out” and collaboratively finding solutions together “to improve the situation.” Mike focused on the severity and duration of wellness issues, suggesting a combination of both, “reaching out to a trusted individual [for a milder concern] and if it’s been prolonged, chronic, or quite serious, …seek professional help.”

Although some caregivers, reflective of Paula for example, shared they found difficulty in “recommending things for other people because” every family has “different challenges,”
many suggested seeking counselling or consulting a professional therapist or doctor as a beneficial approach.

**Health Habits.** Several families recognized the diligent need to cultivate wellness habits to support their physical wellness. Paula shared that habits were integral to her wellness routine. She established “wellness habits more solidly before having her” daughter. Paula displayed a level of foresight, self-awareness, as well as self-compassion as she went on to share that “I'm a lot more forgiving and gentler with myself.” She stated that she'll “try to make sure I get some sort of workout in during her nap.” Julia was committed to promoting outdoor experiences and “getting outside into fresh air in trying to instill the habit.” Julia demonstrated her dedication in nurturing her family’s physical wellness, starting important habits for her daughter from an early age regardless of whether it’s her or her husband’s personal preference. Lisa advocated that sustainable health habits being with small, continuous actions and choices, “finding one thing to …focus on…if you can… incorporate going for a walk for 10 minutes, …or make healthier food choices…start small and make that a part of a routine.” Maya’s approach to physical wellness included building a safe environment to express one’s emotional wellness too, “we try and talk about feelings, acknowledging when things are hard instead…and providing lots of opportunities for play or doing things that he wants to do.”

Diverse and intentional self-care practices were employed to nurture one’s physical wellness daily. Helen talked about intertwining her spiritual practices such as bible study and waking up to watch the sunrise, and that personal time was crucial. She also mentioned her necessary desire of finding and “needing more space”, both figuratively and literally by escaping the city. This revealed the profound impact of prioritizing your own needs as a caregiver.

On that note, the collective message from caregivers was clear: self-care is a mosaic of practices that recharge and rejuvenate, each uniquely tailored to individual preferences and needs. From workouts and walks to simple pleasures like getting coffee, many caregivers spoke to the importance of getting out and taking the time “to recalibrate” (Gema). Quin encouraged finding something joyful to participate in, “doing things that feed your brain and body”, whether it's pursuing a master's degree, engaging in ceramics, or reading a good book. Julia echoed “finding joy throughout the season of your life.” Bonnie, like Quin, also enjoyed reading and socializing, “doing something that makes me feel good” as crucial elements in preserving her individuality. This also exemplified the importance of planning and prioritizing time for herself.
amidst the demands of motherhood. Demi spoke to “slowing down,” Mike commented on “living your life at you’re your own pace,” and Farah spoke to having “a balance.” Caregivers engaged in a variety of activities like hiking with girlfriends, cross-country skiing in the woods, learning new skills, running in the mountain and getting a workout in on the peloton or at a gym. Gema made a critical point, “I’ve recognized more tangibly about wellness since I've been a mother.” Caregivers reflected a commitment to maintaining equilibrium in both personal and family life. They acknowledged that prioritizing one’s wellness is not only beneficial for the individual but also contributes to the strength and harmony of the family unit.

**Motivation.** Discipline and motivation played a crucial role in a caregiver’s approach to maintaining physical wellness. Maya, for instance, exemplified the influence of external motivation in her fitness routines, as it “forces me to try new stuff.” She highlighted that the knowledge of her dog's need for walks served as a powerful motivator. Keeping in mind her son’s wellness at the forefront, became a driving factor for her to get outside and engage in activities like bike rides. Maya recalled, “if I'm not going for a bike ride with (my son), then I wouldn't just do it for myself.” Maya acknowledged her tendency to be externally motivated too, “if I have accountability to things, I'm more likely to do them.” Accountability was a compelling force that propelled her and many caregivers to try new things. This external accountability became a key factor in shaping the caregiver’s physical activities. Julia also provided how accountability is necessary by sharing insight into her experiences of prenatal yoga classes. For example, the in-person classes with a familiar instructor was motivating, whereas “online classes are just not that motivating. It's like, I could just easily not do this.” The importance of the environment and external factors in sustaining motivation was shared amongst other caregivers. Paula introduced her feelings around self-motivation and how it’s an "easy fix" when she is not feeling great “to motivate (her)self”. This internal drive was a coping mechanism identified by caregivers to overcome barriers and engage in physical activities even when faced with challenges.

Caregivers often touched on the reciprocal relationship between healthy eating and exercise as motivators for their physical wellness. Olivia recognized that engaging in one aspect, “if you eat healthy”, served as a reason to pursue the other – in this case, “you’re more motivate to work out.” This interconnected approach to wellness reflected caregiver’s understanding of how various aspects of a healthy lifestyle can reinforce and motivate each other.
Resembling what Maya explored in the previous section, Gema stated how her son is “basically a mirror for me.” Moments of frustration or fatigue prompted Gema to reflect on “how are we feeding each other’s energy?” Quin echoed Gema’s reflection and mentioned that “you’re more likely to be selfless with children” and you gravitate to not “taking care…when there’s another human.” Demi shared that her children are “learning about how to take care of themselves” through their caregivers, so taking care is so important. Demi also elaborated on this notion by sharing that, “I'm aware of how much I need to improve my own wellness, and I can use my kids as a catalyst for that maybe.” For many caregivers, this awareness of child wellness translated into an enhanced commitment to self-care, leading caregivers to prioritize their physical wellness more diligently than ever before.

Alexis, discussed her son's self-motivation, sharing that motivation styles can vary among family members. Her son's inherent motivation lessened the need for her to “take a lot of time trying to teach him.” This example illustrated how many caregivers demonstrated that individual motivation dynamics within a family can influence a family’s state of physical wellness overall. In essence, these caregivers' perspectives shed light on the multifaceted nature of motivation, encompassing external factors, interpersonal dynamics, and personal determination. Understanding these motivational nuances becomes essential in shaping effective wellness strategies for caregivers and their families.

4.6 Play

The relationship between play and its influence on family physical wellness, as well as how family wellness impacts play, was a recurring theme that fluctuated throughout the discussion. In many ways, the fourth and final theme of play could have been considered as a unique, independent, standalone theme. Caregivers provided rich and diverse insights into the themes of family physical wellness through their relationship to play. Through their responses to the question, "does play resonate with you, and is there something that you do to enhance your own play?" a variety of perspectives emerged, highlighting the intricate role of play in the lives of caregivers and their families. Four subthemes were identified: (a) learning through play; (b) outdoor play; (c) social and family connections; and (d) playful life balance (see Figure 4.5). These four overarching themes were identified by caregivers on what the relationship to play was like for them, encompassing learning opportunities, outdoor play, activities, social connectedness, and the balance between responsibilities and personal joy.
4.6.1 Learning Through Play.

For the 19 families in this study, learning through play included actively engaging in enjoyable and self-directed activities to support their family’s wellness. For example, Paula emphasized the significance of play in “guiding,” teaching, and bonding with her child. Learning through play and the impact of play on family bonding was shared by Adam as well, “play is very important, we try to do everything with our son through play.” He emphasized communication and maintaining a strong caregiver-child bond through play. Embracing mistakes as part of learning, self-discovery, and play, was discussed by Mike: “experiential learning through play… play is great for learning. That’s where mistakes happen and learning occurs… when they get to do things and explore things on their own.” Maya mentioned engaging in playful activities like science learning experiments, painting, and watching cartoons with her son, highlighting the versatility of play in education and relaxation. Maya shared, “we chose my son's daycare specifically…as play-based…because I wanted him to have the freedom to play.”

Kara commented on giving individualized attention to both of her children, emphasizing the importance of play in creating meaningful caregiver-child interactions, “that way he gets some individualized attention he gets to play with toys that he normally wouldn't get to play with. And he gets to have time to himself.” Quin highlighted the positive influence of exercise as a form of play, creating a more positive atmosphere and improved interaction with children.

Nina and Kara were the only two participants to mention playdough. Demi was the only participant to directly use the words “structured” and “unstructured play” regarding her family’s experience of play. Families still emphasized the importance of incorporating structured and unstructured play into their daily routines, balancing routines, and activity with resting time for their children.
Some caregivers found play to be a challenging experience. Kara and Isla expressed discomfort with play as they “don't know how to play anymore” (Kara) and they "cry..., feel so silly, and hate it." (Isla). They might try to “focus on a particular activity” to add structure to play or give up on play altogether as they feel they're "really not very good at it" (Kara). The acknowledgment of personal limitations for play for these two caregivers prompted a discussion around the importance of rapport-building beyond the immediate family. For example, Isla declared the significance for her child, “to build relationships with other adults and whether that be his grandparents, his teachers, my friends, ...their friend's parents or whomever. It's good for him to get things from other people. He doesn't need to get everything for me.”

Chris was the sole participant to comment on the importance of upholding wellness and play while managing financial restraints. He acknowledged the value of joy although focused on exploring affordable play options. Utilizing city facilities for inexpensive leisure activities showcased his family’s commitment to “staying happy within your means and boundaries.”. Together, these shared stories indicated a shared value in a holistic approach to caregiving that intertwines play with learning and joy.

4.6.2 Outdoor Play

In exploring the varied facets of caregiver play, a myriad of activities surfaced as integral to a family’s lifestyle. There was a spectrum of activity from traditional outdoor pursuits, that might be expected from Canadian families as the experience of winter is prolonged, including sledding, skating, skiing, indoor swimming, and walking and playing in the snow. Families commented on indoor and outdoor spaces as part of their experience of play including play in the backyard, at the park, and at a swimming pool (indoor and outdoor pools) or lakes.

Families mentioned indoor playgrounds, with 6 out of 19 participants noting this choice, despite outdoor playgrounds being the more conventional option as mentioned by other caregivers. Many participants emphasized the importance of outdoor activities such as playground play, hiking, and biking, as well as community sports like hockey and baseball. They discussed the impact of weather on outdoor play and shared challenges and solutions for engaging in outdoor play in Canada. Some mentioned visiting indoor playgrounds or trampoline parks in cold temperatures, while others spoke to indoor activities like YouTube dance videos or downloading activities to do at home.
Quin noted the positive impact of playing outside on emotional wellness by sharing that her children, “challenge me less, they're generally more agreeable and positive. They play better, and express themselves way, way more if we get out there first.” Bonnie clarified that she adapted family play plans based on weather conditions, “we just have to stay home if it’s really cold like minus 40, it limits us a bit”. She voiced that they go to indoor playgrounds and indoor green spaces instead, showcasing her family’s relationship with both play and nature. Helen related to the same feelings about extreme cold and also remarked her dedication to still getting outside to play, “when it’s minus 30. I try and get the kids outside at least once to play, sometimes twice. It… takes longer to bundle them up than the amount of time we are outside.” Consistent with Bonnie and Helen, Julia confirmed the same extreme weather sentiments. In her location, the extreme wind not only disrupts her sleep but also hinders her family’s engagement in outdoor play. She did make note of her job providing her with opportunities to play, “working with 6-year-olds… you get a chance to play.” She also confirmed that everything is a game to her daughter and that “she’s very play-centered.” Paula’s outdoor play for both her and her family is necessary for reducing stress, “playing outside is a big part of it, as we do it all together”. Spending time outdoors emerged as a key strategy to enhance her mental wellness, patience as a caregiver, and her family’s wellness overall.

4.6.3 Social and Family Connections

Social wellness was illuminated through various perspectives, including playing with neighbours, family time, playdates with friends or extended family, and the role fathers had in keeping their children engaged, busy and happy. Social interactions, both for caregivers and children, were viewed as vital including activities such as playdates, community events, and group activities contributing to a sense of connection. Family bonding through play was a recurring theme, including shared activities like board games, card games, and outdoor adventures. Mike discussed his wellness maintenance through seasonal and socially driven activities, including playing hockey in winter and baseball in the summer with friends. The importance of maintaining connections with friends and participating in activities that bring joy accentuated the social aspect of wellness for him and his family. He stated “we like to see our group of friends who generally have kids around the same age so we have some playdates and we then get to converse with (the adults) as well.”
Erica's response delves into the social and environmental dimensions of play in her family's life. The importance of social interactions and outdoor activities, “we play games, we love games, …card games, board games, …soccer, bocce, barbequing, … softball…constantly playing” were crucial contributors to her family’s sense of play, connectedness, and wellness. The challenges of being isolated during special occasions and the impact of the environment on their play experiences were demonstrated.

4.6.4 Playful Life Balance

Several individuals commented on the significance of incorporating play into daily life. Music, swimming, dancing, and games (including card games, board games, video games, and even YouTube videos/games) craft a tapestry of the play these families were involved in every day.

Gema emphasized the unique freedom found in play, describing it as “unattached freedom that can't be reached any other way”. For her, play was embodied in activities like daily activity (reading, engaging in board games and playing Lego) with her child. She also recounted how, before having her son and even more so now, she engaged in a morning play ritual of practicing yoga and “plays a lot”. Gema shared that being silly could be a simple, uncomplicated action of play. She noticed that “sometimes (my son) takes it too seriously and I’m like: oh yeah, I take that seriously too. Let’s just laugh about it.” This suggests that for Gema, play served as a channel for shared experiences, laughter, and connection.

Echoing Gema, Alexis emphasized that she’s trying “to be more playful in (her) day-to-day life”. This demonstrates the recognized link between personal wellness and energy levels and the ability to engage in play creatively with children. Alexis stated that when “you get involved in their play, you can get really goofy” and that “not everything has to be serious”. Nina said she engaged in “a lot of creative play like dancing, yoga, board games, colouring, and playdough.” Spontaneity seemed to be an important characteristic at least for some participants. In contrast, Alexis mentioned that her husband was better at play then her:

[My] husband is really good at play because he's a lot more - he makes things fun.

Whereas I'm kind of more of the taskmaster sometimes because I have to be…It's easy to get swept up in the logistics of to-do lists and chores.

Even in seemingly mundane activities like daily chores, there's a recognition that not everything has to be serious, as expressed by Alexis. Her acknowledgment of her husband bringing a sense
of fun to their lives while she took on a more task-oriented role reflected the balance of playfulness within caregiver partnerships.

Another common thread weaved throughout the experiences of caregivers who devoted their time to care for their families was by laughter and lighthearted moments. Adam, for instance, shared that he and his friends like to get together to "have a good time and laugh." This straightforward yet powerful directive emphasized that laughter could build connections and resiliency, despite the trials of caregiving. Both Adam and Paula shared they tend to find playfulness in physical activities such as playing in the snow. Chris echoed Adam’s sentiment, “we still get out to have fun and still have laughs”, observing that finding laughter and joy is a commitment that’s necessary for maintaining a sense of normalcy. Demi disclosed that she used laughter and humour for coping, providing some relief. Often, wellness was a personal struggle for caregivers and Demi illuminated this by expressing “because I know all these things and I also don’t get to them” in reference to her wellness practices.

Farah introduced her playfulness by recounting a moment of sheer joy as she went "poof, down the hill" with her children “chasing” her, she shared “I was laughing.” Farah defined play as an embrace of humor and camaraderie, “when I say play, it's like this, it’s to have jokes and laughter.” For Farah, the absence of laughter, “if I’m not laughing and having a good time”, seemed inconceivable. Caregivers alike recognized the therapeutic value of laughter within play. Finding joy in simple, playful moments (such as dancing, crafting, reading, and playing games) was highlighted as a way to combat stress and enhance overall wellness.

Participants discussed the challenges of balancing adult responsibilities with the need for personal play. The idea that play provides caregivers an avenue to reconnect with their inner child or tap into their creativity was expressed by Farah and Alexis. Maya resonated with this too by expressing that “every once in a while, I like to get weird or just twirl. So we just do that, we twirl together.” Erica communicating that she was “constantly playing” demonstrated her mission to infuse play into her daily routine. Many participants echoed this sentiment, demonstrating the frequency of play in caregiver’s lives. Caregivers frequently commented on discovering joy in the simple, playful life moments. For example, Paula reflected on a childhood memory:

When I was a kid, running on the playground, I would run to a swing or a slide or something I was excited about. And so I just thought how adults don't run just out of
excitement, just for fun. It's as if I'm never gonna stop running, I think of that every now and then… When you're a kid, it's more of a playful run than okay, I'm going out for exercise.

Paula's contemplation on the differences between carefree, playfully running as a child and the more organized, structured approach to exercise as an adult is intriguing, suggesting a shift in play with age. Maya echoed this reflection as she shared about her past competitiveness playing soccer before having kids and expressed reluctance to return to the sport, stating “I used to (play soccer) but I know that because I am not physically in the same place that I was, I don't try…I don’t want to do it.” This signified how one’s personal history with play shaped caregiver's perspectives as well.

These reflections about play, as shared by the 19 participants, highlight the diverse ways in which play is incorporated into family routines. Even in the absence of a direct question about the relationship to play in some interviews, an organic conversation on play developed, demonstrating that play is woven into the fabric of family life. The narratives together illustrated the many diverse aspects of the caregiver-play relationship.

4.7 Summary

In this chapter, the narratives of 19 Canadian caregivers were presented, highlighting their perceptions and experiences regarding family physical wellness in the context of play, outdoor interactions, and physical activity. Their accounts within the qualitative interviews identified four major themes: (1) Environmental Wellness; (2) Physical Wellness; (3) Self-care; and (4) Play offering insights of the caregiver perspectives of and encounters with family physical wellness. There were multiple subthemes and sub subthemes the developed within each of the four major themes (see Figure 5.1 in chapter five for an interconnected depiction).

Family physical wellness is multifaceted and complex. This findings chapter delves into the overarching themes and insights through rich, detailed semi-structured interview conversations conducted with caregivers. This chapter serves as a reflective exploration of wellness as multidimensional through the lens of caregivers’ lived experiences. Expanding upon this understanding, a discussion will progress further in the following chapter. Chapter 5 will link and connect the participant voices with the identified themes, subthemes, and sub subthemes to the existing literature. Additionally, it will also explore the practical and theoretical implications of these findings within existing and current literature, while also offering an assessment of the
strengths and limitations of the present study. Furthermore, potential avenues for future research will be explored.

5.0 Chapter 5: Discussion

The objective of the current study was to explore caregiver perceptions and experiences of physical wellness in the context of play, outdoor interactions, and physical activity. This chapter presents the findings in context and in relation to significant results and outcomes identified in the extant literature. How the key findings of this study are interrelated to two of the five domains of social determinants of health (SDOH) (WHO, 2008; Healthy People 2030, n.d.-c) and three of Swarbrick’s eight dimensions of wellness Swarbrick and Yudof (2015) is also explored. Additionally, this chapter outlines the study's practical implications, strengths, and limitations, along with potential directions for future research.

5.1 Summary and Integration of Findings

Nineteen participants were qualitatively interviewed to examine caregiver’s perceptions and experiences of family physical wellness. The data was subsequently organized into four major themes (environmental wellness, physical wellness, play, and self-care) and multiple subthemes and sub subthemes (see Figure 5.1). Subsequent sections of this chapter, following the figure, delve into each theme in greater depth, outlining their implications based on current research findings and proposing avenues for future research.
5.1.1 Environmental Wellness

Within the theme of environmental wellness, the 19 participants reflected on their relationship to and experiences of micro and macro environments. Participants underscored the importance of safe spaces; nurturing and purposeful environments intentionally chosen for education, leisure activities, play, and work. Finally, within the caregiver’s examination of the impact of weather and their families’ outdoor interactions, the emphasis on fostering a sense of belonging and inclusion encouraged overall wellness within this theme.

5.1.1.1 Location matters. Caregivers described several subthemes within the subtheme location matters: (a) sense of belonging; (b) intentional location; and (c) supportive environments.

5.1.1.1.1 Sense of belonging. Every participant in this Canadian wellness investigation discussed a sense of belonging and the desire to be in the presence of others within their community, detailing its effect on their environmental wellness. Previous Canadian studies on a sense of belonging have emphasized its impact on self-perceived positive wellness as well as its influence on physical and emotional wellness (Kitchen et al., 2012; Kitchen et al., 2015; Ross, 2002; Statistics Canada, 2022). However, no study to date has been identified that explores a
sense of belonging and its significance on one’s environmental wellness, as uncovered in this study. Future research should include further inquiries on how Canadian families experience their physical wellness and the relevance of a sense of belonging.

Only one participant provided a land acknowledgment in their interview. According to Kirmayer et al. (2011), Canadian Indigenous identities, cultural bonds, and experiences of wellness are deeply intertwined with and linked to an individual’s ancestral and spiritual relationship with the land. The authors emphasised that “communities exist in an ecological balance with their surrounding environment” (Kirmayer et al., 2011, p. 89). By acknowledging the land's significance, the participant acknowledged the ancestral and spiritual relationship that Indigenous communities have with their environment, reinforcing the idea that overall family wellness is also intricately connected to a balance within one’s environmental wellness.

5.1.1.1.2 Intentional location. Thirteen participants commented on selecting a purposeful location to reside and felt connected to their microenvironment environmentally and socially. A previous study by Jutras and Lepage (2006) depicted caregiver perspectives on how neighbourhoods and schools impacted the child’s wellness. According to Jutras and Lepage (2006), a significant majority of participants (71.7%) characterized “their neighborhood as a child-friendly environment,” highlighting its positive impact on their children. Additionally, they noted the importance of “the proximity of places frequented by their children…” including “schools, church, recreational centres, parks, or home of grandparents.” (Jutras & Lepage, 2006, p. 313). Similarly, caregivers in this study discussed the desire to reside near to their child’s grandparents, fostering intergenerational bonds. A few caregivers even shared they lived in the same neighbourhood or even the same household as their parents. Sadruddin et al. (2019) conducted a systematic review examining the direct impact of grandparental relationships and care on child health, development, and wellbeing. While the Sadruddin et al. (2019) study did not provide insight into the impact of supporting family physical wellness specifically; the authors proposed a parallel recommendation for future research: to advocate for family-centered programs that support families and can further enhance the wellness of grandparents, grandchildren in their care, as well as the caregivers or parents also involved.

5.1.1.1.3 Supportive environments. Purposefully residing in neighborhoods that foster family wellness was highlighted by several participants, underscoring the importance of supportive environments for caregivers’ perceptions of wellness. One caregiver mentioned
offering childcare on their rural property, providing much-needed respite for fellow caregivers. An Austrian study, by Peters et al. (2019) focused on exploring the psychological wellness of children in rural areas, demonstrated that feeling supported by one’s community served as a buffer to mental health challenges. The study also suggested that “future studies could develop a child’s sense of community measure” (p. 8). The current study aligns with the Peters et al. (2019) study in the aspect that having community within supportive environments was critical to the experiences of family physical wellness. Caregiver perceptions were explored, and it was found that having supportive environments was important. In contrast, some caregivers in urban settings praised the supportive atmosphere of their child's daycare, expressing relief in knowing their child is in a nurturing environment.

Regardless, having access to like-minded families, whether in the neighborhood or through community groups, was valued for its role in fostering family social wellness, connectedness, and support networks. As Weiss-Laxer et al. (2020) pointed out in their family health study, communities of wellness “-promoting families are able to model and communicate ways to positively promote the health of members and prevent health hazards” (p. 3). This was also true for caregivers in this study. Engaging in activities not only promoted physical wellness for families but also contributed to social wellness, as caregivers bonded over shared interests and involvement in the community. As suggested by Peters et al. (2019), one’s emotional wellness could also be supported, therefore reducing future mental health challenges for the family.

5.1.1.2 Impact of weather. Within the subtheme of environmental wellness, impact of weather, all but one participant shared that Canadian temperatures and weather conditions directly impacted a family wellness. The rapidly changing climate is disrupting ecological systems and environments world-wide, leading to both immediate and indirect repercussions on wellness (Clayton et al., 2017, Middleton et al., 2020, Watts et al., 2017). As per the findings of the IPCC 2018 Special Report: Global Warming of 1.5°C, the Intergovernmental Panel on Climate Change (Allen et al., 2022), suggested that if the current rate of increase persists, it is highly probable that global warming will surpass 1.5°C before mid-century, amplifying the already observed alterations to the land, oceans, temperatures, weather patterns, infrastructure, economic stability, public health and human wellness to a significant extent. Awareness of Canadian weather among participants reflected concerns for maintaining a safe and clean
environment, aligning with the environmental wellness dimension outlined by Swarbrick and Yudof’s (2015) eight dimensions of wellness.

Two Canadian-specific studies shed light on the impactful relationship between weather and wellness. In Middleton et al.’s (2020) article “we’re people of the snow,” a voice was brought to participants from Nunatsiavut Inuit, Canada, revealing a fluctuating bond relationship between weather and mental wellness. Middleton et al. (2020) found that “experiences with weather can reinforce local concepts of climate, strengthening social determinants of mental wellness, in addition to altering daily and seasonal emotive and mental experiences.” (p. 9). In Tam’s (2012) exploration on the effect of weather on the wellness of rural and urban Indigenous populations in Ontario, Canada, Tam noted the “intrinsic connection to their land” and emphasized that “culture, identity, lifestyle and well-being are deeply rooted to native land and environment” (p. 1). Caregivers in this study frequently noted their efforts to remain active outdoors despite weather conditions. The influence of Canadian weather on family wellness illustrated how macroenvironmental factors, such as climate, can greatly impact individual and family wellness.

The five domains of social determinants of health included a domain on neighbourhoods and the environment (Healthy People 2030, n.d.-a), which focused on enhancing safety and wellness by bolstering opportunities for people to feel safe and experience wellness in their surroundings. Although existing literature references global warming and climate change, and a few Canadian studies explore the relationship between weather and mental health, literature doesn’t appear to focus on the experiences of weather and environmental wellness specifically.

Future research could explore different samples of populations, as the population sample ($n = 19$) was not diverse. What might be revealed is less of an emphasis on proximity to schools more on the proximity to family members for example, as this finding arose in this study. Whether or not supportive environments matter to family physical wellness matters needs to be further examined further as there wasn’t a strong consensus amongst this population of caregivers. Had the data explored the relationship of family physical wellness to environment, for example in rural versus urban settings, perhaps more commonalities or differences would have been accounted for.

There were other potential aspects or sub subthemes of the impact of weather that were not extensively discussed. Considerations such as climate change, comparisons between
precipitation and wind or cold, and specific concerns regarding weather-related challenges were missing from the caregivers’ conversations. Future research could focus on how to navigate barriers during inclement weather, the necessity of outdoor chores despite poor weather conditions, and restricted opportunities for outdoor play. While these topics may not have been explicitly mentioned, discussions did revolve around factors such as temperature, seeking refuge indoors during harsh winter months to escape the biting cold, and the quest for protective environments. Understanding caregiver perceptions of support regarding their environmental wellness is valuable and necessary.

5.1.1.3 Outdoor interactions. Caregivers described several sub subthemes within the subtheme outdoor interactions: (a) mind-body-nature connection; (b) planned time outside; and (c) swimming.

5.1.1.3.1 Mind-Body-Nature Connection. Participants emphasized the benefits of getting outdoors on family wellness, highlighting the healing power of nature. Many expressed a love for hiking, particularly since 12 participants (11 participants from Alberta and 1 participant from British Columbia) were situated conveniently close to mountainous areas. A study by Potestio et al. (2009) examined whether childhood obesity in Calgary, Canada was correlated with access to green space. Findings indicated that “Calgary's climate, characterized by long and sometimes very cold winters, precludes parks/green space, despite their location, from being an important resource for children” (p. 8). Caregivers in this study observed the opposite to Potestio et al. (2009), as most participants discussed how much they valued fresh air to reset family behavior, patterns, and moods regardless of weather. Caregivers often commented on being “outside people” and that conversely, anytime they were stuck indoors with their little ones it felt constraining for both the caregiver and the child. A recent study conducted in British Columbia by Duflos et al. (2023) provided an interesting lens. They proposed that incorporating grandparents into upcoming family interventions and programing could contribute to bolstering family unity and closeness, while also encouraging outdoor play for the entire family. Grandparents in Duflos et al.’s (2023) study shared that they felt “they were experiencing parenting again” when engaging in outdoor play (p. 1117). Additionally, outdoor interactions provided grandparents with a space to ponder their past parenting/caregiving methods and recount how attention and time wasn’t always provided to their children, increasing a sense of closeness within the family. Safe exposure to nature, clean air, and access to well-maintained
outdoor environments, including playgrounds, national and provincial outdoor parks, were cherished amongst caregivers in this study. Future research could explore family’s connections to the mountains and their physical wellness as this frequently came up during the qualitative interviews. The link between weather and the inclination towards getting outdoors was briefly examined and requires further in-depth exploration in future works.

Hartig et al. (2014) highlighted the unexpected discovery that a limited number of studies have specifically investigated the degree to which the relationship between nature exposure and health outcomes could be influenced by levels of physical activity. Many times, it is an assumption that physical activity serves as a crucial link between nature and health. A more recent systematic review and meta-analysis by Coventry et al. (2021) examined the utility of interventions using nature-based approaches for enhancing mental and physical wellness among adults within community settings. Within their conclusions, the authors pointed out that “gains in mental health might be attributed to nature connectedness, social support, physical activity and purposeful behaviour” (p. 10). The results of this study support this finding. Coventry et al. (2021) also emphasized a discovery made by Hartig et al. (2014), indicating that the presence of green and blue spaces (such as public parks and areas with natural vegetation, as well as outdoor water environments) has been associated with enhancements in both mental and physical wellness. Twohig-Bennett and Jones (2018) referenced the findings of Hartig et al. (2014) as well, stating that “greenspaces offer opportunities for physical activity, social cohesion, and stress reduction which each carry their own numerous health benefits” (p. 636). Seeing as caregivers in this study discussed the importance of playground time, park time, the mountains, and swimming in lakes in the summertime, the findings of this study strongly support the finding from Hartig et al. (2014), that the presence of green and blue spaces is a part of Canadian family physical wellness.

5.1.1.3.2 Planned Time Outside. Nearly every caregiver in this study emphasized the importance of deliberately scheduling outdoor activities for the family. Those caregivers who discussed engaging in outdoor activities with their family aimed to do so daily. According to Gauvain and Perez (2005), examined planning of informal activities within a family unit. Although they did not include children's influence or caregiver influence on their family's physical activity level directly and didn’t speak to outdoor activities, their study underscored the significance of frequent outdoor planning for families. They reported an increase in a child’s
opportunities to organize informal activities, with the responsibility progressively shifting from caregivers to children as time progressed. This aspect was similarly highlighted in the findings of this Canadian family physical wellness study when caregivers commented on their planned efforts to enjoy the outdoors as a family. Future directions could further examine the importance of frequent outdoor planning on family physical wellness.

Harwood et al.’s (2020) inquiry focused on identifying the educational methodologies utilized in, and the features and geographical distribution of, learning programs that were outdoors and nature-based in Canada. According to Harwood et al. (2020), about 31% of all programs in Canada have been offering “family sessions or sessions for mixed and multi-age groups of children” (p. 10) outside of the learning programs children are involved in. This discovery implies that these programs recognized the value of engaging families in outdoor activities, further emphasizing the significance of planning outdoor time for families. This resonates with the findings in this study and potentially an intervention aimed at promoting regular outdoor planning within families could be implemented in future studies.

Twohig-Bennett and Jones (2018) found in their systematic review that increased greenspace exposure was correlated with positive wellness including better cancer outcomes, decreased respiratory mortality, increased sleep duration, and positive neurological impacts. Therefore, planned outdoor time has the potential to support Canadian families and their physical wellness. Future research could include focus on qualitative perceptions and experiences of family physical wellness with time spent outdoors.

5.1.1.3.3 Swimming. A study conducted in Vancouver, British Columbia, Canada, with a focus on the benefits to accessible swimming infrastructure, investigated the influence of equity on decision-making and planning for public swimming pools. Li (2023) stated swimming and “aquatic services…provide the following benefits: learning water safety, aquatic sports, fitness, rehabilitation/therapy, social opportunities, family opportunities, social mixing, leadership training, volunteering opportunities, special events” and can enhance “personal health, …public health, provide community space, … and recreation… opportunities” (p. 20). As emphasized by Li (2023), the influence of climate change could also be contributing to the increasing number of families opting for indoor swimming, particularly seeking refuge "to seek cooling spaces during heat waves" (p. 21). Families in this study recognized the interconnection between
environmental wellness and their proactive measures to support their physical wellness including the importance of swimming.

Referencing the act of swimming and its therapeutic nature, Foley (2017) pointed out that emotions and feelings arise from individual and group actions repeated in water environments. They also explained that swimmer participants in their Ireland study shared that “mood and mental state shaped the key decision to “go in for [a] dip”” (Foley, 2017, p. 49). Foley (2017) mentioned how individuals are shaped by their landscapes and water in particular sparks a recollection of “memories of swimming experiences, shared with family, friends, and even complete strangers” (p. 49). Caregivers in this Canadian physical wellness study expressed a fondness for swimming because of its nostalgic appeal. Swimming was an activity caregivers mentioned cherishing during their own childhood and therefore, desired to pass on this experience to their own children.

In a qualitative exploration of swimming experiences among American families of children with autism spectrum disorders (ASD), Lawson et al. (2019) highlighted the positive impact of swimming on the physical, social, emotional, and intellectual wellness of the family (p. 1). The study found that the advantages were extensive and often encompassed experiences related to social interaction, community involvement, “[caregiver] support, relaxation, exercise, meaningful activity and swimming as therapy” (Lawson et al., 2019, p. 7). Canadian families in this family wellness study observed that swimming also contributed significantly to family wellness. It provided families with the chance to bond and strengthen their connections while offering an escape from the harsh winter weather conditions often experienced in Canada. Further research on this topic needs to be explored, especially from a Canadian context and with other populations of families.

5.1.2 Physical Wellness

Within the theme of physical wellness, the 19 participants provided their experiences and perceptions of their family’s physical wellness. Participants shared perceptions about four subthemes within physical wellness (exercise, healthy eating, time away from TV and screens, sleep) as well as several sub subthemes (for example, movement is vital as a sub subtheme of exercise). The majority of caregivers expressed that among the four dimensions of physical wellness, listed as subthemes, sleep was deemed the most crucial for their family.
5.1.2.1 Exercise. Within the subtheme of exercise, there were three sub subthemes: (a) movement is vital (activities and the wellness dimensions); (b) emotional regulation; and (c) streaming wellness. As stated by World Health Organization (WHO), “regular physical activity is proven to help prevent and manage noncommunicable diseases (NCDs) such as heart disease, stroke, diabetes and several cancers” (WHO, n.d.-b, para 1). This emphasizes the critical role that exercise plays in safeguarding against chronic health conditions that can significantly impact individuals and families alike. Moreover, the WHO highlighted that physical activity extends beyond structured exercise routines; “refers to all movement” including “walking, cycling, wheeling, sports, active recreation and play” (WHO, n.d.-b, para 1). This broad definition of physical activity and exercise complements the one used by Swarbrick and Yudof (2015) to describe physical wellness. Physical wellness “physical wellness involves the maintenance of a healthy body, good physical health habits, good nutrition and exercise, and obtaining appropriate health care” (Swarbrick & Yudof, 2015, p. 6).

5.1.2.1.1 Movement is Vital. In the sub subtheme of "movement is vital" the fundamental role of movement in maintaining physical wellness among Canadian families was illustrated. Participants consistently emphasized the impact of movement, with one participant pointing out that the body requires movement to maintain mobility and not forget how to move. Whether through structured exercise or household chores and activities, movement reduced restlessness and promoted better sleep for families. The activities caregivers and their families participated in spanned across five of the eight dimensions of wellness including physical, intellectual, spiritual, emotional, and social dimensions of wellness. Caregivers enjoyed and found fulfillment in engaging in a diverse range of activities encompassing academic-focused activities, organized sport and extracurricular-focused activities, mindfulness and creativity-based activities, as well as cardio/movement-based activities. Participants recognized the impact of parenthood on their activity levels, underscoring the need for increased physical activity to improve sleep and overall alertness. Caregivers acknowledged that engaging in physically activity encouraged exploration and adventure within the family.

With regards to movement being vital, participants commented on when their family got outside and engaged in different levels of physical activity several other aspects improved as well: their children were more emotionally regulated, caregivers felt more emotionally stable, sleep and nutrition improved for the entire family, as well as their belonging to their extended
community of friends and family. Participants also noted that there were consequences to when their family was inactive such as depression, moodiness, not being able to provide care well, not fueling their physical wellness with health habits that were supportive. For example, the family’s sleep and eating patterns were impacted, and an increase in sedentary behaviour also occurred. Tremblay et al. (2017) carried out several systemic reviews within one study to glean what the effect physical activity, sleep, and sedentary behaviour had on the wellness of children in their early years (0-4 years). The purpose was to develop the evidence-based *Canadian 24-Hour Movement Guidelines* and to support optimal health and wellness for this age range, as no documented guidelines existed before. Latimer-Cheung et al. (2016) shared that “the combination of movement/non-movement behaviours (sleep, sedentary behaviours, and physical activity) matters for health-related indicators in children and youth” (p. 329). Ross et al. (2020)’s study revealed the development process of the *Canadian 24-Hour Movement Guidelines* for adults. Notable recommendations for this age rage included aiming for 150 minutes of moderate to vigorous physical activity weekly, as well as reducing sedentary time to less than 8 hours daily and ensuring 7-9 hours of adequate sleep daily. Future studies could ask specific questions about how well the families met the guidelines for adults and children. As demonstrated in this study, caregivers acknowledged how important movement was to their family’s physical wellness.

**5.1.2.1.2 Emotional Regulation.** Caregivers provided valuable insights into the relationship between physical wellness activities and emotional regulation. As Weiss-Laxer et al. (2020) stated “while families are not always able to provide the most salutary environments, we maintain that almost universally, they want to do so. To varying degrees, family members rely on each other for emotional, social, and economic support” (p. 2). Participants in this study noted significant improvements in a family's wellness were observed when they engaged in physical activity together. Specifically, outdoor engagement was mentioned as to why their children were emotionally flexible and positive. Recently D’Cruz et al. (2024) suggested there are several contributing factors to a child’s emotional regulation, and therefore, a family’s regulation. D’Cruz et al. (2024) shared that factors encompass interactions between caregiver and child, environmental and social wellness, and the child’s temperament alongside “modifiable health behaviors like physical activity and sleep” (p. 2).

Caregivers in this study often relied on exercise to regulate their own emotions. If physical activity was missed in the day, there was a direct relationship to how it impacted the
Reducing screen time and prioritizing physical activity was identified as effective and consistent strategies in supporting a family’s emotional stability. This connection is elaborated on in the following section on the subtheme time away from TV and screens. Moreover, caregivers in this study recognized that staying physically active, as well as improving their level of activity, improved their emotional wellness and cultivated more positive interactions with their children. Overall, caregivers observed the connection between physical activity and emotional regulation, highlighting its significant impact on family wellness. While research on the link between emotional regulation and physical activity in children ages 3–5 years is expanding (D’Cruz et al.,2024; Lindsey & Colwell;2013; López-Escribano et al., 2021; López-Olivares et al., 2020; Xie et al., 2020), there remains a gap in understanding regarding family physical wellness and caregiver perspectives on emotional regulation within the context of the family. Further investigation is necessary from a caregiver’s perspective to gain a comprehensive understanding of this relationship.

**5.1.2.1.3 Streaming Wellness.** Online fitness platforms were embraced by caregivers to integrate physical wellness routines into their busy schedules, contributing to family wellness. Despite the convenience of online workouts, some caregivers in this study faced challenges such as lack of motivation, scheduling conflicts, and childcare constraints. For those who found online classes less motivating or impractical, accessibility and practicality became crucial factors in determining their engagement in physical activity. A study by Toscos et al. (2011) summarized the most significant barriers to physical activity identified in previous literature such as a lack of time, energy, motivation, interest, enjoyment, and social support. Resembling the caregiver perspectives in this study, Toscos et al. (2011) highlighted that environmental constraints, accessibility, and personal barriers such as busy schedules, unforeseen emergencies, and fluctuations “in work and family responsibilities and other challenges can prevent an individual—even a fitness fanatic—from maintaining a regular exercise routine” (Toscos et al., 2011, p. 1226).

While some caregivers in this study preferred in-person classes over virtual ones, others found solace in the flexibility of online options, including YouTube videos, online dance sessions, and fitness apps. In the literature, a recent study, emphasizing Centola’s (2013) work, stated that there has been an “explosion of new online fitness communities (e.g. RunKeeper, MapMyRun, Strava, etc.)” enabling users to track their everyday activities with “a rapidly expanding collection of tools and technologies” (Zeng et al., 2017, p. 88).
Participants in this study also explored a variety of online courses and activities beyond fitness, including educational programs, marriage classes, spiritual groups, and organized group sports, indicating that supporting one’s intellectual wellness was linked to family wellness. Overall, streaming wellness provided caregivers with accessible avenues to prioritize physical activity, contributing to their overall wellness and that of their families. Online fitness has been a channel to investigate and promote (Centola, 2013; Toscos et al., 2011; Zeng et al., 2017). Although a study on how families are interacting online with fitness has yet to surface, future research could focus on the caregiver perceptions of online fitness and the impacts it has on family physical wellness.

5.1.2.2 Healthy eating. Healthy eating consisted of two sub subthemes: (a) “you are what you eat”, conveying a strong link between food and the impact it has on wellness and how the body feels; and (b) selective eating, including a discussion around the financial implications to eating well.

5.1.2.2.1 “You Are What You Eat”. Caregivers emphasized the importance of healthy eating habits in promoting physical wellness and overall family wellness. Links between nutritious food choices and the motivation for physical activity was especially asserted by a few caregivers emphasizing, "you are what you eat." Many caregivers acknowledged the impact of processed foods on their family's energy levels and emotional wellness, striving to maintain a balance between nutritious meals and occasional indulgences. This aligns with existing research including a recent study carried out by López-Olivares et al. (2020). When exploring the impact of the Mediterranean diet on the emotional wellness of Spanish university students, López-Olivares et al. (2020) suggested that emotions and emotional environments can aid in the development of healthy eating habits which can then translate to “good eating habits in adulthood” and family life as well (p. 2). Despite various challenges such as societal pressures on body image and time constraints, caregivers in this study recognized the significance of prioritizing healthy eating habits for themselves and their families. Through open communication and efforts to provide a variety of nutritious options, caregivers sought to instill positive relationships with food and promote overall wellness. As the Government of Canada (2020) states, “food nourishes the body and gives us energy to get through each day” (Government of Canada, para 1). This was precisely true for participants in this study as food impacted their emotional wellness and energy levels.
Slater and Mudryi (2018) shared that the first Canadian dietary guidelines were established in 1938 and “while most Canadians are aware of the Food Guide, … fewer actually use it for healthy eating guidance” (p. 3). Barco Leme et al. (2022) conducted a qualitative study on caregiver perceptions of the 2019 Canada Food Guide with children aged 2-12 years old. Caregivers in Barco Leme et al.’s (2022) study voiced apprehensiveness as “it seemed like findings from nutrition research and nutrition messaging were changing frequently” (p. 39), making it challenging to trust or evaluate the credibility, efficacy, or effectiveness of Canada's Food Guide recommendations.

Another note from this study was the dichotomous language used to describe food choices underscoring the complexity of navigating dietary decisions in the pursuit of physical wellness of the entire family. A study by Daundasekara et al. (2019) examined the significance of language in altering one’s healthy eating behaviors. They demonstrated how dichotomous thinking and common terms such as “unhealthy” and “healthy” are used to categorize food, further emphasizing the importance of recognizing that food choices are not binary. Caregivers in this family physical wellness study related to the notion, that one participant mentioned, you are what you eat. It would be valuable to examine family wellness strategies concerning food choices among Canadian households, if caregivers are utilizing the Canadian food guide to eat healthy, as well as investigating the language employed when discussing family eating habits.

5.1.2.2 Selective Eating. This study highlighted the challenges caregivers faced with selective eating, acknowledging the difficulty of balancing individual preferences with a healthy diet. Two participants particularly expressed a frustration with catering to varying tastes and preferences while striving for balanced meals. This finding is aligned with previous literature, as about one third of Canadian children, ages 1-5, are described as picky or poor eaters by their caregivers (Leung et al., 2012). Despite these challenges, caregivers in this study recognized the importance of promoting a healthy relationship with food and avoiding restrictive attitudes toward eating. As Raine (2005) underscored in his study on healthy eating in Canada, “personal food choices are structured by a variety of individual determinants of behaviour, ranging from one’s physiological state, food preferences, nutritional knowledge, perceptions of healthy eating and psychological factors” (p. 9). The author also described how culture, social environment, and demographics (gender, income, education, etc.) are invisible influencing factors to food selection. Caregivers in this study were from a specific population, described as having higher
income and education levels. Participants did comment on their perceptions and experiences of healthy eating as a family, contributing valuable and relatable insights to the existing literature as well as discussion for future research.

Additionally, financial wellness considerations emerged as a significant factor influencing food choices, with some caregivers expressing concerns about the affordability of nutritious options. The financial constraints families described experiencing further complicated their efforts to maintain a healthy diet and may have contributed to selective eating habits within the family. This finding was interesting because the families interviewed in this study would be considered having a “very high income” (FCAC, 2018, p. 8) according to a survey by the Financial Consumer Agency of Canada. Seeking to measure financial wellness in Canada, the survey had almost 2,000 Canadians participate. One of the results of that study revealed that “the relationship between income and financial [wellness] is strongest for Canadian households with very low or very high incomes” (FCAC, 2018, p. 8). Therefore, more diverse demographics perceptions and experiences are needing to be accounted for in future research. Regardless, caregivers remained steadfast in their belief that prioritizing nutritious foods contributes to better energy levels, mood, improved emotional wellness, and overall physical wellness for the family.

Existing literature lacks a connection between healthy eating and financial wellness, emotional wellness, or other dimensions of wellness which briefly is mentioned in this thesis. Therefore, further investigation into the interconnectedness of other wellness dimensions on family physical wellness is warranted.

5.1.2.3 Time away from TV and screens. The two sub subthemes within the subtheme time away from TV and screens were: (1) reducing sedentary behaviour and (2) navigating screen time challenges.

5.1.2.3.1 Reducing Sedentary Behaviour. Caregivers in this study voiced concerns about the increase of technology use (smart phones, tablets, smart watches, wireless headphones, laptops, TVs, etc.) and therefore, impact of screen time on family physical wellness. They highlighted the detrimental effects of constantly and overbearingly being plugged in, including a disconnection from oneself and others, mindless habits, and increased sedentary behavior. Reflective of the caregiver comments in this study, Panjeti-Madan and Ranganathan (2023) examined both the advantages and drawbacks of screen usage in children, especially how childhood development can be influenced by screen time. The authors suggested caregivers
should “be conscious of the harmful effects of technology and its usage; and need to set proper guidelines” (Panjeti-Madan and Ranganathan, 2023, p. 6).

Trying to reduce sedentary behaviour was a priority for almost all the families. As López-Olivares et al. (2020) demonstrated, there is an impact of physical activity and inactivity on one’s overall wellness. The study of time spent on screens and its impact on wellness has recently become popular (Kim et al., 2013; Parrish, et al., 2020; and Wafa et al.; 2016). Caregivers also faced challenges in implementing strategies to get off screens, mostly due to resistance from family members and differences in caregiving approaches (ex. TV consumption preferences). Despite these challenges, the consensus among caregivers was clear: reducing screen time was paramount for promoting physical wellness within the family. Only one participant in this study offered a contrasting perspective, expressing gratitude for the convenience of iPads while still valuing the importance of time away from screens. It is unknown how this caregiver engaged with their child during the child’s screen time use. Perhaps they were motivated to do so to connect with their child. Or alternatively, as Panjeti-Madan and Ranganathan (2023) mentioned, time on devices could be a way to “manage…complex behaviour and emotional regulation” (p. 6). Overall, the participants engaged in a reflective conversation about screen time usage and finding a balance between screens and physical activity to support family wellness.

5.1.2.3.2 Navigating Screen Time Challenges. Grappling with the rise in daily screen time usage, caregivers recognized the need for greater self-control and boundaries to reduce screen time. This sub subtheme differed from the previous as it acknowledged the negative impacts caregivers identified as well as the strategies employed in their family. Setting screen time limits, scheduling outdoor activities, and prioritizing family bonding were some of the key approaches used by caregivers to cut back screen time.

Recently, it has been revealed that both Canadian and Australian toddler-aged children, ages 1–5, do not meet the recommended screen time limit of one hour, even though a majority of children are meeting the exercise and sleep time recommendations (Chaput et al., 2017; Kerai et al., 2022). In Olive et al.’s (2021) study on caregiver and child exercise, screen time usage, and sleep health during the COVID-19, they discovered that decreased physical activity, diminished sleep quality, and increased recreational screen time among both caregivers and children were linked “were associated with poorer mental health outcomes” (p. 10).
Caregivers in this study were attentive to the impact of social media on wellness, including its potential to disrupt self-awareness and contribute to feelings of anxiety and disconnection. Caregivers attempted to achieve a balance as much as possible and put forth deliberate and conscious efforts to reduce screen time, especially for their children. Caregiver reflections showcased a willingness to reduce the negative impact of screen time on wellness for the betterment of their family’s wellness. More questions could have been asked around screen time use in the qualitative interviews to get a clearer sense of the positive impacts of connecting on screens.

5.1.2.4 Sleep. The findings revealed the significant role of sleep in Canadian family participants' physical wellness, as participants discussed it as the important, manageable, and inconstant dimension among the four physical dimensions explored. Caregivers emphasized the importance of restful sleep for both themselves and their families, recognizing sleep has a connection to emotional wellness and the ability to fulfill caregiving responsibilities effectively. Based on previous research that formed the Canadian 24-Hour Movement Guidelines “getting 7 to 9 hours of good-quality sleep on a regular basis, with consistent bed and wake-up times” (CSEP, 2021, SLEEP section) is necessary for Canadian wellness. Furthermore, Olive et al. (2021) observed that “poor sleep is closely linked with symptoms of depression and anxiety in children as well as in adults” (p. 2). The authors went on to stress the importance of sleep, noticing a significant link between increased depression in caregivers and inadequate or interrupted sleep. Caregivers in Olive et al. (2021)’s study “rated their sleep quality as problematic” (p. 9). Similarly, Etindele Sosso et al. (2022)’s systematic review, referencing to works by McEwen (2017) and Martire et al. (2020), demonstrated that “chronic stress can adversely affect sleep quality and sleep duration, while insufficient sleep can increase stress levels” (p. 1160). In contrast, the D’Cruz et al. (2024) study differed in a sense, as their population involved caregiver reports on the sleep experiences for toddler-aged children. However, the authors expressed a similar conclusion, echoing previous findings, expanding on emotional wellness connections, “longer duration of sleep and healthy sleep behaviours were associated with better emotional self-regulation” (D’Cruz et al., 2024, p. 6).

Several other sub subthemes existed within sleep including, the importance of shut eye, the benefits of sleep, and establishing rituals and coping strategies to navigate sleep challenges. Studies have explored sleep disruptions in caregivers (Gay et al., 2004; Meltzer & Moore, 2008;
One study highlighted that it may take six years for caregiver sleep patterns to return to levels experienced before the birth of their first child (Richter et al., 2019). A study by MacKenzie et al. (2021) that took place during COVID-19, investigated how families were managing their sleep. MacKenzie et al.’s (2021) study demonstrated that establishing structure and routines within the family helped caregivers to remain flexible to the newfound, chaotic rhythm of life within this duration. In alignment with MacKenzie et al. (2021), this Canadian study on family physical wellness revealed a reciprocal relationship between stress and sleep in both children and caregivers. This present study is unique in that it focuses on how families were coping and mentioned specific rituals or sleep practices that families implemented. Future research should explore the impact of inadequate sleep on individual and family functioning, highlighting the need for consistent and quality rest.

Furthermore, caregivers discussed the relationship between physical activity, screen time, healthy eating, and sleep, emphasizing the interconnectedness within family physical wellness. Ultimately, each dimension of physical wellness discussed in this major theme (exercise, healthy eating, time away from TV/screens, and sleep) are important to explore in more depth in future studies as this study only scratched the surface of caregiver perceptions and experiences.

5.1.3 Self-care

Orem (1995), a pioneering researcher of self-care, defined self-care as encompassing self-initiated activities that are helpful in maintaining and restoring one’s physical and emotional wellness. Caregivers in this family physical wellness study talked about many subthemes related to self-care including the pressures they feel from society and how the combat and overcome self-care challenges by advocating for self-care practices such as seeing professionals, forming routines or daily habits, and keeping in check with a motivational to maintain family wellness.

Extensive and widespread wellness messages have been communicated, ranging from participating in retreats and maintaining gratitude journals to emphasizing wellness habits aimed at achieving personal transformation in becoming a better individual (GWI, 2023). Riley et al. (2019) addressed the topic of gendered approaches to self-help and the direction society has taken in focusing on self-care to support a psychological, individualized, and ideal self. They highlighted that in self-care and self-help literature individuals, particularly women, are “positioned as inherently flawed” (p. 13) and perceived as the “problematic object in need of change” (p. 8). Caregivers in this study shared about their perceptions and experiences of their
own self-care that related to both Orem (1995) and to Riley et al. (2019). For caregivers, a
duality appeared to exist with respect to self-care. On the one hand, relating to Riley et al.
(2019), caregivers in this family physical wellness study expressed experiencing societal
pressures or demands to be a version of wellness that constantly needs to be different than
current state. They described experiencing pressures to change and feeling inadequate to
wellness standards within society. Caregivers commented on having to portray and uphold the
perfect Instagram mom image of wellness even if that doesn’t align with how they experience
wellness daily. On the other hand, in line with Oren (1995), finding me time for oneself, away
from the family, was a shared perspective as well as sharing that you can’t pour from an empty
cup. Caregivers shared the importance of cultivating activities within their busy daily routine as a
form of self-care. For some, this meant finding personal joy and stimulation while for others it
involved completely relinquishing caregiving responsibilities and prioritizing relaxation. In a
recent Statistics Canada report, Canadian caregiver participants, with children aged 0 to 5,
revealed substantial family-related concerns about their wellness (Kerr et al., 2022). Nearly 75%
of caregivers indicated heightened concerns about managing a work-life balance for the entire
family, navigating the many challenges of juggling work, childcare, managing their child(ren)’s
emotional states and behaviour, and other caregiving responsibilities (Kerr et al., 2022).

Recent studies by the Canadian Mental Health Association (CMHA) indicated an 8%
higher prevalence of severe anxiety among adults with children under 18 compared to those
without. Kirk and Glendinning’s (2002) UK study described professional forms of assistance that
caregivers appreciated and found supportive. In their study, the authors presented the value of
“being able to talk to and share with a professional who was familiar with the family, any
worries or anxieties (caregivers) might be experiencing” (Kirk & Glendinning, 2002, p. 629).
The 19 caregivers in this family physical wellness study related to Kirk and Glendinning’s
(2002) findings and illustrated the importance of professional supports in guiding their own
wellness so that they could better support their spousal and family wellness. Additionally,
caregivers in this study referred to the motivation and discipline they have within their health
habits, particularly in relationship to exercise and their child’s wellness as a catalyst. Research
has demonstrated that caregivers who are active can increase the physical activity level of their
children (Moral-García et al., 2020). One longitudinal study by Kaseva et al. (2017) on
caregiving role-modelling behaviours proposed that “(wellness) beliefs and behaviors learned
from a family during childhood tend to remain relatively stable throughout life” (p. 527). Caregiver motivations, especially towards maintaining exercise, could have two-fold impact on family physical wellness, improving wellness outcomes for themselves and their children. Based on contemporary research findings and as demonstrated in this study on family physical wellness, emphasizing self-care within families is increasingly crucial in the present context. Therefore, future family wellness research needs to examine the societal pressures caregivers face and how that impacts a caregiver’s capacity to initiate self-care.

5.1.4 Play

For the 19 Canadian families in this study, play was a cornerstone in how caregivers experienced and perceived family physical wellness. Many of the other eight dimensions of wellness, including emotional and social wellness were a part of the discussion, demonstrating that family physical wellness, play, and other dimensions of wellness (emotional, social, etc.) overlap and are very much interconnected. As Koeners and Francis (2020) eloquently defined play, (citing Burghardt, 2005; Caillois, 2001; Huizinga, 1949) it is “easy to recognize…an activity or expression that is fun, enjoyable, voluntary and non-serious…and involves an in-the-now-attitude” (p. 144). This definition emphasized the value of play as experienced by Canadian caregivers in this study, especially when they reflected on their perceptions and experiences of physical wellness within their families.

Fisher et al. (2008) stated that “play has shifted from its previous child-initiated basis of “free” or “unstructured play” to a structured, educational thrust for early academic preparation” (p. 306). The authors also discussed theorists, like Rubin et al. (1983), who defined structured and unstructured play. Fisher et al. (2008) highlighted that caregivers who perceived both “structured and unstructured activities as playful…” may not be able to distinguish a difference between them “…leading to a potential imbalance of play in children's lives” (p. 314). This finding may be relevant for the Canadian families who were interviewed in this study. Much of the discussion relating to movement and how Canadian families experienced physical wellness in this study fell within these two categories, structured and unstructured play. However, only one caregiver used those specific terms when reflecting on her family’s experience of play. Many families commented on the importance of getting involved in play to some capacity as a family or as an individual and activities blurred the lines between structured and unstructured play. For example, the families in this study described formal caregiver involved structured exercises like
yoga as well as organized activities like swimming or organized sports such as soccer. The families also highlighted informal physical activities like hiking and walking around a mall as well as spontaneous activities such as living room dance. Future research could focus specifically on how families perceive structured and unstructured play within the context of their family’s physical wellness.

Resembling wellness, play is also multifaceted, multidimensional, and challenging to isolate as a distinct concept from family physical wellness. Future research endeavors could expand to encompass a larger population sample and delving deeper into caregivers' perceptions of play and examining its variations across different regions of Canada. Parent et al. (2021) stated that higher income earning families might “be spending less time in unstructured outdoor play because they are participating in more structured activities” (p. 121). Although this study did not collect data linking income status to activity outdoors, future research could explore this further as recent studies support this relationship.

In conclusion, the views of structured and unstructured play within the context of family physical wellness could be essential in further physical wellness promotion as well as families developing stronger social bonds to their children and other families. By embracing play as a fundamental aspect of Canadian family life, caregivers could also potentially impact environmental wellness for the family, by encouraging exploration in their family’s surroundings. Creativity, learning, laughter, and joy are all critical pieces of the overall play experience, and impact other dimensions of wellness such as emotional, social, intellectual, and more, as previously theorized (Arnott, 2018; Piaget, 1962; Pyle & Bigelow, 2015; Thompson & Goldstein, 2019; Yawkey & Silvern, 1977). Therefore, it’s important to continue to support familial play and deepen the exploration of a caregiver’s relationship to and perceptions and experiences of play within family physical wellness.

5.1.3.1 Outdoor Play. As observed by Burke et al. (2021) in their research on Canadian child wellness and outdoor learning during the COVID-19 pandemic, "outdoor and nature-based play is an important ingredient for optimal development of all children” (p. 27). However, this study did not explicitly explore caregiver perceptions regarding their own experiences and connection to outdoor play or their involvement in outdoor play alongside their children. Similarly, Moore et al. (2020) did not delve into caregivers’ perceptions and understanding of their own outdoor activity habits. Despite this, Moore et al. (2020) found an increase in sedentary
behaviour among children and caregivers during the pandemic, as they engaged more frequently in indoor hobbies. Moore et al. (2020) also revealed that “[caregiver] support was a key correlate of children and youth movement behaviours” (p. 8). They emphasized that for children, time spent outdoors is linked to various benefits including “greater physical activity, less sedentary time, improved sleep” (Moore et al., 2020, p. 2). Furthermore, they suggested that encouraging outdoor play and physical activity through “targeting co-participation” (Moore et al., 2020, p. 8) of children and caregivers could improve overall family wellness.

In a recent scoping review concerning outdoor play publications in Canada (de Lannoy et al., 2023), the authors collected 224 published articles regarding outdoor play among Canadian adults. They identified a gap in knowledge wherein the articles failed to examine the positive impact on intellectual and emotional wellness resulting from adult outdoor play. This gap might exist from the authors observation that play in children is characterized as “less structured and more spontaneous” (de Lannoy, 2023, p. 147). The association between the advantages of childhood education, learning, and development with play has been extensively well-researched, dating back to the pioneering work of German educator Fredrich Froebel, the founder of “kindergarten”. In his work, Froebel (1902, as cited in Wloka, 2020), examined the interconnectedness between play and outdoor environments in child development.

The exploration of play for caregivers encompassed several additional sub subthemes including learning through play, maintaining a playful life balance, and creating and connecting to social and family connections through play. Families in this caregiver physical wellness study commented on increased social, emotional, and overall personal caregiver wellness because of play. Participants emphasized the importance of daily outdoor activities like playground play, hiking, and biking, discussing both the challenges and creative solutions for engaging in play in Canada's diverse weather conditions. Several caregivers noted the positive impact of outdoor play on emotional wellness and how some play activities created a community and sense of belonging around the family unit. Play served as a strategy to reduce stress and enhanced family physical wellness.

5.2 Applications of Theoretical Frameworks

The following two frameworks facilitated a comprehensive data analysis and interpretation with the goal of advancing research on the lived experiences of family physical wellness: (1) the five domains of social determinants of health (SDOH) (WHO, 2008; Healthy
People 2030, n.d.-c); and (2) Swarbrick's eight dimensions of wellness, or the wellness inventory-r (Swarbrick & Yudof, 2015).

5.2.1 Five Domains of the Social Determinants of Health (SDOH)

Among World Health Organization’s (WHO’s; WHO, 2008) five domains of social determinants of health, two domains related most to this thesis project. The current SDOH are categorized into five domains: (1) economic stability; (2) education access and quality; (3) health care access and quality; (4) neighbourhood and built environment; and (5) social and community context (Healthy People 2030, n.d.-c, see Image 1, p. 10 of this thesis). In the context of this study, two of these domains were specifically applicable. Social and community context held the most significant relevance and applications to this research, while neighbourhood and built environment had some but considerably less relevance. Participants did converse on topics pertaining to the theory’s three additional domains: economic stability, education access and quality, and health care access and quality. However, only two of the five domains were most relevant to the study and will therefore be the focus of further discussion.

5.2.1.1 Neighbourhood and Built Environment. Building on WHO’s five domains of SDOH, relevant to this thesis, the initial domain to address is “neighbourhood and built environment” (Healthy People 2030, n.d.-c). This domain is oriented towards creating spaces that encourage safety and wellness (Healthy People 2030, n.d.-a). This domain intends to ensure individuals experience improved wellness, “health and safety in the places where people are born, live, learn, work, play, worship, and age” (Healthy People 2030, n.d.-a). Within the domain of neighbourhood and built environment, approximately 29 objectives have been outlined. There were three main objectives that applied to this thesis project. Firstly, initiatives that “increase[d] the proportion of schools with policies and practices that promote health and safety” and wellness (Healthy People 2030, n.d.-a) was detailed in the objective EH-D01. Secondly, promoting active transportation, walking and biking, in adults and adolescents, was outlined in two objectives, PA-10 and PA-11 (Healthy People 2030, n.d.-a).

For the first objective, participants in this study did not elaborate on their experiences with their school environment and link the importance of having health and safety measures in place. However, a couple of participants made the intentional choice to enroll their child in outdoor school, acknowledging the positive impact of such school practices on promoting wellness, health, and safety. Forest School Canada (2014) recognizes and aligns with the
objective EH-D01. Participation in outdoor schools is associated with various potential advantages including “positive identity formation… environmentally sustainable behaviours and ecological literacy… increased frequency of visiting nature within families… healthy and safe risk taking… improved academic achievement and self-regulation…” (Forest School Canada, 2014, p.16).

In the future, it may be important for the EH-D01 objective to encompass improving homes with measures that support family health and safety. Some participants in the study remarked on residing and working in the same environment, with co-caregivers exemplifying this by working from home while simultaneously providing care and living in the same space. Notably, caregivers emphasized the direct influence of the environment on the overall mental health and wellness of the entire family. This observation is consistent with previous research that demonstrates how environments characterized by poor caregiver mental health can affect children through various mechanisms including modified or diminished caregiver-child engagement, reduced attachment in early childhood, and exposure to harsh or severe discipline (Herba et al., 2016; Pitchik et al., 2021).

5.2.1.2 Social and Community Context. This domain is characterized by a central goal, to enhance community and social supports (Healthy People 2030, n.d.-b) The aim is to ensure individuals are “get(ing) the social and community support they need” to improve their wellness (Healthy People 2030, n.d.-b). Several objectives are outlined within this theoretical framework domain. For instance, the objective DH-D01 “reduce anxiety and depression in family caregivers of people with disabilities” (Healthy People 2030, n.d.-b), aligns with the theoretical framework that enhanced social and community support is pivotal and mitigates caregiver stress and future mental health challenges. Especially in this Canadian physical wellness study, families discussed how their physical wellness was closely interconnected to their intellectual and emotional wellness. Caregivers are more likely to experience reduced feelings of isolation, burnout, and emotional strain if the buffer of social and community support is present (Blair & Perry, 2017; Day et al., 2014; Griffith, 2022; Lutz, 2010; Meyer et al., 2015; Perry et al., 2010; Vercio, 2021, Ward-Griffin et al., 2011). Similarly, AH-03, focusing on “increase(ing) the proportion of adolescents who have an adult they can talk to about serious problems” (Healthy People 2030, n.d.-b), reflects that social connectedness can serve as a protective layer against future mental health issues in the adolescent population (Peters et al., 2019). Accordingly, we understand from
This Canadian physical wellness study that having social connections and someone to talk to about emotions improves family wellness. The objectives EMC-01 and EMC-D07, centre on increasing positive communication and resilience in children and adolescents (Healthy People 2030, n.d.-b), respectively as social and community support contributes to the psychological development and strengthening of coping skills in younger populations. Correspondingly, we heard from caregivers that role-modeling and engaging in self-care was imminent in how their children perceived family cohesion and a child’s behaviours was very much linked to if mom/dad were taking care of themselves. In addition, caregivers shared that they wanted their children to receive information and role-modeling through other relationships, with grandparents, teachers, friends of the family, etc. showcasing again why it’s imminent for families to interact socially and within a community. Furthermore, HC/HIT-04, which seeks to “increase the proportion of adults who talk to friends and family about their health” (Healthy People 2030, n.d.-b) and wellness showcases that social support is a key influencer in health- and wellness-seeking behaviours.

Lastly, the objective NWS-02, aimed at “eliminat(ing) very low food security in children” (Healthy People 2030, n.d.-b), emphasizes that a supportive community can play a pivotal role in addressing fundamental socio-economic determinants impacting both a child’s and a family’s nutritional wellness. Although families were not experiencing low food security in this present study, caregivers did discuss nutritional challenges that related to their family’s physical wellness. Some caregivers identified the increasing cost of food, making some groceries inaccessible, and others mentioned the difficulty in attending to child food preferences as some families were experiencing children with picky eating food habits. While not the primary focus of this study, future research could delve deeper into the nutritional challenges experienced by Canadian families with children ages 2-8.

5.2.1.3 Other domains of consideration. Beyond the domains of neighborhood and built environment and social context and community, there exists an objective closely associated with all five SDOH domains known as health behaviors, which can be found on the Healthy People 2030 website. This objective includes several subtopics such as: health communication, nutrition and healthy eating, physical activity, and sleep. These subtopics did relate to the study as they emphasize increasing wellness literacy globally across families. Goals of Healthy People 2030 under this subtopic health behaviours, also targets improving nutrition by promoting increased
fruit and vegetable consumption while reducing added sugar intake. This is directly something the caregivers talked about, most participants specifically mentioned monitoring the amount of sugar and/or junk foods their family consumed. Additionally, efforts are directed towards encouraging physical activity among adults and adolescents, including walking or biking for transportation, and adhering to recommended screen time limits for children. Caregivers mentioned some of their main outdoor activities, such as getting out for a walk or cycling with their family. Furthermore, there is an aim to address sleep health by promoting adequate sleep duration for both adults and children. More than half of the caregivers in this study recognized sleep as the top valued dimension of family physical wellness, even more important than exercise healthy eating, and time away from TV and screens. These objectives, although falling outside the lines of neighbourhood and built environment and social and community context, are important to outline as they were discussed as relevant factors to family physical wellness within the context of this Canadian study.

5.2.2 Eight Dimensions of Wellness

Among Swarbrick’s eight dimensions of wellness (Swarbrick & Yudof, 2015), the dimensions most related to this thesis project were: physical, environmental, emotional, and social wellness.

5.2.2.1 Environmental Wellness. Environmental wellness involves being and feeling physically safe, residing in safe and clean surroundings, and being able to access clean air, food, and water” (Swarbrick & Yudof, 2015, p. 8). According to the authors, it includes both the “microenvironment (the places where we live, learn, work, etc.) and our macro-environment (our communities, country, and whole planet)” (p. 8). A term that may have been useful to use during the qualitative interview process, that Swarbrick touches on but is not explicit about, might have been human-nature connection (HNC), as suggested in Ives et al. (2017) multidisciplinary systematic review on the use of this term. HNC is used to describe “systems of meaningful relationships between mind, body, culture, and environment that can promote […] sustainable living” (Giusti, 2019, p. 19). Caregivers in this present study touched on sustainability and the meaningful connections they had within where their family was situated. The theme of environmental wellness explored in this study delves into participants' perceptions and experiences related to micro and macro environments. Participants emphasized the importance of safe and nurturing spaces, as Swarbrick and Yudof’s (2015) definition reveals, for various
activities like education, leisure, and work, highlighting the significant influence of surroundings on their wellbeing. Notably, the concept of sense of belonging emerged strongly, with participants valuing community connections for enhancing environmental wellness. The intentional selection of living spaces was another prominent aspect, with caregivers prioritizing locations that fostered both environmental and social connections. Moreover, the impact of weather on outdoor interactions was a key consideration, with caregivers acknowledging its influence on their emotional wellness and family physical wellness. Planned outdoor activities were emphasized as essential for family wellness, with caregivers making deliberate efforts to incorporate nature into their routines. This emphasis on nature is particularly noteworthy, considering research by Garbett (2020) highlighting the increasing trend of "indoor-ification" (p. 11) in childhood in North American cities, potentially undermining children's connection to nature and their sense of belonging within it. Future research could look at whether things like weather or screen time usage are real barriers or perceived barriers to outdoor physical activity. Swimming surfaced as a particularly cherished activity, symbolizing nostalgia, and offering therapeutic benefits for families. For a more in-depth discussion on the environmental wellness theme, see pages 66 – 79 in chapter four and pages 116 – 123 in this chapter. Overall, the findings underscore the intricate relationship between environmental wellness and family physical wellness, suggesting the need for further research to explore the interplay of specific wellness dimensions more in depth, particularly within the Canadian context and with diverse populations.

5.2.2.2 Physical wellness. According to Swarbrick and Yudof (2015) physical wellness “involves the maintenance of a healthy body, good physical health habits, nutrition, and exercise, and obtaining appropriate health care” (p. 4). The notion of participating in “good… health habits” such as healthy eating, exercise, getting a good night’s rest, and taking time away from TV and screens were explored in the current study and this wellness dimension, physical wellness, was one of the main themes. Caregivers mentioned that movement was a vital component of their family physical wellness, and it was also a form of emotional regulation for their families.

Furthermore, a study by Rodrigues and Machado-Rodrigues (2018) suggested that “future interventions should be family-based and focus on the promotion of higher levels of [caregiver] physical activity” (p. 159). Although the present study centred on the family and
explored caregiver physical activity along with caregivers’ reports on child physical activity and its potential impact on the overall family physical wellness, it did not explore the same age range of 6-10 years old that Rodrigues and Machado-Rodrigues (2018) did. It was also conducted in Canada rather than Portugal. The current study was also unique in that it addressed other components to physical wellness beyond just exercise, unlike the Rodrigues and Machado-Rodrigues (2018) study.

A recent systematic review conducted by Matos et al. (2021), focusing on an older age group of children than those investigated in this study, uncovered that about 78% of the reviewed studies demonstrated a significant relationship between the physical activity levels of caregivers and their children, aged 6 to 12. However, similar to what’s absent from the work of Rodrigues and Machado-Rodrigues (2018) and other studies, this systematic review fails to address whether any of these studies examined the family physical wellness dimensions which this study explored. Notably, there is no mention of the family’s relationship between screen time, sleep, exercise, and nutrition and their overall family physical wellness in the systematic review. Strong evidence demonstrated the importance of sleep to a family’s physical wellness in this study. Future research needs to advocate for additional studies that delve beyond the relationship to physical exercise.

5.2.2.3 Emotional wellness. According to Swarbrick and Yudof (2015) emotional wellness “involves the ability to express feelings, enjoy life, adjust to emotional challenges, and cope with stress and traumatic life experiences” (p. 14). However, participants in this study mostly discussed in detail emotional regulation, as it was defined as a sub subtheme in the major theme physical wellness. Discussions in further detail can be found primarily in chapter four on pages 82 – 84 as well as within some of sub subthemes that related to sleep and physical wellness. Adjusting, expressing, and coping through challenges and life’s emotional experiences indeed related to the current study. Right from the initial part of the interview, when asking caregivers to define wellness, the majority of caregivers defined wellness as taking care of their physical and emotional wellness simultaneously. As mentioned, when participants discussed their physical wellness, emotional regulation was identified as a sub subtheme. Caregivers shared participating in creative and expressive activities such as art, painting, sewing and more as a part of caregiver self-care. In the literature, caregiver emotional regulation has been found to profoundly impact child and adolescent emotional and social development (Bariola et al., 2011).
A meta-analytic study by Zimmer-Gembeck et al. (2022) examined how research in this area often delves into a caregiver’s emotionality, emotional regulation skills, and responses “to their children's emotional reactions and regulation” (p. 74). This is in direct alignment to the present study, as caregivers often commented on how there was a cyclical relationship between their child’s emotionality and their own, impacting the entire family unit. If one of the caregivers or children in the home was experiencing discomfort or emotional unwellness, it often affected the entire family's wellness, as observed in the families interviewed. Breathing exercises and outdoor play facilitated by the caregiver for the child to participate in as well as the caregiver provided family emotional regulation, positivity, and flexibility. Studies are lacking in this area of research and warrant further investigation.

5.2.2.3 Social wellness. According to Swarbrick and Yudof (2015) social wellness “involves having relationships with friends, family, and the community, and having an interest in and concern for the needs of others and humankind” (p. 12). The notion of surrounding yourself with kind individuals within your family, friends, and the larger community related to the current study. Many participants talked about their relationships outside of the family and especially advocated time spent with their child’s grandparents. They discussed the significance of scheduling time with their own friends and organizing playdates for their children to socialize, emphasizing the importance of fostering relationships. Additionally, they highlighted the importance of encouraging their partner to engage in activities with friends. Families noted the desire of connecting with their wider community, seeking additional friendships and a sense of belonging in public spaces such as the climbing gym, zoo, or other venues where they could interact with like-minded families. From the caregiver’s perspective, birthday parties and celebrations played a crucial role in their family’s social wellness. Several families noted their longing for normal social activities and opportunities during the COVID-19 restrictions. Celebrations, especially a child’s birthday, was greatly missed by some families in this study which was due to the context of living through a pandemic which is when the families were interviewed.

In a relatable American-based study, Plesko et al. (2023) explored how group-based caregiver or parent-training (PT) programs could impact and strengthen social connectedness for caregivers in low-resource settings. The authors found that focusing on the social wellness of caregivers was important to help address challenges in child rearing, enhance bonds to problem
solve together, and provide opportunities to learn and adopt new caregiving techniques. Consequently, it was found that child behavior improved and caregivers continued utilizing their training skills learned in program because of the social support they received. Plesko et al. (2023) stated that “understanding the role of SC for [caregivers] of young children is now more critical than ever as families have experienced increased social isolation throughout the pandemic” (p. 12). Plesko et al. (2023) concentrated on a specific group of caregivers, like the present study, however, only examined one dimension of wellness (social), which varied from the focus of this multi-dimensional study. Overall, these insights underscored the importance of social connections and the challenges posed, by disrupted celebrations for example, on a family’s social wellness, emphasizing the need for support and meaningful social interactions.

5.2.2.4 The Other Four Dimensions. In contrast, the four other dimensions (i.e., intellectual, occupational, spiritual, and financial) that make up Swarbrick’s eight dimensions of wellness (Swarbrick & Yudof, 2015) were not discussed by the participants in detail. This study focused on questions that were asked regarding caregiver perceptions and experiences of physical wellness in the context of play, outdoor interactions, and physical activity. The semi-structured questions in this qualitative interview prompted participants to discuss which dimensions of wellness they considered most significant, for instance. While families mentioned these additional four dimensions in some of their responses, there wasn't a dedicated emphasis or focus on intellectual, occupational, spiritual, or financial aspects of wellness. Future studies should continue to ask questions that specifically involve each of the eight dimensions of wellness.

5.2.3 Enhancing Theoretical Framework Applications: Integrating Two Additional Models

Theoretical frameworks such as Maslow's Hierarchy of Needs (Maslow, 1943) and Bronfenbrenner's Ecological Systems Theory (1979, 1986) offer valuable perspectives for understanding family physical wellness. While Maslow's theory underscores the importance of psychological needs, particularly in times of financial insecurity or unemployment, Bronfenbrenner's ecological theory emphasizes the influence of proximal family-related factors. Although not directly employed in this Canadian study, both frameworks provide avenues for exploring the interplay between caregiver perceptions and family wellness. By delving into these frameworks, future research could deepen insights into family physical wellness, enriching an understanding of overall familial wellness and resilience.
5.2.3.1 **Maslow's Hierarchy of Needs.** According to Bowen (2021), Maslow’s Hierarchy of Needs (Maslow, 1943) stands out as the most prominent and universally recognized concept in psychology worldwide. A recent exploration by Noltemeyer et al. (2021) discussed the relationship between deficiency needs and growth needs related to child academic performance with applying Maslow’s hierarchy theory (1943). The authors stated that “few have investigated the role of family and child factors which are highly related to Maslow’s love/belonging needs” (Noltemeyer et al., 2021, p. 35). This study on Canadian family physical wellness sought to investigate wellness, revealing that a sense of belonging and loving relationships, or Maslow’s love/belonging needs, are crucial factors for family wellness.

In this family physical wellness study, the caregiver population comprised of individuals with high incomes, no underemployment or unemployment, and a high level of education. Those who were stay-at-home caregivers had made this choice willingly. Noltemeyer et al. (2021) noted that a caregiver who might suddenly face unemployment may also temporarily prioritize their own emotional wellness or intellectual wellness for example, to ensure “food security for their family over personal growth” (p. 26). Changes in employment status might affect one’s psychological needs directly, as Maslow's hierarchy of needs theory (1943) explored. Financial insecurity or unemployment can create stress and anxiety, hindering one's ability to meet both basic and higher-level needs. In relation to Swarbrick’s eight wellness dimensions (Swarbrick & Yudof, 2015), being unemployed or underemployed can specifically impact one’s occupational and financial wellness, significantly influencing both caregiver and family wellness. Swarbrick and Yudof’s (2015) eight dimensions of wellness at first glance might be a better fit exploring different aspects of psychological needs. However, a discussion of one’s deficiency and growth needs, as Maslow’s theory (1943) investigated, would deepen the understanding of how caregivers perceive and experience their family physical wellness. Even though the study did not utilize Maslow’s theory (1943) as a foundational framework, it would be interesting to apply this framework in the future. Incorporating specific elements of Maslow’s theory (1943) could enhance future investigations into physical family wellness.

5.2.3.2 **Bronfenbrenner's Ecological Systems Theory.** Bronfenbrenner's bioecological model theory of human development (1979, 1986) and Swarbrick's eight dimensions of wellness (Swarbrick & Yudof, 2015) are both theoretical frameworks used to understand human development and wellness, but they differ in focus and scope. Although this Canadian family
physical wellness study may have benefited from encompassing Bronfenbrenner's ecological theory (1979, 1986), it did not employ this theoretical framework. Additionally, a multitude of studies, before this one, have used this theoretical framework including a recent meta-analysis investigating the protective and risk factors for antisocial behavior among youth (Gubels & van der Put, 2023). The authors, in line with previous researchers utilizing Bronfenbrenner’s ecological theory, revealed that child development is influenced by various social ecological systems surrounding the child. Gubels and van der Put (2023) included that children are more influenced by Bronfenbrenner’s proximal factors, than distal social systems, such as “family, peers, and the school environment (microsystem), the extended family (exosystem), and the culture, laws, and social-political conditions (macrosystem)” (p. 234) and stated, “that family-related factors were most protective” (p. 235). This very much related to the present Canadian family physical wellness study and could have been used as an overlay. For example, caregivers discussed the significance of factors such as proximity to schools and grandparents, underscoring how their micro- and exo- systems influenced where they wished to reside.

Both Swarbrick (Swarbrick & Yudof, 2015) and Bronfenbrenner (1979, 1986) emphasized the multifaceted and holistic impact of specific external aspects are massively influential to an individual. This study expands upon this exploration by placing a group of individuals, the family unit, at the focal point. The frameworks differ in that Bronfenbrenner’s theory (1979, 1986) was focused around a five-dimensional framework, highlighting human development and the impact of an individual’s environment across a lifetime. In contrast, Swarbrick (Swarbrick & Yudof, 2015) presented an eight-dimensional framework that promoted wellness in the present moment. There was some overlap between the two frameworks. For example, the exploration of connections to structured spiritual organizations, which Bronfenbrenner (1979, 1986) investigated, also aligns with Swarbrick's spiritual dimension (Swarbrick & Yudof, 2015). Future studies of Canadian family physical wellness could be strengthened if they choose to also explore spiritual wellness in different ways. Another similarity between the two frameworks was within environmental aspects. Swarbrick (Swarbrick & Yudof, 2015) defined environmental wellness using the terms micro- and macro- environment which is linked to two of the four layers of influence that Bronfenbrenner’s (1979, 1986) ecological model discussed. In summary, while both frameworks acknowledge how an
individuals' wellness is influenced, a deeper exploration of how Bronfenbrenner’s theory (1979, 1986) could be applied in the future is needed.
5.3 Strengths and Limitations

5.3.1 Strengths of Current Study

The current study exhibits several strengths that distinguish it within the field of family wellness research. First, the study benefited from rich, qualitative data gathered from a large sample of 19 participants across Canada, allowing for exploration of perspectives, experiences, beliefs, and feelings related to family wellness across many participants.

Second, there is minimal research that explores Canadian family physical wellness, specifically from the perspective of caregivers (Carroll et al., 2020; Charnock et al., 2021; Jansen et al., 2021; Pyper et al., 2016). This study may represent one of the first attempts in investigating the multi-dimensional complexity of family physical wellness from the perspective of the caregiver, especially utilizing Swarbrick and Yudof’s (2015) eight-dimensional wellness model. For example, Pyper et al. (2016) conducted a Canadian quantitative research study and probed the impact of caregiver physical wellness behaviours (screen time, physical activity, and healthy eating) on child wellness. Pyper and colleagues (2016) did not focus a discussion on sleep and only addressed child wellness. Moreover, their study did not provide detailed insights into caregivers' own perceptions and experiences regarding physical wellness or their family’s experiences. Charnock et al. (2021) focused on the wellness of Canadian peoples one year into the COVID-19 pandemic and touched on the work-life balance of caregivers. Their study demonstrated that over three quarters of caregivers surveyed were feeling extremely worried about how to balance, work, schooling, and childcare (Charnock et al., 2021). In parallel with Pyper et al.'s (2016) discussion, their review also failed to incorporate caregivers' perceptions on personal and family physical wellness. Concordant with Charnock et al. (2021), Carroll and team (2020) explored in their mixed methods study the influence that the COVID-19 pandemic had on healthful behaviours, such “eating patterns, physical activity, sleep, and screen time, among families with young children” (p. 2), as well as the relationship of wellness to financial security and stress. Carroll et al.’s (2020) research was Canadian, had participants from middle to high income families. It explored some caregiver perceptions of all four physical wellness dimensions utilized in this current study. Carroll et al. (2020) does not include an in-depth discussion on personal or family physical wellness perceptions and experiences from the perspective of the caregiver. These three studies discussed, and research within the realm of family wellness, clarifies the significant influence Canadian caregivers have on a child’s wellness, inclusive of
their screen time usage, healthy eating, physical activity, and sleep. Caregiver wellness, however, is a perspective that is consistently overlooked in existing literature as caregivers typically report on child wellness (Carroll et al., 2020; Charnock et al., 2021; Columna et al., 2017; Gayatri & Puspitasari, 2023; Jansen et al., 2021; Linville et al., 2018; López-Aymes et al., 2021; Pyper et al., 2016; Thompson et al., 2010; Zovko et al., 2021). Jansen et al. (2021) explored how American families experienced all four dimensions of physical wellness, including the three identified by Pyper et al. (2016) as well as sleep. Jansen et al.'s (2021) research demonstrated that caregiver wellness can impact child wellness. However, their research focus was primarily on caregiver stress and its association with food caregiving practices (Jansen et al., 2021). The perspective of caregiver wellness itself is often unobserved when examining child or family wellness. This Canadian family physical wellness study looked at the relationship specifically and although, Jansen et al. (2021) discussed the importance of this relationship, most studies appear like they might discuss caregiver wellness but focus more on the impact of child wellness. Child wellness is part of family wellness and not only is that a finding consistent with the present study but also with previous literature that explores caregiver perceptions of child’s wellness (Columna et al., 2017; Gayatri & Puspitasari, 2023; Jansen et al., 2021; Linville et al., 2018; López-Aymes et al., 2021; Pyper et al., 2016; Thompson et al., 2010; Zovko et al., 2021).

Most commonly the research does not take place in Canada and focuses on caregiver role-modeling behaviours (Kaseva, 2017; Moreno, 2011; Schoeppe, 2016; Yang et al. 1996), caregiver perspectives on a specific intervention program (Craig et al., 2013; Haines et al., 2018; Hennessy et al., 2020; Nelson & Laurenendeau, 2001; Prilleltensky, et al., 2001; Wilhite et al., 2012), caregivers supporting vulnerable populations with children needing additional care (Coologhan, 2017; Keville et al. 2021), or focus on obesity-prevention/weight maintenance and reduction (O’Kane et al., 2017; Po'e et al., 2013; Uijtdewilligen, 2017; Zhao et al., 2013). Furthermore, this study supports previous research findings indicating that physical activity can serve as a coping strategy among populations characterized by higher socio-economic status, higher educational achievements, and younger age (Cairney et al., 2014; Guy Faulkner, 2021)

As a third limitation, it is important to acknowledge that only one of the four physical wellness dimensions, named in this study, are explored at one time. For example, an American research team, Pratt et al. (2017), examined mother’s perspectives of physical activity, asking about the obstacles families face when in engaging in family physical activity, as well as
nutrition, and feeding dynamics for pre-school aged children (ages 2-5). Several researchers have examined family physical activity (Barnett & Chick, 1986; Burdette, 2004; Gordon, 2018; Jago et al., 2014; Kaseva, 2017; Myrhaug & Østensjø, 2014; Rhodes et al., 2020; Wilk et al., 2018) and/or family eating habits (Dwyer et al., 2008; Lindsay et al., 2021; McMinn et al., 2013; Neumark-Sztainer et al. 2000; Pratt et al., 2017; Zhao et al., 2013) in their studies. Additionally, the link between physical activity and the prevention of obesity in families is commonly researched (Burdette et al., 2004; Haines, et al., 2018; Hennessy et al., 2020; Mehdizadeh et al. 2020; Moreno et al., 2011; O’Kane et al., 2017; Po'e, et al., 2013; Pratt et al., 2017; Uijtdewilligen, 2017).

Fourth, the current study highlighted the significance of physical activity habits, routines, and the language participants used regarding their overall caregiver physical wellness, providing valuable insight into how these factors contributed to overall family wellness. Caregiver perceptions of caregiver engagement with these wellness behaviors was addressed in this study and not in others, highlighting a potential gap in research. From this current study, caregivers discussed how their personal wellness might have been strong and their family’s wellness was lagging, and vice versa. In some cases, both caregiver and family wellness were flourishing, while in others they both experienced challenges to wellness simultaneously. By focusing on caregivers as representatives of the family unit, this study acknowledges the complexity and multi-dimensionality of family physical wellness. Finally, a recurring gap was potentially identified in Canadian literature regarding this research topic. While the primary focus of this research was on family wellness, this investigation highlighted a close relationship between family wellness and caregiver wellness. Caregivers discussed about how important it was for them to consider their own personal wellness and how it is interconnected to family wellness. This approach of investigating how caregivers perceive and understand their physical wellness (research question), both on an individual level and in relation to their family's wellness, holds potential significance. Future research should examine the relationships between caregiver wellness and family wellness because the findings from this study pointed to a strong relationship between caregiver and family wellness. In summary, these strengths potentially contribute to the advancement of family wellness research.
5.3.2 Limitations of Current Study

Recognizing the strengths of the current study, it is also essential to acknowledge the potential limitations. One notable limitation pertained to the selection of the participants and their characteristics. Despite having a relatively large sample size for qualitative research, the sample was homogenous, and individuals were primarily well educated, professional, and employed. For example, seven of the 19 participants in this study possessed an advanced educational background, with 13 participants possessing degrees at the undergraduate degree level or higher. Moreover, there was a prevalence of individuals with an elevated socioeconomic status, as indicated by 15 participants reporting their family household income was $100,000 and above. Furthermore, a significant portion of the participants had occupational backgrounds focusing on counselling or wellness. For example, the ability to send children to a forest school or choose specific, desired neighbourhoods to reside in may not be possible for some caregivers due to financial constraints.

Secondly, this sample did not include families from lower income or education brackets, (as seen in Figure 4.1 Participants). Moreover, there were no recent immigrants to Canada, although a subset of three families identified recently moving provinces and were experiencing a new location. Additionally, it is important to note that demographic information such as ethnic background was not gathered; thus, none of the individuals in the sample identified as Indigenous. Not providing detailed demographic information could potentially be limiting because the study might miss capturing the perceptions and experiences of marginalized or underrepresented families, potentially narrowing the understanding of family physical wellness in Canada.

A third limitation is related to the geographical distribution of participants. While the study included individuals from five provinces, a notable concentration emerged with 11 participants residing in Alberta. This geographical skew raises the prospect of a provincial bias, particularly considering the study occurred during the COVID-19 pandemic, at a time when provinces implemented varied restrictions nation-wide. These differing restrictions meant that some participants had the opportunity to engage in certain activities such as dance, swimming, or skating lessons, while others did not. This variation in available activities may have influenced participants' perceptions and responses regarding the level of activity or inactivity within their families at the time of the interviews. As a result, the findings may only be representative of one
province over others and should be interpreted with consideration of this geographical concentration and the associated pandemic-related disparities.

Fourth, recruitment was conducted using snow-ball sampling, wherein the procedure encourages initial participants to recruit friends. However, this method likely limited the diversity of the sample, as it was dependent on existing social connections. Additionally, since recruitment was conducted over social media and technology channels such as email, the study might have overlooked individuals without access to a computer and smartphone, thus potentially excluding certain demographics from participation (i.e. families who don’t access social media or computers by choice or by financial constraints). Additionally, future studies could promote participation in alternative, non-technological/virtual spaces (such as schools, daycares or day homes, community, or extracurricular programs like soccer teams, etc.).

In my capacity as a novice interviewer, I employed a semi-structured interview approach. I acknowledge the possibility of posing leading questions or swaying participants’ responses potentially contributing to bias. The adherence to a semi-structured interview format led to occasional lapses in asking certain questions which created a unique dataset (i.e. questions were not asked due to running out of time). While this individualized approach initially could be perceived as a strength, it resulted in a collection of specific responses that may have added a layer of difficulty in linking themes together. Despite my efforts to maintain a 30-minute timeframe for each participant interview, sessions consistently exceeded this limit, and instead typically lasted between 30 to 45 minutes in length. The time variations might have restricted participants’ responses as I might have redirected participants prematurely, fragmenting their answers. For instance, asking participants to describe their living situation might have prompted a detailed discussion in some interviews, including follow-up questions such as proximity to amenities or the quality of neighborhood relationships. However, due to timing constraints, this level of detail may have been missing from other interviews. These discrepancies, alongside disruptions in the interview flow, may have contributed to interviews being either brief or prolonged.

Another notable limitation of this research was the dynamic nature of wellness definitions. Over the duration of the study, a shift occurred in the conceptualization of wellness. This is exemplified by organizations like the World Health Organization (WHO) whose explicit recognition of wellness was discontinued, and the term wellbeing started being embraced instead
in 2023 (Smith et al., 2006; WHO, 2021). This evolution within the literature landscape had a
direct impact on how research questions were framed and constructed. For instance, had the term
*wellbeing* been employed earlier, the research inquiry would have explored *caregiver wellbeing*
and *family physical wellbeing*, thus prompting a modification in search criteria. Acknowledging
and addressing this limitation becomes crucial in accurately situating the findings within the
broader context of the ever-changing discourse on *wellness, health, and wellbeing* (Carter &
Anderson 2023; Corbin & Pangrazi, 2001; Holdsworth, 2019; Larson, 1999; McCallum & Price,
2016).

5.4 Short-Term and Long-Term Implications

The aim of this study was to explore Canadian caregivers’ experiences and perceptions of
family physical wellness and how wellness related to outdoor interactions, play, and physical
activity. In the short term, families may have experienced an immediate impact, as many
participants highlighted the importance of having a space to discuss wellness during their
qualitative interviews. Building an awareness of how caregivers perceive and experience
wellness, both for themselves and their family members, including their spouses and children,
could be beneficial. For example, a few participants mentioned that they could be doing more
primarily in the way of supporting their own wellness (i.e. caregiver wellness) but also in support
of their family’s wellness. Caregivers also shared that when they are experiencing an increased
wellness state, they have capacity to care for their family’s wellness. Findings like these can
contribute to our limited comprehension of how Canadian caregivers perceive and experience
family physical wellness. By focusing on family physical wellness from the perspective of the
caregiver, caregivers might begin to prioritize self-care and stress management strategies more
regularly in the short term. This shift in emphasis could lead to reduced stress and contribute to a
more balanced caregiving experience. The short-term implications encompass a spectrum of
immediate effects and demonstrates the value of working with families to address their physical
wellness. It also exemplifies the need to further study family physical wellness from the
caregiver’s perspective.

There are long-term implications to consider as well regarding family physical wellness.
For example, sustained efforts to improve and become more wellness-aware could occur leading
to a more broadened understanding of how to support a family’s physical wellness across
Canada. Caregivers who are integrating and adopting a focus on family physical wellness could
impact their children and spouse who in turn could impact their communities at present and influencing future generations. Participants reviewed their family's interaction and perception of family physical wellness in a new way, related to four research-supported dimensions of wellness: exercise, time away from TV and screens, eating healthy foods, and exercise (Jansen et al., 2021). As well, Swarbrick (2010) sought to define the dimensions of physical wellness as six important dimensions: “physical activity, sleep and rest, relaxation and stress management, eating well, habits and routines, and access to health screenings" (p. 2). This would suggest that caregivers could relate to family physical wellness within the scope of at minimum four dimensions of physical wellness. Thus, the aim would be to provide more opportunities for families to consider, reflect on, and assess their wellness as a whole unit, ultimately impacting the broader community.

At an institutional level, the ripple effect of deepening a community’s understanding of family physical wellness could reach educational practices as well. Educators might also begin to understand how to support families better and could work in a more thorough collaboration with caregivers to provide more physical wellness opportunities at an educational level. Schools, school divisions, and provincial educational authorities might begin to incorporate more comprehensive wellness education into their school curriculum. Schools could enhance education in supporting both caregivers and their children, acting more as a liaison for caregivers to have conversations with their children from a young age on how to care for their eight dimensions of wellness as well as their four dimensions of physical wellness. Reflective questions could be part of weekly conversations. Promoting activities that incorporate positive and effective communication around family physical wellness is critical. Building on what families do at home, finding ways to support their home activities and link them to school activities would help facilitate the deepened understanding of family physical wellness.

The discussion also sheds light on the importance of cross-cultural communication and acquiring knowledge on how families from all backgrounds connect to their family physical wellness. Some integration of understanding how to address caregiver unwellness or caregiver burnout for example could be integrated into healthcare policies. Health professionals receiving a regular snapshot of family physical wellness, how families are eating, sleeping, exercising, and turning off screens, could be very supportive to the caregiver. Monitoring and managing family physical wellness over time could also lead to more societal support (reword sentence, might be
vague). Ongoing studies could further refine how we can support family physical wellness and lead to more future research.

5.4.3 Implications for Model Development

The model employed in this Canadian family physical wellness study explored eight dimensions of wellness: physical, emotional, social, spiritual, intellectual, environmental, financial, and occupational wellness (Swarbrick & Yudof, 2015).

5.4.3.1 Identifying dimensions of wellness. Another model that could have been used, but hasn’t been well-researched to date, is Melnyk and Neale’s (2018) nine dimensions of wellness. Both Melnyk and Neale’s (2018) nine dimensions of wellness and Swarbrick and Yudof's (2015) 8 dimensions of wellness exhibit similarities in their emphasis on comprehensive, multi-faceted wellness but differ slightly in their specific dimensions. For example, Melnyk and Neale's (2018) career wellness aligns with Swarbrick and Yudof's (2015) occupational wellness but is labeled differently. While both models emphasize various aspects of wellness, Melnyk and Neale's (2018) wellness model expands on Swarbrick and Yudof's (2015) work by incorporating creative wellness as an additional ninth dimension. Caregivers participating in this study on family physical wellness could have found value in incorporating Melnyk and Neale's (2018) model, particularly inquiring about creative wellness, which involves engaging in diverse cultural and artistic pursuits. Many caregivers in the study referenced activities falling within this creative wellness dimension, such as visiting museums or engaging in painting and dancing together at home. Moreover, the creative wellness dimension outlined in Melnyk and Neale's (2018) model emphasizes steering clear of self-criticism and following a life aligned with perfectionism. Similarly, caregivers in this study expressed similar sentiments regarding self-care, striving to embrace life and avoid succumbing to societal pressures, such as striving for perfection often portrayed on social media platforms like Instagram.

Unfortunately, no wellness model to date has captured family physical wellness from the perspective of the caregiver. While Melnyk and Neale (2018) proposed a nine-dimensional model, there is a lack of published literature utilizing it. Since the literature review in Chapter 2 of this thesis, several models have become available. One example is the Northern Kentucky University’s (n.d.) model, emphasizing 10 dimensions of wellness. This university seemed to utilize Swarbrick and Yudof’s (2015) model of eight dimensions (emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual) as a foundation but expanded
their work to include cultural and digital wellness. The current study on family physical wellness does investigate digital wellness, which is discussed as a sub subtheme within the broader major theme of physical wellness. Another example includes a Canadian university's faculty of engineering (Waterloo University, n.d.) who has shared a nine-dimensional model of wellness on their website, further building upon Swarbrick and Yudof's (2015) model. While six dimensions remain consistent with Swarbrick and Yudof's (2015) original eight dimensions (physical, intellectual, emotional, spiritual, financial, environmental), two have been revised: social wellness to relational wellness and occupational wellness to vocational wellness. Additionally, cultural wellness has been added as a new dimension to their model (Waterloo University, n.d.).

Caregivers in this study could find value in enhancing their relational wellness, as described in Waterloo University's (n.d.) model. This dimension embraces effective communication, fostering intimacy and connection, cultivating teamwork, nurturing relationships, and establishing support networks, which are part of the conversation in this study.

Two more Canadian universities, University of Victoria and Ontario Tech University, have posted on their health and wellness websites dimensions of wellness models that include seven dimensions of wellness. Both universities seem to model after Swarbrick and Yudof’s (2015) dimensions of wellness and include much of the same dimensions. Nevertheless, some distinctions exist. For instance, Ontario Tech University (n.d.) includes physical, mental, social, environmental, vocational, financial, and spiritual dimensions in their wellness model. This differs from Swarbrick and Yudof’s (2015) model by combining emotional and intellectual aspects into one dimension labeled mental and changing occupational to vocational wellness. Additionally, Victoria University (n.d.) includes emotional, financial, environmental, spiritual, academic and career, social and cultural, and physical dimensions in its model. Here, occupational is combined into academic and career wellness, spiritual wellness is omitted, and cultural is added to social wellness compared to Swarbrick and Yudof's (2015) model. However, no publications or research utilize any of these example models.

Although an eight-dimensional model was utilized in the present study, the families interviewed highlighted that there were three dimensions paramount to family wellness, each family noting a different variation of the top three. Nonetheless, eight caregivers emphasized the emotional dimension as the most important dimension, when listing the three top important dimensions for their family wellness. Furthermore, there was minimal emphasis on the financial
or occupational dimensions of wellness, as none of the follow-up questions in the pre-interview specifically addressed financial or occupational implications. Future investigations could adopt one of two approaches when interviewing families regarding their physical wellness: 1) delve more deeply into the eight or nine dimensions with families, or 2) examine a caregiver's experiences and perceptions concerning the three dimensions that developed as the most prominent in this study: emotional, physical, and environmental wellness.

5.4.3.2 Defining metrics. Establishing criteria for each singular wellness dimension, either the eight that Swarbrick and Yudof (2015) outlined or based on the other models discussed in the above section, is critical. Future research needs to develop metrics (i.e. self-report surveys, etc.) that are observable, quantifiable, and reliable. To potentially advance research on caregiver perceptions and experiences of family physical wellness, there is a need to adopt, adapt, or construct a suitable model, as currently one does not exist. Bart et al. (2018) did not discuss Swarbrick and Yudof’s eight-dimensional wellness model. However, Bart and colleagues (2018) suggested that in terms of currently available tools, “there is room for improvement and for creation of a more accurate, shorter, and more encompassing assessment” (p. 18). In this study, participants noted an additional dimension of wellness, relationship wellness, not described in Swarbrick’s original eight dimensions (Swarbrick & Yudof, 2015) was important to consider. Following the development of a revised model, relevant questions can be formulated or adapted from existing tools, leading to the creation of a self-report survey instrument that is effective in evaluating caregivers' perceptions, experiences, and understanding of family physical wellness.

5.4.3.3 Context. There are likely contextual factors to consider such as socio-economic status or, as Fujishiro (2010) explained it, one’s occupational status, educational attainment, income, and social status or prestige within society. The 19 families were middle to high income earners as well as obtained higher education. Unfortunately, information on one’s cultural or ethnic identity was not gathered. Environmental factors encompassing stress levels experienced both at work and home, as well as varying communication styles and shared roles and responsibilities among caregivers and families were not considered strongly and should be examined in future research. Many families reported that there was equal distribution and division of caregiving duties, no primary caregiver was identified. Additionally, there needs to be investigation on the availability of childcare options, such as daycare and grandparents or friends, along with access to support services and resources. This study briefly touched upon the
availability of counselling services to families, although a thorough exploration was lacking and could be part of future research. Additionally, further exploration of options like family wellness counselling could be pursued. Contextual factors imply considerations for future model development in family physical wellness.

Selecting an appropriate assessment tool, whether it's a survey, wheel, diagram, or questionnaire, poses a challenge due to the lack of clarity regarding valid wellness instruments historically (Das, 2015; Roscoe, 2009). After spending time researching the literature, there were no identifiable existing wellness instruments that were specifically designed to assess family wellness comprehensively. This gap highlights the necessity in developing new assessment tools tailored to evaluate the multifaceted dimensions of family wellness accurately, subsequently extending to the evaluation of family physical wellness.

5.5 Directions for Future Research

Future research should focus on developing an instrument for family physical wellness. Developing a standardized measurement for family wellness aspects, such as physical wellness, play, and self-care, will be quite challenging due to their intertwined nature and the diverse dimensions that they encompass. They cannot be discussed separately and most of the wellness dimensions are not mutually exclusive. For instance, play and self-care could be equally as important as physical wellness based on the findings of the thematic analysis in this study.

Considering the outcomes of this study and the implications detailed in the section on model development (page 27 of this thesis), a comprehensive 10-dimensional framework capturing caregiver perceptions of family physical wellness might be most sustainable. This model would encompass Swarbrick and Yudof’s (2015) eight dimensions of wellness: emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual, along with two supplementary dimensions: relational wellness (as drawn from Waterloo University’s (n.d.) model) and creative wellness (taken from Melnyk and Neale’s (2018) model). These models have not been researched and therefore, it is essential to conduct validity testing before implementation. Since caregivers in this current study recognized the importance of three main dimensions of wellness: emotional, physical, and environmental wellness, subscales with items pertaining to each of the three top valued dimensions of wellness would be necessary to include as well.
With participants being predominantly middle-class, suburban, and highly educated, achieving a more representative and diverse sample becomes crucial. The absence of representation from diverse populations, such as families with varying abilities as explored in previous family wellness research (Gordon, 2018; Ku et al., 2022; Lee et al., 2021; Po'e et al., 2013) highlights a significant gap. Further research with children in a different age range (9-12 for example) or including the report of adolescents on family physical wellness (age range 13-17) could benefit the study based on having more engagement and willing participation in the interview process as well.

Expanding beyond Alberta to encompass Canada-wide participation would provide a more comprehensive examination into family wellness, as well as investigating urban-rural and northern differentials. Employment and educational attainment were possible sources of bias in this study as well, with individuals interviewed from the field of counselling who would have been familiar with concepts of wellness. Inclusion across various socioeconomic, age, education, employment backgrounds and geographical settings must be carried out in future research studies. A potential avenue for future research could explore regional preferences for outdoor recreational activities, such as visits to lakes or mountains. This could involve investigating whether geographical location within Canada influences individuals' or families’ inclinations towards specific natural landscapes. In this study, observations suggest that residents of provinces like Saskatchewan or Ontario expressed preferences for mountain destinations. Incorporating indigenous perspectives and consultation with indigenous communities, perhaps through frameworks like the medicine wheel (including four dimensions of wellness: physical, emotional, mental, and spiritual) or Traditional Ecological Knowledge (TEK), focusing on the interconnectedness of environmental wellness, remains imperative within the Canadian context (Wilson, 2003).

Regarding environmental wellness, it’s worth noting that while the theoretical frameworks employed in this study did not explicitly address weather, they both discussed the significance of reducing health and safety risks to enhance overall wellness. While for some families, weather posed obstacles to wellness, others leveraged the weather to enhance their family’s wellness and resiliency. Future research can continue exploring the relationship between the impact of weather and family physical wellness.

Acknowledging the distinct needs of caregivers compared to the entire family illuminates the multi-dimensional nature of any suggested instrument in assessing family wellness from the
caregiver's experience and perception. Subsequent research should prioritize examining caregiver wellness, followed by family wellness assessed through caregiver proxy. Considering both perspectives in a survey to correlate the two is crucial. While for some individuals, caregiver wellness aligns seamlessly with family wellness, in other instances, particularly among mothers, their own wellness may not receive as much attention as their family’s wellness. The participants in this study, particularly a subset of mothers with counseling backgrounds, exhibited reflective awareness. However, the experiences reported by other women may differ based on their positionality and employment status. Although family physical wellness is complex and multi-dimensional, addressing these considerations offers promising avenues for advancing research in this field.

5.6 Conclusions

In conclusion, family wellness is complex and multi-dimensional. This qualitative study investigated caregivers’ perceptions and experiences of family physical wellness in the context of play, outdoor interactions, and physical activity in relation to two theoretical frameworks Swarbrick and Yudof’s (2015) eight dimensions of wellness and the five domains of the social determinants of health (SDOH) (WHO, 2008; Healthy People 2030, n.d.-c). The findings from this study revealed four significant outcomes. First, caregivers expressed the significance of belonging, living in an intentional place, and being able to access supportive environments. They highlighted the influence of weather on their family’s activity and overall physical wellness. Moreover, outdoor activities were illuminated as crucial for environmental, social, and emotional wellness. The activity of swimming arose as an important aspect of family wellness for 12 of the 19 families, indicating the significance of a connection to water environments among Canadian caregivers. Second, caregivers shared their experiences and understanding of the four dimensions of physical wellness: exercise, healthy eating, time away from TV and screens, and sleep. Families reported that their top physical wellness dimension was sleep and described sleep as foundational impacting every other dimension of wellness. Most participants felt that it was the most controllable and variable dimension of the four physical wellness dimensions. Exercise included formal and informal activities. Regarding healthy eating, caregivers recognized a strong association between food and how the body feels. A few caregivers discussed selective eating as well as the financial implications to eating well. For screen and TV time, caregivers seemed to prioritize and consciously pursue a balance between screen time, physical activity, and spending
As a potential future direction, it would be valuable to delve deeper into participants' perceptions and experiences of family wellness, particularly regarding sleep. Despite participants highlighting sleep and physical wellness as crucial throughout the interviews, caregiver rankings of wellness components varied, with social, emotional, and financial wellness often taking precedence. Notably, some caregivers did not prioritize physical wellness within their top three rankings. This observation suggests the need for further investigation into the factors influencing a caregiver’s prioritization of different dimensions of wellness. Third, caregivers revealed that play serves a fundamental role in their family’s learning and in the way they connect socially with each other and other families. It is also integrated into both their outdoor activities and daily routines at home as a family. While most caregivers detailed rediscovering play as a means of self-exploration, embracing play can be a way to promote reconnection and active engagement with their children’s play experiences. Lastly, caregivers expressed external pressures to excel as or conform to an idealized version of wellness beyond their current state. Many pointed out I should statements regarding their physical activity level or their perceptions and experiences of family physical wellness. As an antidote to this changing landscape caregivers are facing, many caregivers touched on the metaphor of a cup, an individual cannot support someone else effectively if their own cup is empty. Caregivers highlighted the importance of self-care, advocating for me time, and doing activities that bring joy and fulfill personal wellness as essential in fostering family physical wellness. Within the findings of this study, strategies can be integrated into daily life to enhance family physical wellness. It is critical for caregivers, educators, and other stakeholders to recognize that consistent implementation of these strategies will effectively promote family physical wellness, resulting in wellness across the greater community and one’s life span.
Appendix A: Informed Consent

The University of Winnipeg

Study: Evaluating Parental Engagement & Use of Early Learning and Support Strategies in the Home

Information Letter and Informed Consent
You are invited to participate in a study about learning activities for children developed by Dr. Sheri-Lynn Skwarchuk of the University of Winnipeg. These fast and fun activities are intended to encourage caregivers to play with their child(ren) using games related to numbers and letters. Wellness activities are designed to promote health and wellness. The purpose of the project is to invite you to be a ToyBox Tester; testers help us learn what is working in the project. We want to understand how best to reach caregivers, what activities they prefer, what they want to know, how their children enjoy the activities, and how the activities encourage family involvement.

What will you be asked to do? ToyBox Friends help by providing input on how we develop the TOYBOX project. We will ask you to complete the consent form, an activity survey and a wellness survey. We will also invite you to complete a 30 minute one-on-one interview before we send you the TOYBOX strategies, and then another 30 minute one-on-one interview after the study is complete. The interview will be about the wellness and education activities you do in your home, and how using TOYBOX materials can fit into existing lifestyles. We would like you to do these two interviews whether you complete all of the TOYBOX strategies or not. We want to know what people like about the strategies and what can be improved.

Beginning on 31 January 2022, you will receive three ToyBox strategies every week for six weeks. At the end of each week, you will be asked to answer a very short survey (less than 5 minutes) about the strategies you received (i.e., how often did you try them, did you enjoy using them etc.). You chose how to receive the survey (phone call, text, or email). At the end of the project, you will be asked to complete one additional survey that asks you more generally about the program (e.g., were the strategies too easy, too hard, too many? etc.). This final survey will take 10 minutes to complete.

Will I get paid? Every time you report on a strategy, your name will be entered in a draw for one of three $50 gift cards. The draws will be held at the end of Weeks 2, 4, and 6. Your odds of winning depend on the number of responses we receive. In addition to the draw, to thank you for your time, you will receive a $25 gift card (one-time payment) for your participation as a TOYBOX FRIEND.

How will by information be used? The data we collect from this study may be presented at conferences and written up for publication in an academic journal. Only group data will be used in the final analysis, no identifying information will be linked to the data. Any identifying information you do provide (e.g., email addresses) will be destroyed after the study is completed. Data collected from the project will be stored for a minimum of 5 years in a
locked research office. When the data is no longer needed for research purposes, it will be destroyed.

**Are there risks?** The study has no known risks; but does have the potential to create personal positive change. However, you may stop participating at any point without penalty. To withdraw from the study and to have any data you have provided destroyed contact Sheri-Lynn Skwarchuk.

The University of Winnipeg Human Research Ethics Board has granted permission for the researcher to request your participation in this study. Participation is completely voluntary, will be kept strictly confidential, and your name will not be associated with the data. If a caregiver chooses not to participate, there will be no impact on their ongoing relationship in any school program.

If you have concerns, I can be reached at (204)-804-1793 or s.skwarchuk@uwinnipeg.ca. You may contact the Ethics Board Officer at (204)-786-9058, ethics@uwinnipeg.ca.

=============KEEP THIS PAGE FOR YOUR RECORDS=================

**Consent Form**

I have read and understand the request to participate in the ToyBox Manitoba study. I understand that I will be asked to complete two surveys, and 18 activities to try with my child. I will be asked to participate in two interviews (one at the start and one at the end of the study, using a university authorized zoom platform or via phone conversation). I will be asked to rate the activities. At the end of the study, I will be asked to complete an exit survey assessing the program. I do not need to do all the activities or surveys. My name will be entered into a draw for one of three $50 gift cards each time I rate an activity. I will also receive a one-time $25 thank you gift card when I submit the exit survey.

☐ Yes, I agree to participate
☐ Yes, I agree to have the interview audiotaped (via phone) or video-recorded (via zoom)
☐ No, I do not agree to participate
☐ Yes, I am interested in participating in follow up studies/interviews with TOYBOX

Please indicate how you would like to receive the weekly surveys and then enter the applicable contact information. Choose one only:

☐ Email: Please enter your email address ______________________________
☐ Text. Please enter your number for texting ____________________________
☐ Phone. Please enter your phone number ______________________________
Although we recommend doing these activities with all your children, for this study we can only collect information about one child. Please give us some more information about yourself and the child who will do the activities:

Your Name (please print): __________________________________
Current Date: (MM/DD/YYYY): _____________________________
Relationship to child (mother, father, etc): ___________________________
Highest level of education : ______________________________________
Postal code/zip code: ___________________________________
Age of child participating: ____________________________
Gender of child participating (optional): _________________
Language(s) spoken at home: ___________________________
Thank you for your help with our project!
For more information on our project, see: www.toyboxmanitoba.ca

Sheri-Lynn Skwarchuk, PhD
Professor Faculty of Education, University of Winnipeg, MB, s.skwarchuk@uwinnipeg.ca
Appendix B: Pre-Interview Questions

BEFORE TOYBOX STRATEGIES PRE-INTERVIEW QUESTIONS

To read at the beginning:

Thank-you for agreeing to participate in this interview. My name is Britt and Madison is participating in the background taking notes in case the technology fails us. We are both Master’s students. I am a Masters of Educational Psychology student at the University of Saskatchewan and my thesis is on wellness and how wellness fits into everyday life. Madison is a Counselling Psychology Masters student at Yorkville University.

We are both research assistants for the Toybox project. Some of the research questions that we are trying to answer with this study are: (1) knowing how to increase the ratings for our wellness activities (2) we want to know what kind of wellness ideas to focus on given that there are 8 dimensions, (3) should our strategies focus on the person’s wellness or family wellness? (4) How does wellness in our study relate to conceptual and theoretical underpinnings of wellness.

We estimate this interview or conversation will take about 30 minutes. Please know there are no right or wrong answers. We are just interested in knowing your opinion. Do you have any questions? If not, let’s get started with a few questions about you and your family...

- What are the names and ages of your child(ren)?
  - Which child have you decided to focus on for the ToyBox study?

- Tell us about where you live.
  - Can also ask follow-up questions depending on their response such as What city and province do you live in? What does a typical weekend look like? Does the weather of where you live affect your wellness?

- Which caregiver will be the one completing the weekly wellness strategies with your child?
  - Can follow-up with Are you the one who is most involved with the activities of your child(ren)

- How many adults live in the home with you?

- Do you work outside the home? If so, what do you do for employment?
  - And depending on how many adults are in the home, can follow-up with What does the other adult do for work?

- How did you hear about the TOYBOX project?
• Why did you choose to participate?

• What do you expect to learn?

*That concludes our questions on demographics. The next section of our conversation will focus on how you and your family are doing.*

• Many people talk about wellness and how it is a good thing. How would you define wellness? Do you think wellness is important? Why is having wellness a good thing?

• Do you think wellness is a concern for our society right now? Why/why not?

• Do you think wellness affects parenting? Yes/No; If yes, How?

• What would you recommend if another parent was having wellness concerns?

• Research suggests there are different kinds of wellness. What kinds of wellness do YOU think needs improvement in your life? 5= needs lots of improvement, 1= no improvement, with 2, 3, and 4 being somewhere in the middle. For this question, we are talking about your personal wellness.

  1. Emotional wellness - how you are coping with your thoughts and feelings
  2. Social wellness - what is your connectedness, support, belonging with friends and family like
  3. Physical wellness - such as sleeping, healthy foods, and exercise
  4. Financial wellness - such as feelings towards your monetary and investment situation.
  5. Occupational wellness - to do with your work/work-life split (and if currently unemployed, how do you find personal satisfaction and enrichment in any work that you are doing)
  6. Environmental wellness - such as how you are feeling about where and how you live
  7. Intellectual wellness - such as how your brain power is being challenged, lifelong learning
  8. Spiritual wellness - such as having meaning and purpose, your connection to religious or other senses of being
• If you had to choose, what 3 dimensions are most important to your family? (To summarize, there above dimensions of wellness are: Emotional, Financial, Social, Spiritual, Occupational, Physical, Intellectual, Environmental).

• How do you support your own personal wellness? Probe: Do you take time away from family for you? Are there activities you do that contribute to your own personal wellness?

• How do you support the wellness of your child(ren)? Spouse? Other family?

• Finally, how do you think the wellness of others in your family affects your wellness? Or vice versa?

• **HOW** do you think physical wellness is related to…
  1. sleep?
  2. healthy eating?
  3. time away from TV’s and screens?
  4. exercise?

  Is one more important than others for your family?

• Do you think you have the same experiences as other parents around you or are you an exception? Why/how?

• Has your wellness changed over the years (pre having kids, having a baby-toddler-preschooler, more than one child)? Why so?

• Do you find that you are able to give equal attention to your wellness and to your child(ren)’s wellness? If not: *Who is more prioritized? And why?*

• How do you (or how could you) maintain a family wellness balance?

• How would you improve your family wellness if there were no constraints (time/resources)?

**Currently, our TOYBOX strategies offer ideas for parents with the option to do them with children. Is this the best way to offer the ideas, or do you have a better idea? What would work best for your family?**

• We know the pandemic has affected almost everyone’s life during the last two years. Would you say that overall, your physical wellness has: improved, worsened, or stayed the same? Why?

• As a result of the pandemic, over the last 22 months, have you changed the type of physical activity that you engage in?
  1. Probe: For example, in some locations gyms and recreation facilities have closed down and reopened and been modified in some way (like needing to wear masks at the gym).
• Have you mostly done the same thing? (e.g., run, walk, jog; work out at home)
• Have you accessed classes online or virtually?

• Are you getting outdoors more, less, or about the same compared to before the pandemic? Why or why not?

• When you are getting outdoors, what kinds/types of activities are you doing/involved in (i.e., going for a walk, playing a sport, etc.).

• Has the pandemic impacted your family’s wellness? In what ways? Which dimensions stand out to you as being the most affected? (To summarize, there above dimensions of wellness are: Emotional, Financial, Social, Spiritual, Occupational, Physical, Intellectual, Environmental).

We are coming to an end in our conversation, we have 3 final questions

• In this study, we have chosen to focus on play-based activities as we know that play is important for healthy childhood development. As we age and move into teenhood, adulthood the message seems to fade away. Does ‘play’ resonate with you and is there something that you do to enhance your own play?

• Is there anything missing from this interview or anything that you would like to add related to wellness, physical wellness or the ToyBox strategies?

• Is there anything that really resonated with you?

Thank you so much for participating. It’s been great chatting about your and your family’s experiences of wellness. Next steps are to continue to watch your email from TOYBOX and to participate in the weekly activities or strategies involving literacy, numeracy, and wellness. I hope you have fun with the activities, and we look forward to interviewing you again in 6 weeks when the weekly strategies are complete. Feel free to email us at any time as well at toybox@uwinnipeg.ca.

**For emergencies, if we can see someone is not doing well with the questions, as wellness questions may provoke emotions, can give Sheri’s email s.skwarchuk@uwinnipeg.ca to talk to someone and receive emotional support/debriefing**
Appendix C: Email Recruitment Advertisement

Good morning Friends of TOYBOX!

Thanks for taking interest in TOYBOX Manitoba and for being part of our “Friends of TOYBOX” group. You are receiving this email because you have expressed an interest in family wellness.

Please follow the link to your consent form and intro survey: https://uwinnipeg.qualtrics.com/jfe/form/SV_abfzJPgRvcI9PHo

This step should take about 25-30 minutes.

Once you have completed the consent/survey form, please respond to this email as the next step is interviews! Interviews begin on Wednesday, Jan. 26th.

When we find an interview time that works, you will receive an interview calendar invite from toybox@uwinnipeg.ca.

We look forward to speaking with you soon!

TOYBOX

Reminder of rough study outline (what to expect):

1. Provide consent, complete an intro survey (25-30 mins)
2. ‘Pre’ Interview before February 4th (30 mins)
3. Receive three strategies/activities by email weekly (on literacy, numeracy, and wellness)
4. Continue participation for 6 weeks and rate the activities weekly (max 3 mins) and be entered into a draw for 1 of 3 $50 gift cards
5. Complete an end of study survey (10 mins) to rate your experience.
6. ‘Post’ Interview after March 11th (30 mins)
7. Receive $25 for participating!!

Our team is wanting parents to comment on what encourages them to try the activities with their children, and if they stop, (lots of people discontinue), to let us know why they stop! Absolutely no pressure to continue for the 6 weeks duration.

---

Good morning Friends of TOYBOX!

Thanks for taking interest in TOYBOX Manitoba and for being part of our “Friends of TOYBOX” group. You are receiving this email because you have expressed an interest in family wellness.

Please follow the link to your consent form and intro survey:
https://aswinipeg.palliativecare.ca/forms/SV_cO8OjPyxv3P4k

This step should take about 25-30 minutes.

Once you have completed the consent/survey form, please respond to this email as the next step is interviews! Interviews begin on Wednesday, Jan. 26th.

When we find an interview time that works, you will receive an interview calendar invite from toybox@aswinipeg.ca.

We look forward to speaking with you soon!

TOYBOX

Reminder of rough study outline (what to expect):

1. Provide consent, complete an intro survey (25-30 mins)
2. ‘Pre’ Interview before February 4th (30 mins)
3. Receive three strategies/activities by email weekly (on literacy, numeracy, and wellness)
4. Continue participation for 6 weeks and rate the activities weekly (max 3 mins) and be entered into a draw for 1 of 3 $50 gift cards
5. Complete an end of study survey (10 mins) to rate your experience.
6. ‘Post’ Interview after March 11th (30 mins)
7. Receive $25 for participating!!

Our team is wanting parents to comment on what encourages them to try the activities with their children, and if they stop, (lots of people discontinue), to let us know why they stop! Absolutely no pressure to continue for the 6 weeks duration.
Appendix D: Wellness Questionnaire

**Wellness Questionnaire (To Be Completed by Adult Caregiver)**

The following items are focused on *your* personal wellness. Please rate each item using the following scale:

- 4 If the item is **Always True** for you
- 3 If the item is **Sometimes True** for you
- 2 If the item is **Rarely True** for you
- 1 If the item is **Never True** for you

<table>
<thead>
<tr>
<th>Item</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do physical activity for 20 to 30 minutes at least three times per week.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I eat fresh fruits, vegetables, or whole grains daily.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I do not use tobacco and nicotine products (cigarettes, cigars, e-cigarettes, and chewing tobacco).</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I do not use illegal substances, such as drugs that were not prescribed for me.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I do not drink alcohol.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I choose water rather than drinking sugary beverages (juices, powder mix, pop, etc.).</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I get an adequate amount of sleep (7-9 hours/night).</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I get an annual physical.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I brush my teeth daily.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I try to keep on top of current affairs/events.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I do stimulating mental activities or games, such as puzzles, word searches, etc.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I try to see more than one side of an issue, especially for things that are controversial.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I engage in intellectual discussions.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I look up things that I don’t know and/or ask questions to learn from others.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I seek new information that can help me grow.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I regularly clean my living environment.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I keep my work/home space clean and /or organized.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I conserve energy (fuel, electricity, water, etc.).</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I recycle (glass, paper, plastic, clothing, furniture, etc.).</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I do not litter.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I set aside time to enjoy nature.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I can name my own personal values and beliefs about life.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>When I get depressed or frustrated, I draw on my beliefs and values to give me guidance.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I reflect quietly each day.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I feel a sense of purpose in life.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I feel positive about life.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>I read or listen to inspiring messages.</td>
<td>4 3 2 1</td>
</tr>
<tr>
<td>Statement</td>
<td>4</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>I see challenges as opportunities for growth.</td>
<td></td>
</tr>
<tr>
<td>I believe that I have considerable control over my life.</td>
<td></td>
</tr>
<tr>
<td>I feel good about myself.</td>
<td></td>
</tr>
<tr>
<td>I am able to effectively cope with stress and tension.</td>
<td></td>
</tr>
<tr>
<td>I am able to recognize and express my feelings.</td>
<td></td>
</tr>
<tr>
<td>I do things to increase my emotional wellness, such as listening to music, walking, meditation, etc.</td>
<td></td>
</tr>
<tr>
<td>I have a good handle on my financial situation.</td>
<td></td>
</tr>
<tr>
<td>I have money to meet my current expenses.</td>
<td></td>
</tr>
<tr>
<td>I can comfortably manage within my budget.</td>
<td></td>
</tr>
<tr>
<td>I balance my bank account.</td>
<td></td>
</tr>
<tr>
<td>I resist impulse spending when my funds are limited.</td>
<td></td>
</tr>
<tr>
<td>I make educated spending decisions by comparison shopping and researching products before purchasing.</td>
<td></td>
</tr>
<tr>
<td>I have a network of supporters.</td>
<td></td>
</tr>
<tr>
<td>I try to help others when I can.</td>
<td></td>
</tr>
<tr>
<td>I have a sense of belonging within my community.</td>
<td></td>
</tr>
<tr>
<td>I communicate with a wide variety of people.</td>
<td></td>
</tr>
<tr>
<td>I have people in my life who can provide practical help when I need it.</td>
<td></td>
</tr>
<tr>
<td>I am able to draw on supporters for emotional support.</td>
<td></td>
</tr>
</tbody>
</table>

**If you are Currently Employed.**

<table>
<thead>
<tr>
<th>Statement</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am happy with my career choice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am productive on most days at work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I look forward to the work day.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am happy with the balance between my work time and my leisure time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am happy with the amount of control I have in my work.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My work gives me personal satisfaction and stimulation.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**If you are Not Working Outside the Home due to family caregiving responsibilities, looking for work, being a full-time student, retirement, or disabilities.**

<table>
<thead>
<tr>
<th>Statement</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am happy with how I spend my time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have plans for things that I want to do.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I look forward to most days.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do things with other people often enough so that I don’t feel isolated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have some structure and routines in my week.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I use my time in a way that gives me meaning and purpose.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Physical Activity Questions.** The following questions are about any physical activities **YOU** may have done in the LAST WEEK. You may choose to SKIP any questions.

1. In the last week, **how many times** have you walked continuously, for at least 10 minutes (without stopping), for recreation, exercise, or to get to or from places?
   - Weekdays
     - (Monday – Friday)
     - ______ times
   - Weekends
     - (Saturday & Sunday Only)
     - ______ times

2. What do you estimate was the **total time** that you spent walking in this way in the last week? Record “0” if no time was spent in this activity
   - Weekdays
     - (Monday – Friday)
     - ______ hours ______ mins
   - Weekends
     - (Saturday & Sunday Only)
     - ______ hours _____ mins

3. In the last week, **how many times** did you do any other moderate activities that you have not already considered (e.g., gentle swimming, social tennis minutes (e.g., gentle swimming, golf, etc.)?
   - Weekdays
     - (Monday – Friday)
     - ______ times
   - Weekends
     - (Saturday & Sunday Only)
     - ______ times

4. What do you estimate was the **total time** that you spent doing these more moderate activities in the last week? Record “0” if no time was spent in this activity
   - Weekdays
     - (Monday – Friday)
     - ______ hours ______ mins
   - Weekends
     - (Saturday & Sunday Only)
     - ______ hours _____ mins

5. In the last week, **how many times** did you do any vigorous physical activity which made you breathe harder or puff and pant (e.g., jogging, aerobics, cycling, heavy work around the yard)?
   - Weekdays
     - (Monday – Friday)
     - ______ times
   - Weekends
     - (Saturday & Sunday Only)
     - ______ times

6. What do you estimate was the **total time** that you spent doing this vigorous activity in the last week? Record “0” if no time was spent in this activity
   - Weekdays
     - (Monday – Friday)
   - Weekends
     - (Saturday & Sunday Only)
The following questions relate to what *you* did in your FREE TIME in the LAST WEEK. These questions are about the time when you were SITTING and NOT DOING CHORES.

7. What do you estimate is the total time that *you* spent watching TV, videos, DVDs, YouTube, Netflix, Amazon, etc. as your main activity IN THE LAST WEEK? Please do not include time when the TV or screen may have been on but you were doing something else like preparing a meal.

   Weekdays (Monday – Friday)  Weekends (Saturday & Sunday Only)
   ______ hours ______ mins  ________ hours ____ mins

8. What do you estimate is the total time that *you* spent playing electronic games on a gaming system, cellphone, IPAD or other device IN THE LAST WEEK?

   Weekdays (Monday – Friday)  Weekends (Saturday & Sunday Only)
   ______ hours ______ mins  ________ hours ____ mins

9. What do you estimate is the total time you spent using the computer or another electronic device such as IPAD or cell phone at home in your free time IN THE LAST WEEK? (DO NOT include use of computer for work or time spent playing games)

   Weekdays (Monday – Friday)  Weekends (Saturday & Sunday Only)
   ______ hours ______ mins  ________ hours ____ mins

The following physical activity questions are about YOUR CHILD. You may choose to SKIP any questions.

10. On average, how many days per week does your child get at least 60 minutes of moderate to vigorous physical activity or play (heart beating faster than normal, breathing harder than normal)?
    Number of days per week:_______

11. On most days of the week does your child:
    -Participate in organized physical activity (sports, dance, martial arts, etc.)?
      yes  no
    -Spend 30 minutes or more playing outside?
      yes  no

12. On average, how many hours per day of recreational screen time (video games, TV, Internet, phone, etc.) does your child get?
    ________ hours _________ mins
13. How many hours of sleep does your child typically get (including naps)? hours per day: ___

How much do you agree with the following statements? Please select one statement.
14. I encourage my child to play outside when the weather is suitable.
   a. Never
   b. Rarely
   c. Occasionally
   d. Frequently
   e. All the time

15. I am physically active with or in front of my child.
   a. Never
   b. Rarely
   c. Occasionally
   d. Frequently
   e. All the time

16. I limit what my child does as I worry that he/she may injure themselves.
   a. Never
   b. Rarely
   c. Occasionally
   d. Frequently
   e. All the time

17. My work schedule or other commitments limit the time I have to play with my child.
   a. Never
   b. Rarely
   c. Occasionally
   d. Frequently
   e. All the time

18. On average, how many days per week does your child eat a healthy breakfast? days per week: ___

19. On average, how many servings of fruits and vegetables does your child eat each day?
   fruits: /day: ___
   veggies: /day ___

20. On average, how many 12-ounce servings of sweetened drinks (soda, sports drinks, chocolate milk) does your child have each day? servings per day: ___
21. On average, how many servings of dairy does your child have each day? servings per day: ___

22. On average, how many times per week do you eat a meal together as a family? times per week: ___

23. On average, how many times per week does your child eat fast food? times per week: ___
Appendix E: Ethics Approval Documentation

This letter serves as acknowledgement that the University of Saskatchewan is in receipt of the above named research project application and associated Certificate of Ethics Approval from the University of Winnipeg REB.

The University of Saskatchewan REB has issued a Letter of Acknowledgement in lieu of a Certificate of Approval. All post-approval research activities including continuing ethics review or the review of amendments to the project will be conducted by University of Winnipeg REB. It should be noted that you are also responsible for bringing any project specific deviations, unanticipated problems, or new project information related to the research project to the attention of the University of Winnipeg REB.

When the research project completion report is filed with the University of Winnipeg REB, please also provide a copy to the University of Saskatchewan Research Ethics Office (ethics.office@usask.ca).

The University of Saskatchewan will retain this Letter of Acknowledgement and would ask that you provide a copy to the University of Winnipeg REB.

This agreement is limited to and applicable only to the above named research project.

Digitally Approved by Diane Martz, Chair Date: 18 April 2022
Behavioural Research Ethics Board
University of Saskatchewan
Details of Ethics Amendment

The following changes have been made to the ethics protocol HE12700 for a study entitled: Evaluating Parental Engagement and Use of Early Learning and Support Strategies in the Home. I had sent in an ethics amendment just before the holiday break (20 Jan 2021). But due to further restrictions resulting from the COVID pandemic, further amendments are needed. Since we have not yet heard back from our initial amendments, I am including all of them together here in this package. This letter outlines the changes to the project.

(1) We will include a group of 10-20 parents who are “TOYBOX FRIENDS.” They will be asked to complete a wellness survey at the start of the study; they will be asked to participate in a 30-minute interview on zoom or before the six-week strategy intervention; and in a 30-minute interview again after the six-week strategy intervention. Since we cannot test the strategies in person, we want to ask a small group of willing parents to give us more feedback about the strategies and the processes. We will also ask them to pilot test a new longer version of the wellness questionnaire we intend to use in future projects. The wellness questionnaire, a set of semi-structured interview questions, and a revised consent form for this group of “TOYBOX FRIENDS” parents are attached.

(2) We changed a few items on the parent survey (highlighted in yellow) to obtain more background information about our sample. In our research field, strategy use is highly dependent on socio-economic status. We have asked the participants to complete a question on their family income in broad terms, but they can choose not to answer if they are not comfortable responding.

(3) The pilot testing consent form was changed (all changes highlighted in yellow): (a) to note we are having three random prize draws (at strategy release week 2, 4, and 6) for staying involved in the project; (b) to have the option to receive a call, text or email to report their strategy use suggestions (as opposed to just via email); and (c) to ask participants if they would like to participate in any follow up TOYBOX projects.

(4) Since we are unable to test the children in person, we have added the following 5 point rating scale questions (strongly agree/agree/neutral/disagree/strongly disagree) and one open-ended question) to the exit survey to see if parents feel that their children learned from participating in the program.

a) My child learned about numbers when we worked with the TOYBOX ideas.
b) My child learned about letters when we worked with TOYBOX ideas.
c) My child learned new words and language when we worked with TOYBOX ideas.
d) My child participated in the wellness activities.
e) I learned new ideas to support my child’s number learning with TOYBOX.
f) learned new ideas to support my child’s letter learning with TOYBOX.
g) I learned why it is important to work with my child on language activities on the TOYBOX.
h) I learned why it is important to work with my child on number activities on the TOYBOX.
i) I learned why wellness activities are important on the TOYBOX.
j) Describe what happened when your child learned something new with a TOYBOX activity:
References


https://link.gale.com/apps/doc/A276519134/AONE?u=anon~39bd9c64&sid=googleScholar&xid=d0787836


definition and measurement. Academic Psychiatry, 42, 94–108.

https://doi.org/10.1007/s40596-017-0781-6


https://stacks.cdc.gov/view/cdc/11130


https://doi.org/10.1186/1477-7525-1-60


184


http://www.iffs.se/media/1326/20080109110739filmZ8UVQv2wQFSNcMR6cuA.pdf


socioeconomic status, and sleep disparities. *European Journal of Investigation in Health, Psychology and Education, 12*(8), 1143–1167. [https://doi.org/10.3390/ejihpe12080080](https://doi.org/10.3390/ejihpe12080080)


Gamby, K., Burns, D., & Forristal, K. (2021). Wellness Decolonized: The History of Wellness and Recommendations for the Counseling Field. *Journal of Mental Health Counseling, 43*(3), 228–245. [https://doi.org/10.17744/mehc.43.3.05](https://doi.org/10.17744/mehc.43.3.05)


206


Roberts, K. (2014). *Convenience sampling through Facebook*. SAGE Publications Ltd. [https://doi.org/10.4135/978144627305014526836](https://doi.org/10.4135/978144627305014526836)


212


Statistics Canada. (2022). Life expectancy and other elements of the complete life table, three-year estimates, Canada, all provinces except Prince Edward Island [Data table]. https://doi.org/10.25318/1310011401-eng


https://www.toyboxmanitoba.ca/_files/ugd/efdb10_8add2ef3505748c9af88feaf6a7e472.pdf
https://www.toyboxmanitoba.ca/_files/ugd/efdb10_dad1af856d46474963409abfa1565a.pdf


Victoria University (n. d.). Health and wellness: Dimensions of wellness. [https://services.viu.ca/health-and-wellness/dimensions-wellness](https://services.viu.ca/health-and-wellness/dimensions-wellness)


218

Waterloo University. (n.d.). Faculty of engineering: The nine dimensions of wellness. [https://uwaterloo.ca/engineering-wellness-program/the-nine-dimensions-wellness](https://uwaterloo.ca/engineering-wellness-program/the-nine-dimensions-wellness)


219


https://doi.org/10.1037/prj0000510


https://doi.org/10.1097/FCH.0b013e31826d7601

https://doi.org/10.1177/01650254211051086

https://doi.org/10.3389/fpsyg.2021.741735