Developing an Online Health Community for Autoimmune Disease Patients Through Self-Managed Diet

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DEVELOPING AN ONLINE HEALTH COMMUNITY FOR AUTOIMMUNE DISEASE PATIENTS THROUGH SELF-MANAGED DIET

by

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SYNTHESIS*
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* The Synthesis can take a variety of forms, from a position paper to curriculum or professional development workshop to an original contribution in the creative arts or writing. The expectation is that students use their Synthesis to show how they have integrated knowledge, tools, experience, and support gained in the program so as to prepare themselves to be constructive, reflective agents of change in work, education, social movements, science, creative arts, or other endeavors.
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Introduction

The following synthesis paper is broken into three parts. Part I, *Autoimmune Disease Management and the Need for Intervention*, discusses current and standard Autoimmune Disease- (AI/AID) management and the shortcomings within. Typical AID-management led by healthcare professionals lack a holistic, symptom-based approach, thus further contributing to the daily chronic pain of the afflicted. This analysis indicates the need to connect those suffering with AID’s to scientific research that has determined strict dieting can significantly reduce symptoms associated with AID’s (Gardner). I discuss my personal experience with sub-par professional disease-management and how I overcame this struggle by adapting a self-managed approach through diet. I have since successfully guided others on this journey, thus suggesting that with the right educational tools, resources, and emotional support, reducing symptoms without physician assistance is possible. I will discuss my qualifications to engage and influence the AID community and perhaps, decision-makers and influencers that can also help bridge the gap between AID-diet science and the people.

Part II, *Synthesizing A Model For Online Health Community Engagement*, examines the prototype I have created, via user-centric design, in a theoretical, physical, and creative sense. First, I will describe the importance of prototyping in web development and how the creation of products through the lens of the user is an effective way to develop and maintain a thriving, interactive community. Since user experiences will significantly vary, the prototype reflects different user-journey designs, including individual and community interactions. Then, I will move into website content and organizational structure. Readers will learn and encounter what the user experience will consist of in paper form, which will eventually be converted to digital. The presentation and delivery of my material is formulated based on how people learn online, the
AID community specifically, and what has to exist for learning to occur. Additionally, the website design and content developed is intent on reducing or eliminating the most-common barriers associated with participating in online communities of this nature. Therefore, throughout this paper, each physical item and organizational element will include an audience-determined rationale to connect content to prototype design.

Within Part III, *Final Thoughts and Reflection on the Process*, I will review my experience as a researcher and a producer of original, creative content meant to influence a specific audience. Here I connect Parts I and II by reflecting on my learning and practices as both a creator and an educator determined to engage and influence others. I discuss how the prototyping experience has evolved my understanding of this complex issue and my role within it. Additionally, part of this analysis includes potential next steps I plan to take to bring this website to fruition, as well as ways for others to adapt or adopt elements of audience-centric prototyping.

**Part I: Autoimmune Disease Management and the Need for Intervention**

**A. Illuminating the Background**

**My Experience with Autoimmune Disease**

For two years I struggled with sickness and couldn’t make any sense of it. After endless tests, specialist visits, and countless dollars and minutes spent, I was finally diagnosed with an Autoimmune Disease (AID) called Hashimoto’s Thyroiditis, more commonly known as Thyroid Disease. Three miserable years after that, I would go on to be diagnosed with something called “generalized AID - Systemic Lupus,” which ultimately means I have all the signs and symptoms
of Systemic Lupus, but without a positive blood test to make it official. I am likely to receive a positive blood test within my lifetime. My entire AID journey has been close to eight years, and although I have been medicated and monitored the whole time professionally, I have experienced endless debilitating symptoms regardless. My doctors doubted and disregarded my concerns and went through the motions on a lot of extraneous testing. Throughout this endeavor, Fibromyalgia, anxiety, depression, IBS/IBD, Celiacs, Chronic Fatigue Syndrome, arthritis, eczema, and edema were just some of the incorrect diagnoses I received.

Celiac Disease is an AID that disrupts and prevents nutrient absorption due to intestinal damage caused by the ingestion of gluten (“Beyond Celiac”). In those with this disease, consuming gluten will produce a wide array of symptoms, most of which occur outside of the digestive system (“Beyond Celiac”). Since my Celiac tests were consistently negative, diet left my mind as a potential symptom cause and solution. In my internet pursuits to find symptom relief, I eventually saw hints that strict dieting could help reduce symptoms in AID patients. I disregarded this because I didn’t have Celiacs, it was all too confusing, and it also didn’t seem remotely plausible that giving up gluten would reduce my arthritis.

There were also several AID diets out there with no way to differentiate which was the “right one.” Additionally, I saw a multitude of specialists and dieting was never even mentioned. I was skeptical, but I was so sick and tired of being sick and tired. I was gaining weight by the day, losing mobility in my joints, and sleeping 10 hours a night. I had spent so much time, money, and aggravation and felt rock-bottom quickly approaching, which is why I determined it was time to make a change. I pieced together an informal elimination diet based on a combination of internet sources and got to work. An elimination diet includes removing all food groups for several weeks at a time with systematic and controlled reintroductions, all while
monitoring the body’s daily response. When I gave up the categories of “gluten” and “dairy,” I lost 45 pounds in three weeks, my nails and hair became healthy again, I slept much less and much better, my arthritis was improved, and life became much more tolerable. All my symptoms were eliminated or significantly reduced shortly after that.

The Gap Between the Science and the People

It is incredibly difficult to obtain an AID diagnosis and even more challenging to treat the disease once it’s found (“AARDA”). According to Palmer, a registered dietitian, 5% of the U.S. population has an AID, with about 75% of these cases being women (Palmer). Women are more susceptible, but they are also more likely to seek help (“AARDA”). AID research is still incredibly new, and we don’t even know what causes these 100 complex and chronic diseases (“AARDA”; Sampson). Also, though the pathogenesis is unknown, 25% of AID patients will develop more AID’s throughout their lifetime (Cojocaru et al.). Furthermore, AID patients treated with medication will most likely still experience a wide array of symptoms that change day-to-day, throughout a lifetime, will vary in severity, and will impact all systems of the body (“AARDA”). Specific symptoms may be the development of new and different diagnoses that require additional treatment, such as arthritis and gastritis (“AARDA”). Therefore, it becomes impossible to sort out what-causes-what, making the disease-management journey stressful and maddening.

AID patients are mostly uninformed about the possibility of diet improving their symptoms because doctors tend to focus on disease treatment (medication) and not comprehensive symptom management (Gardner). Often, treating the accompanied easy-to-find and more-serious ailments, like gastritis and arthritis, are the physicians’ primary focus (Palmer).
Since every system is impacted, correct management requires a holistic medicinal approach, which is difficult to achieve (Palmer). The American Autoimmune Related Diseases Association, Inc. (AARDA) stresses that there is no specialty field for autoimmunity, but rather modern medicine bases AID treatment around the afflicted body part (“AARDA”; Palmer). Meaning, Celiac Disease is treated by a gastroenterologist, and Psoriatic Arthritis is managed by a dermatologist (Palmer).

Science knows so little about AID’s and even less about the AID-diet connection (Manzel et al.). Sonya Angelone, RDN, is a nutritionist that states, “most autoimmune diseases show a response to changes in diet” (Gardner). If a Celiac disease test is negative, the poorly named diet “sensitivities” are not seriously considered. NCGS (Non-Celiac Gluten Sensitivity) and Celiac symptom experiences are incredibly similar; the only noted difference being NCGS doesn’t cause permanent intestinal damage when gluten is consumed (“Celiac Disease Foundation”). Also, because there isn’t a diagnostic test for NCGS, it isn’t classified as a disease thus further contributing to the lack of attention. Due to the lack of diagnostic tools and also, the gluten-free diet fad, NCGS is not being talked about as a real condition, even in the medical field (“Celiac Disease Foundation”). Another reason the AID-diet connection remains out of most doctor offices is because there isn’t one perfect AID diet that cures all (Gardner). Gluten is just one possible food irritant, and the only way to figure out irritants is to do a full elimination diet and create a personalized diet, which is difficult to task and guide a patient through (Gardner). As stated by Palmer, “dietitians need to specialize in autoimmune diseases such as celiac disease, as they are very complex conditions” (Palmer).

The National Institutes of Health’s (NIH) funding for AID research is less than 3% of their total budget, despite how common AID’s are (Palmer). I believe there needs to be more
research and a better understanding of the AID-diet connection to make it a primary focus in disease treatment and symptom-management, instead of it being a shot in the dark after trying everything else. Also, there are popular AID diets that can trap a desperate person. The Autoimmune Protocol Diet, the Anti-Inflammatory Diet, and the Low FODMAP Diet all present themselves as an AID cure-all diet (Gardner). The fact that there are several options is the first indicator; this isn’t an exact science. These diets share common threads such as reducing inflammation and removing whole groups of food, yet many wouldn’t have to eliminate to the degree these diets suggest. These diets will never work like they are intended because, though they have value, they are missing the necessary personalization by way of an elimination diet. As Gardner states, “there’s no one accepted definition of an ‘autoimmune diet.’” Although there are common threads to so-called autoimmune diets, specific dietary changes need to be tailored to the person” (Gardner).

Palmer states that “people who suffer from autoimmune diseases often experience loss of function, disability, increased hospitalizations and outpatient visits, decreased productivity, and impaired quality of life” (Palmer). Therefore, it is entirely understandable that an individual dealing with chronic pain and illness can’t or is unwilling to take the time to plan, develop, and execute extreme lifestyle changes as they relate to diet. Implementing an elimination diet plan requires a great deal of know-how, work, and motivation. It can also be costly and time-consuming. The information on the internet is incredibly confusing, and even if one can gain an understanding, initiating, developing, and implementing these changes is difficult, especially for a chronically ill person (Gardner). Diets are temporary, whereas elimination diets indicate life-long changes that need to occur. If one is to embark on this journey alone and cluelessly, it is much more likely they will make mistakes or revert to their harmful diet. Also, once the irritants
and severity of impact is known, AI patients most likely need a complete lifestyle change to learn and maintain their new diet. AID patients must be informed on the impact diet can have, supported through educational resources and community validation, and empowered to adopt a new diet so they can begin to make the necessary changes needed to improve their quality of life.

B. Position to Create Change

I am not in a position to influence the medical field (directly), nor can I beg for more AID-diet research. What I can do is offer my own disease experience and dietary knowledge to influence and support those in the autoimmune community and perhaps, decision-makers and influencers, to bring diet into the conversation of AID-management. What started as a headache has become a very passionate life-long project, which I can attribute to my overarching love of cooking. I have been a dedicated home-chef for about ten years and formerly served as a meal specialist and diet coach. Therefore, when I decided to embark on my own elimination diet, I felt confident I could come up with alternative meal solutions. Odd though it may sound, I appreciate the creativity, experimentation, and, most importantly, the extreme planning involved with maintaining a strict diet.

I also have a passion for developing processes and educating others. I have guided two formerly reluctant friends with AID’s on elimination diet journeys by providing them with a daily symptom-tracking sheet (as seen in Appendix 3), meal plans, meal preparation guides, recipes, and other educational sources. Granted, the process wasn't very formal, but they both experienced rapid improvement in their quality of life. As part of the development of this website, I interviewed these two friends. I will draw upon these interviews and how they helped drive user-centric prototyping decisions throughout the next sections.
I also recently provided my father-in-law a heart-healthy guide to reduce cholesterol and lower blood pressure, and he has been very successful in this feat as well. In addition to the heart-healthy guide, I created him a Pinterest account and pinned dozens of recipes that I vetted based on his specific needs. This account was monumental for the adaptation of his new diet. These experiences indicate that with the proper resources and support, informal guidance on diet in lieu of physician-led programs can be successful. Due to these successes, I have felt compelled to engage the wider AID community on what I have learned and decided to research the best means of accomplishing this goal over several semesters. Through my research process explained below, my overall plan is to harness my passion for education to help others struggling with Autoimmune Diseases by building an online, supportive community to encourage participants to identify their food irritants and create a personalized diet for symptom relief.

Key Propositions, Part I

- Years of experience battling Autoimmune Diseases and exposure to the commonly experienced subpar medical treatments lacking a holistic approach provides me with an empathic understanding of the typical barriers encountered by AID patients in general.
- Symptoms associated with Autoimmune Diseases can be significantly reduced or eliminated by identifying and removing food irritants.
- Formerly serving as a diet coach has allowed me to help three individuals successfully adapt to self-managed health by assisting in the creation of personalized diets.
- By providing Autoimmune Disease patients with proper educational resources, concise and knowledgeable direction, as well as an emotional support community based on
shared experiences, the patients will be more inclined and empowered to adapt to self-managed health through dietary changes.

Part II: Synthesizing A Model For Online Health Community Engagement

A. Prototyping

Systematic Development

There are many steps between developing a theoretical framework and piloting this website, and I believe a successful platform is determined in these critical developmental stages. In Figure 1, Millington describes the lifecycle of a thriving online health community (Millington). Iriberri also describes a similar lifecycle, displayed in Figure 2, and I appreciate the defined mitosis section as opposed to the death-of-platform outcome in Millington’s (Iriberri). I have used these models to fully immerse myself in the first stage of inception, which includes defining a need and having a vision, which I hope to convey in this next section (Iriberri). This stage of development is also defined as slow, intentional, and with no real sense of community or outside engagement (Millington). I have used a combination of these life cycles as a step-by-step prototyping guide to not only learn the stages, but to look ahead at
potential challenges/solutions, new features/designs to be implemented later on, and methods to keep the website running and running well throughout its life stages. To expect tangible change in users through engagement with the website, careful steps adhering to a website’s lifecycle must be considered through user-centric prototyping.

Notability of Prototyping

As stated by Stevens, “no matter how thorough your user research is, many people find it difficult to truly conceptualize a product until they have it in front of them. Prototypes allow you to iterate, refine, rework, and make improvements until you have a market-ready product” (Stevens). Although there are many varieties, website prototypes are essentially a snapshot of what a product will look like and how it will be interacted with by users. By testing the product, one can validate their ideas, find and solve challenges, and gather feedback before investing in a live website (Young). Although prototypes may be created to provide a web-designer an instructional creation guide, it also allows the creator to use the sampled version to simulate a pilot before investing time and money (Stevens).

Prototyping puts the user at the center of the development process because the specific audience is the focus from inception and forward (Stevens). This process that focuses on the audiences’ needs and wants throughout the entire developmental lifecycle is known as user-centric design (Young). This audience-centric focus is essential when attempting to influence communities to adapt to lifestyle changes (Gallant). Although prototyping can often be a
frustrating experience when there is a need to go live with a product, slow and intentional development is the key to a successful and influential digital platform as defined by the lifecycles above (Iriberry; Millington). Lastly, prototyping is a way to gain support and feedback early in the process (Young). I hope to use this prototype to engage constituents in the future, which will provide me with support in the digital building of this website (Young).

Prototype Organization

There are many versions of a prototype varying in form, fidelity, interactivity, and lifecycle (Stevens). I will describe what the readers can expect, the type of prototype I have followed, and why. The prototype described below will demo both individual as well as community interactions.

As stated by Stevens, prototypes range in design, complexity, functionality, and interactivity (Stevens). To describe what I have created I present the following descriptions based on Steven’s design guide;

**Form:** The form is a combination of hand-drawn and digital elements. Although the digital components were produced on the computer (Microsoft Word/Excel) to create organized products closer to their finalized stage, they do not currently exist in a digital platform (online/website).

**Fidelity:** I would describe this prototype as mid-fidelity because the content is detailed and polished in appearance. However, as mentioned above, it does not exist in a usable platform and, therefore, will require conversion.

**Interactivity:** At this time, the prototype is not functional in the sense that it can be interacted with digitally by testers. Due to my lack of knowledge on making a website itself, the
user interactions (both on an individual and community level) will be described as potential scenarios.

**Lifecycle:** The lifecycle of the prototype, as described by Stevens, poses the question if the prototype is a disposable version to be replaced by something new and better, or is it a working early-stage model? In these terms, what I have created here is “disposable,” however, I see it more as a glimpse into the future. The features expressed in the appendices will remain consistent, yet they will exist in an interactive digital space. By taking into consideration the attributes of form, fidelity, interactivity, and lifecycle, my expectation is that the final product will be highly polished and user-friendly so individual and community learning can occur.

**B. Greenebean, A Website; User-Centric Organization, Content, and Appearance**

**An Unknown First Iteration**

In a previous CCT course, we were tasked with developing our creative practice through an artistic avenue of our choosing. Cooking is my daily creative expression, and so I wanted to create a Pinterest-style food blog of all my recipes. The purpose of this blog was to simply be a creative outlet only, not meant to influence or even be seen by anyone outside the class. Due to my unique diet, the recipes I uploaded were all gluten and dairy-free, which sparked some questions from my classmates. I explained how AID-symptom management influences my cooking, and they encouraged me to make that part of the blog. It became an incredibly cathartic experience to put my experiences, struggles, and interventions into word.

I started to establish various content pages I was passionate about, such as meal planning, the elimination diet, and the AID-diet connection exploration. Soon, completely by accident, I began the first prototype iteration of what would go on to be the platform I describe below. Since
it was for creative purposes only, I didn’t do any research on AID patients, online learning, or prototyping. The whole blog consisted of what I knew in that moment only. Eventually, I lost the majority of the creative elements since it went on to be very text-heavy and educational. Still, I realized I might have something of value to expand on. I will refer to this early stage blog as the “first iteration” moving forward.

Choosing a Platform

I decided to develop an online website because I need a platform that will allow me to reach and influence a lot of people in the AID community as a non-physician. I want the site to serve as a bridge between AID patients and AID-diet based research. It mainly serves two purposes; informing, implementing, and monitoring a restrictive-diet lifestyle and maintaining a restrictive-diet lifestyle. As a tech-heavy society, we must adapt the healthcare field and utilize technological communication advancements to empower patients to advocate for their health, seek assistance, and take a hands-on approach (Willis & Royne). Self-management programs are essential in controlling and reducing symptoms, and therefore, the research recognizes the value of these digital platforms (Willis & Royne). The online platforms are a solution to disease management because they offer psychological benefits, social support, and health information (Willis & Royne).

Research found that online health platforms gave individuals a place to share their experiences, but also learn through dialogue with others (Willis & Royne). According to Willis and Royne, “interpersonal channels have been more successful in influencing attitudes and motivating behavior change. Online health communities are an intersection of mass media and interpersonal communication, and thereby provide a viable option for initiating health behavior
change” (Willis & Royne). Therefore, I believe support and active engagement are necessary because, speaking from experience, there can be no back-seat drivers when it comes to health management.

The Willis and Royne article also stressed that people are much more likely to listen to others similar to themselves instead of authority figures (Willis & Royne). This finding is a relief considering my non-professional status. Engaging in a collaborative healthcare community can give individuals the autonomy to adopt a self-managed healthcare approach. This assertion means an online community, when built and appropriately monitored, should be very effective at persuading users to change their behaviors. As stated in the research, “rather than trying and failing, observing other people's behavior allows for a more efficient way of learning behaviors” (Willis & Royne). The research also stated that patients participating in self-managed health communities discussed perceived benefits far more than perceived barriers (Willis & Royne).

As stated by Gallant, “dietary behavior appears to be particularly susceptible to social influences” (Gallant). Gallant did a literature review on the relationship between support and chronic illness and determined the relationship was ‘modest.’ However, diet-themed self-management programs were much more influential and had a higher level of perceived support (Gallant). Gallant also describes the “various aspects of social support, such as types of support, perceived and enacted support, desired and received support, and satisfaction with support” (Gallant). “Satisfaction with support” reminds me that monitoring for quality improvement is vital. Therefore, based on the needs of this website, an online platform with collaborative elements and monitoring tools is required in order to convince others to alter their behaviors.

Website Organization and Structure
Creating a sitemap as part of one’s website prototype is a simple way to organize the many pages and tabs. By grouping and establishing an organizational framework, clicking pathways and website engagement can be better understood and developed. I started the sitemap process by creating an overwhelming abundance of post-it notes to help organize the content required for learning on this platform. First, I wrote down what I felt the website should contain, which then led to the creation of established and titled subpages. Then, I grouped the subpages based on similarities and determined the main page based on the various subpages’ supporting content. In terms of organization, as expressed in Appendix 3, each main page’s sub-pages are grouped and categorized, so clicking pathways follow user inquiry pathways. Appendix 3 should be referenced throughout the next sections, as detailed descriptions are discussed.

To better understand website design and potential beneficial features, I explored the commonly used site generator, Wordpress. The filterable feature list immediately reminds me that creating and adhering to a theme is crucial. Custom colors, logo, headers, and background are all mentioned as components to consider when creating a brand, which I have strictly followed throughout the Appendices (Wordpress). There is also a big focus on the website’s “theme” (or purpose) and “subject,” which compliments the CCT-approach of clearly defining one’s purpose, subject, and audience in research and development (Wordpress).

The Wordpress feature list also includes “threaded comments,” which I hope to incorporate heavily throughout Greenebean (Wordpress). The Q&A tab, as seen in Appendix 6, as well as the Share YOUR Story tab, with an example in Appendix 12, will both incorporate threaded comments. The intention is that inquiry and dialogue can occur organically, leaving space for users to participate as much as they desire. This level of participation will inform and support users. Still, more importantly, it encourages active engagement in self-managed
healthcare, which is ultimately the goal of the website (which will be discussed heavily in later sections). Additionally, the Wordpress list mentioned “Front Page Posting,” which I hadn’t previously considered (Wordpress). Upon reflection, a one-way blog-style of communication can be beneficial in terms of creating long-term and frequent visitation, as well as a continuous flow of information and support. Therefore, based on this understanding, I decided to incorporate front-page posting in the prototype. An example of what Front Page Posting will look like can be found in Appendix 4, the Homepage.

The last Wordpress feature that sparked some consideration are “RTL Language Support” and “Accessibility Ready.” These items remind me that not all users will be able to read, comment, and interact with the site in the same fashion. Additionally, my audience is unwell in varying degrees of severity. Therefore, it is critical that disabilities, languages, and alternative ways of learning are incorporated so all visitors can engage with the site as intended.

At this time, I do not have any features built into the prototype to support alternative learning. Eventually, I will learn more about these participation challenges, potential solutions, and the website features that can be incorporated to make sure no one falls through the cracks.

**Website Appearance**

In the first iteration of my online platform, the aesthetic elements can only be described as random and inconsistent. I can honestly say that I didn’t consider the storytelling appearance elements of the website whatsoever. It wasn’t until I delved into the AID audience, and what needs to exist for their learning to occur in a digital platform, where I started paying attention to the details. In this next section, please refer to Appendices 4-13 for visual representations of the described formats. The list of items below was formed using Lorelle and Rose.
Domain Name: Unknown until creation, however, it will be similar to the website title.

Website Title; Greenebean. When developing this prototype, I was very unsure of what the website’s name should be. How can I create a condensed website name that encompasses the necessary attributes I hope to create in this website? The main points I wanted to somehow incorporate into the title were a feeling of fun, a nod to health-foods and diet, and sneak peek into my personal approach (i.e., the “Rachel Style,” without being so obvious). Most importantly, I didn’t want the title to focus on being sick, nor did I want to limit the website’s function by condensing it into a packaged, disease-based name. Through this critical analysis, I landed on the title of Greenebean. A long-term nickname of mine derived from my last name incorporates enjoyable wordplay, personalization, and alludes to health and food-related content. As intended for the website’s purposes, it’s simple, charming, and humorous in a sensitive way.

Artwork, Overall Artistic Design; To appeal to a chronically ill audience looking for support and relief, interacting with the website cannot feel like “work,” nor should it be negative. Greenebean, in short, should feel good to look at without overwhelming users with bright colors and inconsistent, aggressive styles. To try to create these attributes in the prototype, I focused on descriptive words like simple, rustic, and eye-catching. The hope is to have participants feel calmed, intrigued, and inspired. Therefore, as seen in Appendices 4-13, I attempted to make the design muted by using negative spaces, relaxing by using opaque pallets, and engaging by presenting content creatively.
Additionally, as mentioned above, women are more likely to be diagnosed with an AID and are more likely to seek support online. Therefore, I wanted to incorporate a subtle feminine style without deterring male visitors. Femininity can be noted through the use of ethereal cursive fonts and pastel pallets. Although there are no human pictures in the prototype as it exists now, moving forward in development, images of females will be used more heavily to provide recognition in the majority of the sites’ future visitors.

**Artwork, Logo:** As seen in Figure 3, the website logo is a simple green bean with a vine wrapping around to form the cursive title. The green bean was drawn with green color pencils to create a simple, natural, and rustic feel, while still contributing to the wordplay and food-related elements of the website/title. To incorporate an ethereal and feminine style, I decided to use cursive text emanating from the green bean itself. I feel the logo represents the desired website attributes well and would appeal to the audience.

**Artwork, Color Scheme:** When establishing a color scheme for the prototype, I wanted to derive it from nature to create a sense of serenity, but also a sense of healthfulness. Color Theory indicates that an analogous color scheme is used in the prototype, where the primary color of forest-like green predominates, and the adjacent colors on the color wheel, like yellow, beige, and other green shades, are the supporting colors (Morton). Figure 4 displays how an analogous color scheme is generated by selecting a nature-based green as the primary color, which creates consistency of style (Morton).
Therefore, the backgrounds are a clean oak wood to remind visitors of nature, but also a natural
wood cutting board, bringing it back to the food theme. There is an array of green shades to
match the logo and whites and blacks for text. However, when creating prototype content, I soon
realized I couldn't rely on greens and browns only. There had to be some other colors to keep the
appearance engaging, and therefore, in the next iteration, I incorporated various pastel colors
where I needed items emphasized. The scheme remains natural and feminine, but more exciting
to view.

**Artwork, Photos:** The photos used in *Greenebean* should evoke a feeling of nature and inspire
others to make health-conscious food decisions with eye-catching and inviting food images. To
create a certain calmness, the color scheme and backgrounds are rather muted. Also, blank
spaces between content elements are used to not overwhelm users. Therefore, it is crucial the
food images stand out and appear exceptionally delicious. To add artistic flare and consistency, I
will incorporate *color grading* so the photos contribute to the element of storytelling that occurs
throughout the website.

    Color grading for this platform consists of several elements to make the food images
more captivating against the muted background and color scheme. Increasing the images’
exposure is key, so there is a brightness and emphasis on the content (Kopcok). Contrast should
be increased as well, to create texture and clarity, since raw images are often dull by nature
(Kopcok). Also, raising the saturation intensifies the colors, which adds a certain boldness and
artistic element (Kopcok). Lastly, using a blue-tone curve creates a cool temperature and
additional pop of color, which works particularly well for food-themed images. Each image is
different, so playing around to find the appropriate balance is required.
Figure 5 shows a picture without and with color grading, where the latter is much more eye-catching. Additionally, cropping an image may be necessary to eliminate backgrounds and focus on the food subject. The hope is the image appearance, as well as the content, keeps the users interested and in short, hungry for food and therefore, hungry for diet alterations. As of now, in the prototype, the pictures provided are all food-related; however, moving forward, all images will remain positive and captivating.

Profiles: Members will create an avatar and a username that will consist of a first name and unique number (example: Rachel27), so other users easily recognize them. Names can be real or invented. By keeping the profiles pictureless and nameless, users can maintain confidentiality and anonymity.

Audience Considerations and User-Centric Development

Prototyping is essential for the design of any web-based platform, however, the nature of this website, as determined by the users, requires extra attention. There are several associated barriers to joining any online health community. Willis and Royne conducted research and evaluated patients with arthritis and their feelings around online health community engagement (Willis & Royne). Like arthritis, AID’s cannot be cured, can only be managed, and is silent. The article states that those with arthritis participating in self-management online programs have significantly reduced their symptoms, but only 1 in 10 are actively engaged (Willis & Royne).
The research found that people were not participating because the programs are labor-intensive, time-consuming, and they doubt the effectiveness. Lastly, logistical challenges are another major deterrent (ergo, scheduling/technological hurdles) (Willis & Royne).

There are also challenges specific to the AID community that would prevent or limit engagement as well. For example, when one is chronically ill and fatigued, labor-intensive and time-consuming endeavors are much more strenuous and unappetizing. Additionally, due to the medical runaround typical in AID management, skepticism runs high. I have specifically developed the website around these two multifaceted barriers. I have assembled a chart, found in Appendix 2, outlining the barriers/challenges associated with joining online health communities, considering the AID audience, and how I plan to reduce or eliminate these barriers by way of design, content, and engagement. In these next sections, I will elaborate on these barriers in the context of user-centric design.

Allow me to explain the blue titles in the following sections, which are reflective of an attempt to synthesize a vast amount of information. After learning about AID’s, those with AID’s, online learning, and self-managed healthcare support on digital platforms, I somehow had to connect this knowledge to prototyping. The thought of presenting and delivering material formulated based on how people learn online, the AID community specifically, was overwhelming. At the time, I knew my audience well and needed to make development and design decisions based on said audience, so I started with a simple CCT post-it grouping exercise to help organize the content. I listed what I thought needed to exist for learning to occur on the platform I had envisioned and named each of these elements or attributes on post-its. I then grouped similar post-its and created an order based on coherent reading, which came out as follows;
Acknowledge Fatigue/Reduced Productivity

- simple/not medically-dense

Educational

- leverage experience
- rely on story
- rely on community

Adopting New Behaviors

- inspire/influence
- different experiences/reasons for using website
- skepticism
- self-advocating

Creating Community

- positivity
- membership

Emotional support

- validation

Then I made these temporary blue titles and arranged the relevant discussions underneath. Though these titles started as temporary fixes, I began to appreciate their organizational value in breaking down all the user-centric considerations. Hopefully, you, the reader, agrees.

Acknowledged Fatigue & Reduced Productivity/Simple, Not Medically-Dense
Due to the fatigue and decreased productivity associated with AID’s, interactions with the website mustn’t feel like “work.” “Work” (and the unknown) is what deters people away from extreme lifestyle changes, especially the chronically ill. So, I view this time and labor barrier as an opportunity, since it is the exact notion I am combating. When interviewing my two friends who I previously assisted in their AID-diet journeys, one noted that adopting a new strict diet would be simply, “too hard” and most likely “not worth the effort.” Therefore, the website appearance and the content must engage users with a certain level of fun, so the notion of difficulty and effort is reduced. Eliminating the work and the incorporation of fun elements should increase my enrollment and the effectiveness of the website.

My goal is to create an artistic appearance without being insensitive to the content matter. I have attempted to incorporate fun throughout the website appearance by relying heavily on images, charts, and creative fonts and displays to captivate the reader. Additionally, I have created (or have the intention of creating) recipe, meal-prep, meal-planning, shopping, and restaurant guides that do not focus on disease or disease-management directly. I have shown these beta materials to several people who do agree that the appearance is captivating, and it doesn’t seem like “work” to engage, nor does it appear to be a disease-management website by design appearance.

Since so many of the current AID websites are confusing, Greenebean must be organized simply and contain straightforward content. Admittedly, a lot of the existing confusion rests on the fact that we know so little about AID’s and the AID-diet connection, so the subject matter is confusing by nature. Although I was aware of confusing internet information from my own past experiences (hence, why I set out to create something different), I was reminded of this sobering fact when starting research to begin developing this blog. In Greenebean’s first iteration, I
attempted to explain each potential possibility as to why and how AID’s and diet are related. It was, like so many of the other internet sources, confusing, medically-dense, and provided no real understanding of the complexities.

Through my extensive exploration, I found there are two types of resources out there; general and vague articles loosely based on science, and medical experiments around the AID-diet connection to be reviewed by other physicians. In short, the information was either incredibly superficial or unrealistically dense. Through trial and error and the altering of key search words, I eventually found what I needed for development, however, an average person looking for simple solutions would be out of luck. Therefore, through my exploration and annoyance with current resources, I continue to aim to make my content simple and easy to understand to appeal to my audience.

In terms of website content and the reduced productivity of future visitors, I must fight all my basic instincts and keep the website text to a minimum. Throughout development, I vowed to keep the content simple to appeal to and engage my audience with ease. Still, it wasn’t until I started making the prototype where I realized this is incredibly challenging to achieve. I have an urge to overload visitors with information, so their understanding is optimal, however, antibody pathogens and food mimicry are not simple concepts regardless of what creative fonts I use. An information overload would also go against my audience’s needs, which is to have a platform that is informative but not confusing or medically-dense (Willis & Royne).

As stated above, we don’t know what causes AID’s and why diet changes help reduce symptoms, so there is a lot of confusing and often conflicting speculation out there. For this reason, and because I am not a doctor, my understanding of complexities is limited, which makes developing certain website content difficult. Through prototyping, I have determined that heavily
linking to (trusted) outside sources will solve several of my challenges. By linking to reputable sources, the amount of text is limited, the medically-dense content is reduced, and information remains evidence-based. Also, I don’t appear to be moonlighting as a doctor by grossly summarizing information myself. Furthermore, users can inform themselves to the degree they desire, which speaks to my goal of appealing to all types of users and user-disease knowledge. Keeping things simple is also beneficial for varied technological skills.

Additionally, strict diets based around food irritants can also be incredibly confusing. For example, maintaining a gluten-free diet means one must be aware that gluten may be found in much more than pasta and bread, such as canned foods or even spices. When someone is just getting started on their new diet, recipes must be clearly labeled to indicate the food irritants they contain to avoid confusion and guesswork, which is another user-centric approach. To achieve simplistic labeling, I have adapted what the grocery chain Wegmans does. Every single Wegmans store-brand product contains various circles indicating health and wellness goals right on the front label, as seen in Figure 6 (Wegmans).

Working from the Wegmans model, each recipe uploaded will select from a series of common food irritants. Once the recipe is posted, the corresponding circles will appear at the top right of the page. Please look at the recipe prototype example found in Appendix 8 to see how these symbols will be applied. The goal is that when searching for recipes, users can filter by their individual needs (i.e., gluten-free, dairy-free, etc.). Then, only recipes that adhere to their dietary requirements will be shown, as seen by the filtering option in Appendix 7.
If users don’t filter and prefer to browse the pictures openly, the symbols will always be on the recipes to determine if it is safe for that person or not.

Educational

Willis and Royne state that there isn’t a lot of research on peer-to-peer communities and their ability to behave like an educational program (Willis & Royne). Meaning, the communities may be supportive but may lack the pedagogical knowledge and credibility to convince others to try specific lifestyle changes. However, interpersonal channels are very effective at convincing others, which further validates the need for community interactions (Willis & Royne). Though Greenebean cannot ignore the gaps in AID-diet related science, an effective way to educate directly is to appeal to the emotions of the users (Senge). That being said, the website must be both educational and influential by way of evidence-based content and the sharing of personal experiences.

I did struggle with the concept of Greenebean serving as an educational channel throughout development. In the first iteration, I attempted to inform my audience by writing out every single factoid and detail possible. It was so dense and text heavy that I know I lost clarity along the way. I know spoke very factually, which was misleading and rather inappropriate since I am not a physician. The pathology of the AID-diet connection is unknown and ignoring that knowledge gap is misleading. Moving forward in the prototype, I still aimed to be educational and comprehensive, but with clarity and without overstated my position.

In terms of evidence-based content, all that is written in the prototype came from reputable sources. I have determined what is trustworthy based on the content and the content's origin. Meaning, I will use websites like “AARDA,” not single-page articles from secondary
reporters. I have added links in the prototype that loop back to these sources that users can click to read more if they desired. Additionally, in terms of the AID-diet connection, science does not know why this connection exists. Instead of elaborating on the multitude of theories and confusing users, I simply note “leaky gut” and “inflammation,” two things everyone with an AID experiences, as seen in Appendix 11. I learned this to be true throughout my early diet adventures and confirmed these facts before I assisted my two friends with their diets to make sure I was being factual. Otherwise, since I am not creating a doctor-led website community, the majority of the evidence and influence will come from the sharing of stories and community interactions, which have been proven to be very influential in convincing others to adopt new behaviors (Willis & Royne).

The Share Your Story feature, as seen in Appendix 12, is my favorite page on the website. It seems insignificant, or perhaps like it falls into social media propaganda. Still, it is arguably the most important page in terms of educating others and influencing users to adopt new behaviors. The idea is by showing repeated examples of success and also, the hardship that came before the success; users would relate to the other users and be more willing to adopt a fundamental self-management approach. The Q&A page seen in Appendix 6 is another way for users to engage and learn because discussion threads will be created which, of course, will draw on personal experiences. By engaging with these two pages in particular, community interactions boost the educational value of the site while also creating and strengthening interpersonal relationships amongst users. The generating of bond and trust through validation and support is an effective way to encourage lifestyle changes (Barlow).

When creating the prototype, I was hung up on the development of the Q&A discussion thread page for several reasons. This open page is critical when adhering to the needs of the AID
community to provide clarification and educational content. Leveraging community interactions as a means to influence and generate emotional support is also necessary. Therefore, the page is needed to help achieve the various goals of both the participants and the website overall. The challenge is; how to keep the content credible without policing contributions or having full-time managerial monitoring. For this reason, while developing the prototype, I decided to alter the appearance of profiles. At first, those who created a membership were going to have just a generic username and pictureless profile, however, I want to better utilize frequent visitors to the website’s advantage. Now, users will create a basic avatar with minimal features and a username that consists of a first name and a unique number (which participants can also invent) to establish recognition with other users. I hope the profile personalization will help create recognizable pillars within the community, which in turn creates a core constituency that generates an atmosphere that is replicated by other users to ensure the website remains positive and supportive (identity-based). Also, these frequent users can bulk up content and materials as well as credibility and trust.

However, just because a profile now has an avatar doesn’t mean the contributions are accurate. When creating the prototype, I wasn’t sure how to realistically incorporate a way to check and police the accuracy of each contribution. I reflected on what it means to adopt a self-managed healthcare approach and recalled that part of it is achieved through website engagement, participation, and social networking on health topics (Ziebland & Wyke). Therefore, I hope to keep the Q&A accurate by creating a checks and balance system between users by empowering them to engage in the sharing of content to adopt the self-managed approach as intended. This system will reduce the amount of managerial overrides, will encourage collaboration, self-managing, supporting others, and will help keep the content
accurate. I haven’t quite decided the best option, but when brainstorming, I came up with either a standard rating system such as “7 out of 8 found this helpful,” or a star-rated system to reflect the degree of helpfulness and accuracy. For now, I show the star-rated system in Appendix 6.

Another element I could incorporate, though it doesn’t speak to leveraging users, is a managerial “thumbs-up” sticker that could appear next to fact-checked comments.

   It is also important to acknowledge my position as someone who knows and cares about the AID-diet connection, but without the false promise that I am an expert of some kind. It is fair to the readers, alleviates liability concern, and acknowledges the experimental nature of the websites’ resources (Website Policies). Although the content is evidence-based and reflective of my personal successes (and my interviewees as well), my status as a non-physician must be made clear (Spring). The disclaimer must note the possibility of inaccurate information, the no-guarantee-of-success possibility, and it must also take ownership of the original content I have created (Website Policies). Due to these many reasons, I will include a disclaimer link at the bottom of every website page. For this synthesis, and to provide an understanding of what the disclaimer will look like, I offer a model pasted from Michelle Spring at “thrivingonpaleo.com,” seen in Appendix 16 (Spring). This website is a similar AID-diet lifestyle website, and I believe her disclaimer is a comprehensive example that I will emulate in my disclaimer creation. At this time, because of my lack of legal knowledge, I am not sure what I would change of Spring’s provided disclaimer, if anything, other than to make it my language.

**Adopting New Behaviors - Differences Between Users**

   Barlow states, “some may not feel able to embrace the concept of self-management and may need support in making the transition from pre-contemplation to contemplation of making
self-management part of their lives” (Barlow). AID-related food irritants vary from person to person, and although there are common themes, diet personalization is necessary for success. Creating a personalized diet from scratch may seem impossible, but when armed with the proper resources, participants can accomplish this feat. I was reminded of this when the three diet guides I provided to friends and family resulted in great success. By providing all the knowledge and materials found in the various appendices as well emotional guidance, that should enable users to try to create their personalized diet. This supportive transition some users will require speaks to the eliminate-the-hard-work and guessing game framework I have created. Also, these contemplative users will not only require pedagogical knowledge and how-to guided materials, but they will also need to be inspired by others to understand that the hard work will pay off. I believe influence can be accomplished by enabling and empowering participants to adopt a self-managed healthcare approach by supplying simple and straightforward resources, while also keeping the content personal and inspiring through the promise of an improved health status.

The Share Your Story and Q&A pages (Appendices 12 and 6, respectively) will use interpersonal channels to influence users who are in the contemplative stage. My presence as the creator of this lifestyle website will also be influential because it shows users I care about these issues and the intervention enough to share it with others. As seen in Appendix 5, there is a significant focus on the “YOU.” The tabs on the homepage, as seen in Appendix 4, are meant to evoke a feeling of possibility from within. By keeping the focus on the individual, participants will feel supported, enabled, and empowered to venture into the tabs and begin their journey in self-managed healthcare.

The website’s users will have different reasons for engaging with the site, and they will also have different levels of knowledge and experience. To appeal to all members without
alienating anyone, it is crucial that each person can tailor their experience based on their individual needs. The *Start Here* page, as seen in Appendix 5, is meant to accomplish this. Users can select the box that reflects their position, and the navigation will lead them directly to the content required to fulfill that need. I also believe this level of direction will appeal to those in the contemplative stage. By showing that one doesn’t need to be an expert to engage with the site and its contents, users should feel more inclined to venture in. They will also learn that the website contains all the resources and materials to become informed and make changes. When I assisted my father-in-law with his diet, the creation of the Pinterest account was the tipping point to success. The direct supply of solutions via recipes eliminated the guesswork and allowed him to adopt the new behaviors his health issues required.

**Skepticism**

Skeptical users and uninformed users essentially require the same thing, which is to be accurately informed and influenced to change. I also know from my journey, and from guiding my two friends, that skepticism runs high when it comes to AID-management through food. When interviewing one friend I previously helped, she reflected on how she felt before adopting her new diet. Even though we have the same disease and she was fully aware of the successful diet journey I had, she was still unwilling to try a new diet herself (at first). In the interview, she stated that she “thought medication was going to do more,” “her doctor never mentioned it,” and she “didn’t know how much of a difference it would make for her.” She notes that what got her to finally try the elimination diet was me providing everything for her, and “without those materials, it would’ve never happened.” A skeptical person must engage with the website to understand there is an undeniable AID-food connection and that others have had symptom relief
through dietary changes. This hurdle will be overcome by again, relying on evidence-based research and the personal experiences of others (Willis & Royne). The Share YOUR Story section, I believe, will be the most convincing page for skeptics because of the sheer volume of different experiences, all leading to positive results.

Self-Advocating

Self-advocating and symptom-management are the two primary themes of my research and the intended website. Barlow suggests that “self-management approaches are effective in increasing participants’ knowledge, symptom management behaviors, self-efficacy, and aspect of health status (such as depression)” (Barlow). One must advocate for their health and be part of the decision-making process to potentially reduce symptoms or, at the very least, perceive control over their health (Willis & Royne). By actively engaging in evidence-based health education programs, one can regain control of their life and feel accomplished as well. Therefore, the website must promote attainable self-advocacy and self-management so users feel empowered to make lifestyle changes.

I want my participants to adhere to this self-managed style without limiting or policing their contributions. Kraut et al. described how to limit ‘bad behavior’ through moderation systems and encourage voluntary compliance through example-setting (Kraut et al.). By having core members (and myself) set a positive example, the website essentially creates online identities that participants will mimic, thus promoting positivity and positive experiences. One of my interviewees stated that when she first began internet searching for clarity and support, she found it was all “negative and depressing,” and the “confusing” websites were the “exact opposite of inspiring,” and I would have to agree. For this reason, I feel I must maintain a
presence on the website. I believe it is essential to share my story and explain why I am in the position to help them create change, and through this, I will, in turn, be establishing a framework for participation and attitude. Also, Kraut et al. defines ‘identity-based’ commitment as “people participating in a group because members feel a commitment to the online community's purpose or topic” (Kraut et al.). In contrast, ‘bonds-based commitment’ to a group implies that members feel socially or emotionally attached to members of the online community (Kraut et al.). I think my website will have both identity-based and bonds-based commitment because of the personal connection and shared trauma in having similar chronic diseases.

Creating Community - membership and identity-based thru example-setting

An effective way to build a sense of community is through “membership” (Young). It establishes a community-specific identity, it aligns the goals of the participants, and members feel they can influence and be influenced. Members also feel an emotional connection to each other (Young). By building a membership style and sort-of branding the website a bit, I should be able to create a sense of community, which is an effective way to support participants in an online health community (Bartlett et al.; Kraut et al.; Young). For these reasons, I will offer participants a chance to Join OUR Community right on the homepage (Appendix 5), which will allow them to create a profile, post, and contribute. By having participants ‘buy-in’ to the identity of the website via membership, I can create a positive community based on support. Community development that is successful often stems from the challenges people face and share (Senge).

I aim to accomplish this membership approach through many facets. First, the users will “become a member” instead of merely signing-up. Members will create a profile, avatar, and
username, which will then allow them to share their story, engage in the elimination diet cohort, and interact with other users via the threaded discussions and comments. This engagement will create a sense of camaraderie. Hence, participants feel more invested, more likely to share, and most importantly - they will perceive to have gained emotional support through community building (Bartlett et al.). Non-members can interact with all of the features, and they can also post in the Q&A.

I also have established a website mission, which is; Improving you, together. The mission is meant to convey individualization as well as a community with a shared purpose. It also, in short, summarizes my intention behind creation. As stated by Senge, a mission “represents the fundamental reason for the organization’s existence. What are we here to do together?” (Senge). There is a logo, specific website design style, and an equal focus on the “you” and the “us” of the website. Once the site is running for an extended time and there is an established community, eventually, I hope to create perks, merchandise, and weekly (or monthly) newsletters. Perhaps even live meetings and outings could come down the line, which would increase my access to more people to broaden the community. By expanding the content and overall presence of the website, it will keep user visits frequent to maintain the community aspects.

**Emotional Support**

Due to the nature of AID’s and their ever-changing presence in the body and also, because a patients’ life will personally flux over time, the level of support a participant needs will also change over time. Some may not want any “support” online, while some might want it daily (Kraut et al.). It is worth noting that not all online health groups address psychological well-being, but when they did, there was an improvement (Barlow). This notion solidifies the
attention that needs to be given to the mental state of those in chronic disease self-management groups as it varies over time (Barlow). Therefore, the supportive and dialogue features must be a choice, where participants elect to participate when desired to appeal to a wider range of users.

Establishing this engage-as-needed approach has been a struggle. At first, I planned to require daily check-ins and weekly summaries from users participating in the elimination diet cohort. If I followed this model, I would be forcing “support” and collaboration down their throats, which would not work and would also deter members (Willis & Royne). Both of my interview participants noted that required daily check-ins would be a deterrent. I soon realized that to successfully engage a wide array of people and experiences, flexibility needs to be a primary focus. Therefore, keeping in line with reducing the time/labor for those enrolled and overcoming logistical challenges, I established that members could choose to participate when and as much as they want, leaving the 12-week cohort to be the only regimented website experience. They will have the option to check-in daily or weekly, but comments on other participants’ check-ins are preferred. This openness also stays true to the level of support patients seek changing over time, thus allowing them to seek information and support as needed as the disease(s) change.

When reviewing the Kagalwalla piece, which was about elimination diets and gastritis, I learned that some of the participants, after the study, reintroduced foods they learned to be detrimental to their health (Kagalwalla). I found this shocking. In AI patients, gastritis is just one problem associated with food sensitivities. In short, the experiences are widely different, and eating harmful foods is much more severe for AID patients in comparison to those suffering from basic gastritis. Regardless, this brought to light the issue of “offline” impact and maintaining prolonged guidance and support. Continued emotional support speaks to the
framework I have established, which is based on influencing and supporting all participants and experience levels. The feeling of community cannot just stop. Therefore, I have several elements incorporated into the prototype that hopefully encourages long-term participation beyond the creation of a supportive network. By becoming a member, participants will continue to check-in and respond to questions and use the resources. Also, the Recipes page and the Homepage front loading will be continuously fed new materials to draw in frequent visits. Additionally, I will encourage a 3, 6, and 12-month post-elimination diet check-in to see if participants are sticking to it and what their experiences and challenges are like now.

Validation

Research stresses that online health communities are successful because of the comfort associated with being informed and understood. Bartlett’s research focused on establishing and evaluating empowerment tools (and outcomes), which were defined as; “exchanging information, exchanging social support, comparison with other members, helping others, sharing experiences, feeling informed, increased confidence in treatment, increased optimism/hope for the future, enhanced self-esteem and enhanced social well-being” (Bartlett et al.). The take-away is there is comfort associated with being informed and understood. The interviews I conducted reiterated this notion as well. By encouraging participants to share their stories, they will receive validation through comments and dialogue with others in similar positions. Also, when trying to get an AID diagnosis, physicians are frequently doubtful and suggest other ailments such as depression, anxiety, fibromyalgia, etc., which leads to a delayed diagnoses. Therefore, validation and being understood in the AID world is incredibly important and much more influential in terms of emotional support than it may appear on the surface.
Bartlett et al. aimed to figure out which methods of empowerment were most successful in online support groups for those with chronic illness (mental illness excluded) (Bartlett et al.). Informational support and the ability to compare with others in similar circumstances were evaluated to be the most influential factors (Bartlett et al.). “Relationships with others” was identified as the most influential means of support in online health communities, according to Gallant (Gallant). Being heard and understood is important, and clearly, this research indicates that relationships with others are a necessary, support-based discussion point. As stated by Ziebland and Wyke, “the value of first-person accounts, the appeal and memorability of stories, and the need to make contact with peers all strongly suggest that reading and hearing others’ accounts of their own experiences of health and illness will remain a key feature of online health. The act of participating in the creation of health information (e.g., through website engagement and contributing to social networking on health topics) also influences patients’ experiences. It has implications for our understanding of their role in their health care management and information” (Ziebland & Wyke).

During the interviews I conducted, the need to be validated and relate to others was the primary theme throughout the responses. Some quotes regarding this concept were; “I felt like I was going crazy,” “I started to second-guess if the symptoms were real or in my head,” it was “alienating,” “I felt totally alone,” “my Doctor told me it was just my anxiety for three appointments before even running bloodwork.” I remember my doctors insisting on other diagnoses as well. A friend who has been assisting me in writing this research also had a similar experience with her AID. Despite severe symptoms for a year, her doctor told her it was “impossible” that she had developed an AID since last being tested for it. This person had to get a new doctor, as did I, to receive the positive diagnosis she knew to be true all along. Therefore,
the need to be validated is particularly crucial for the AID community because so often, even the doctors aren’t listening or believing.

Since validation is so heavily referenced in research and within the interviews I conducted, I have used this concept as a driving force in the creation of the prototype. Research states that first-person accounts can not only create peer-to-peer relationships, validation, and emotional support, it can also make patients more aware of their position in their health (Ziebland & Wyke). Meaning, by merely sharing and engaging with others on similar healthcare experiences, they will perceive to have adapted a self-managed approach to healthcare, which is the purpose of the website. As seen in Appendices 4 and 5, the Join as a Member and Share YOUR Story platforms are heavily referenced and used as a means to create tangible change in participants. The Q&A discussion threads will also create the feeling of a self-managed approach by having participants actively engage in the exchange of healthcare information.

**Key Propositions, Part II**

- Prototyping allows the creator to validate their ideas, find and solve challenges, and gather feedback before investing in a live product. User-centric prototyping for websites puts the users at the center of the development process.
- Website appearance elements such as the color scheme, image color grading, fonts, and logo all contribute to the storytelling of a website’s purpose produced for a specific audience
- Current Autoimmune Disease internet resources are often confusing and conflicting. Additionally, the primary barriers associated with participating in online health communities is that they are time-consuming and labor-intensive. For the chronically ill,
it is crucial the website appearance, organization, and materials are simple, comprehensive, and engaging with a certain level of fun.

- By participating in a supportive community where users are validated and connected to others in similar circumstances, Autoimmune Disease patients gain a better understanding of their health and perceive to have more control over their health.
- Inter-personal channels and the leveraging of personal experience are effective methods of influencing and empowering others to adopt new behaviors, even when skeptical.
- Educational resources and emotional support elements must be flexible to achieve inclusivity and to appeal to varying levels of experience and knowledge.

Part III: Final Thoughts and Reflection on the Process

A. Conclusion

Part I details the typical medical experience of an Autoimmune Disease patient. It is a maddening and ever-changing ordeal that requires a self-managed approach due to the lack of holistic medicine and lack of attention given to the role of diet as a way to reduce symptoms. I am very familiar with the medical run-around, and so were my interviewees. Our shared experiences are not unique. It is important to me that AID patients learn the role of diet and adapt to a new, self-managed healthcare approach by indicating and removing food sensitivities.

Part II contains two significant components in tandem. The first discussion is on the notability of user-centric website prototyping and my adventure in creating a product specifically for the AID patient-audience. The second component outlines the AID audience-based rationales that are translated into the web community prototype and its various features.
To summarize Parts I and II, here are the sections’ Key Propositions again;

Key Propositions, Part I: Autoimmune Disease Management and the Need for Intervention

- Years of experience battling Autoimmune Diseases and exposure to the commonly experienced subpar medical treatments lacking a holistic approach provides me with an empathic understanding of the typical barriers encountered by AID patients in general.
- Symptoms associated with Autoimmune Diseases can be significantly reduced or eliminated by identifying and removing food irritants.
- Formerly serving as a diet coach has allowed me to help three individuals successfully adapt to self-managed health by assisting in the creation of personalized diets.
- By providing Autoimmune Disease patients with proper educational resources, concise and knowledgeable direction, as well as an emotional support community based on shared experiences, the patients will be more inclined and empowered to adapt to self-managed health through dietary changes.

Key Propositions, Part II: Synthesizing A Model for Online Health Community

Engagement

- Prototyping allows the creator to validate their ideas, find and solve challenges, and gather feedback before investing in a live product. User-centric prototyping for websites puts the users at the center of the development process.
- Website appearance elements such as the color scheme, image color grading, fonts, and logo all contribute to the storytelling of a website’s purpose produced for a specific audience
• Current Autoimmune Disease internet resources are often confusing and conflicting. Additionally, the primary barriers associated with participating in online health communities is that they are time-consuming and labor-intensive. For the chronically ill, it is crucial the website appearance, organization, and materials are simple, comprehensive, and engaging with a certain level of fun.

• By participating in a supportive community where users are validated and connected to others in similar circumstances, Autoimmune Disease patients gain a better understanding of their health and perceive to have more control over their health.

• Inter-personal channels and the leveraging of personal experience are effective methods of influencing and empowering others to adopt new behaviors, even when skeptical.

• Educational resources and emotional support elements must be flexible to achieve inclusivity and to appeal to varying levels of experience and knowledge.

The main lesson I learned in user-centric prototyping is that nothing is set in stone. For that reason, I am grateful for the fluidity of prototyping and the slow, intentional development it requires. Whether it was the website’s appearance, sitemap pages, or actual words on the page, nothing came out the way I had envisioned when I started this research a year ago. My deep understanding of my audience drove my decisions, but often left me conflicted. For example, the first prototype iteration was simpler in appearance compared to the current version, but it was so incredibly dull. Although I might’ve achieved “simplicity,” I did not achieve “engaging.” Another example is the amount of text on the pages. Mid-way through development when I found myself fully immersed in research, the prototype content pages were overwhelmed with text. Perhaps I would’ve accomplished “educational” with overly wordy pages, but “simple” and “not
medically-dense” would be right out the window. Therefore, the key to creating this prototype was balance.

Another key takeaway from this experience was understanding my dual role as both website researcher and developer, as well as an AID-community member myself. I am all too familiar with the physician run-around, the sub-par disease management, and the superficial, conflicting, and confusing internet information. I created the idea of *Greenebean* to fulfill a need for the AID community, ergo, what I wish I had eight years ago when first diagnosed. Through personal experience with both AID’s and imperfect internet sources, as well as knowledge gained through helping others, I was able to design this website knowing what other sources lack and what the audience requires for learning to occur on a platform of this nature. Granted, I’ve never created a prototype for a community I wasn’t part of, but it certainly seems to me that having this inside knowledge allowed for more effective and accurate user-centric prototyping.

Additionally, I learned that creating a quality prototype takes a great deal of time. For this synthesis, I intended to create every single website page in paper form and then create some of the community interactive pages on digital platforms. However, that completeness was not realistic in a semesterly timeframe. Making user-centric based decisions requires more forethought than just creating content for the sake of it being done. Even as I write these words admitting to an incomplete product, I am reminded of Iriberri and Millington’s website lifecycle and also, lessons from the CCT program, that reward the notion of not knowing everything in developmental stages. So although I am missing several pages, lots of content, images, and digital representation, I feel confident that what I have created does suit my audience’s needs.

**Next Steps**
When I first started creating the *Greenebean* prototype, I thought my “next step” plan was going to be converting to a fully-digital product platform. Although that is absolutely not the case and a lot stands between what exists and a live digital platform, I am relieved that this careful development will create a high-quality product that the AID community so desperately needs. After several months of prototype development, I still have a long list of thinking and creating to do (and then rethinking and recreating).

Elimination Diet: The elimination diet element of the site is the most medically/geared item, and for that reason, it requires a great deal of additional research to make the diet accurate and straightforward. In the scope of this course, I couldn’t realistically do this research and create this item for the synthesis, though I desperately wanted to because it is at the heart of *Greenebean*. However, again, I didn’t want to create a sub-par product, so at this time, it remains an unfinished element. There are two examples of elimination diets found in Appendices 13 and 14. Neither of these products are my own and neither individually represent what I want to create; however, a similar *combination* of these two items is ideal. I put these in the appendices so the reader could see and understand the concept of an elimination diet and to also stress that it is complex and challenging to create. In Appendix 14, the image from Dr. Oz shows the level of detail I want to provide, including daily solutions and shopping lists. It is analytical and encompasses the daily needs and resources a person would require. However, it isn’t very nice to look and ignores the calendar and tracking aspect of the diet. Therefore, the cyclical elements of the image in Appendix 13, provided by Shah, as well as the simplistic design and use of color to break down the phases, better represents the appearance I would aim toward.
Disclaimer: I thought this would be a simple sentence or two to create, but upon prototyping, I realized that would not be the case. When I looked at the disclaimer on “thrivingonpaelo.com” created by Spring as a reference, I couldn’t believe how long it was. Foolish though it may be to admit, but taking ownership of my website’s property is just one of the needs I never considered. Furthermore, concepts like indemnification and assumption of risk is knowledge not in my wheelhouse. Disclaimers are generally created with the help of legal advice, which I have not yet sought. Again, I didn’t want to waste my time and the reader’s time by piecing together a haphazard, useless disclaimer, instead I prefer to leave it untouched and part of my “next step” plan.

Monitoring for Quality Improvement: Collecting feedback is vital to me as a creator of this website, as a researcher, and as someone who genuinely wants to help and improve the experiences of others with AID’s. There is no way to fully know if a product is achieving its purpose until those using it for said purpose verify its ability. Although I know my audience well because I am a part of them, Greenebean is just like any other website until I can confirm it is influencing lifestyle changes the way it’s intended. Also, the specific pages, the design, and the content could all stand to be improved based on the feedback I receive. I need feedback on the actual prototype before investing in any live digital product, and I also need monitoring tools, such as feedback forms and user polls, built into the website itself that evaluate its effectiveness and weaknesses.

To collect feedback on the prototype, I will first have to finish it, and then I plan to show it to my interviewees and a few other creative professionals from my inner circle of family and friends for opinions. Collection will most likely be an informal discussion, but will hopefully
yield some new ideas and concepts to ponder. Then, for the website itself, I plan to have a monitoring tool in the form of a survey, which will occur at the end of the elimination diet cohort as well as in the “Resources” tab. There are apparent metrics to consider, such as the number of participants and posts; however, I am much more interested in quality over quantity. Preece offers alternative evaluative measures such as user satisfaction, trustworthiness, and the amount of reciprocity (Preece). This framework speaks to the productive community I intend to create, as opposed to achieving a significant internet presence. To accomplish the collection and measurement of data in a way where it can be used for quality improvement, I will have to delve into evaluative theory. I must establish what it is I am evaluating (the metrics) and how the data can be quantified in a way where it can be used to create tangible change.

Additionally, because the website use is based on individual needs, I plan to have an open submission form without promoting questions. By keeping the channel open, at least at first, I can collect a higher quantity of suggestions that will better indicate individual needs and challenges not previously considered. Perhaps the feedback would not be the best quality in this open format. Still, the openness will indicate what elements require more attention, which will be crucial for refining the user experience survey. Also, by having users contribute to the website itself, they will strengthen their self-managed healthcare approach as Greenebean intends.

Building Constituency: To eliminate guesswork and aggravation, Greenebean materials must be comprehensive so users feel more inclined to participate in the community and its features. Also, since I am developing a user-centric product, it doesn’t exactly make sense that I do so with only my experiences and knowledge as the creative driving forces. High-quality prototyping does not occur in a silo. If I want this website to be live any time soon, I will need
the help and expertise of others to ensure a high-quality and inclusive website. Furthermore, although I will be the site manager, I will need trusted constituents to help with digital development, operations, and the creation of a participatory community. I plan on starting with my interviewees, who have already indicated interest. Then, I hope to utilize my employment at a college by engaging in hands-on development through tabling and flyers. Perhaps posting a call for others on social media platforms as well might yield greater results. There are a lot of options to explore, which is crucial as I enlist others to gain more insight, to establish a community, and to help with technical operations.

Alternative Learning: To engage all audience members equitably, I will need to incorporate solutions for non-English users and those with disabilities that might hinder or prevent engagement with the site in a traditional fashion. First, I will need to research and identify who these alternative learners are and what is required for their learning to occur on a platform of this nature. Then, I will need to find and incorporate these solutions into the prototype. Since these alternative learners are subsects of my audience that I am not part of, collecting feedback on the effectiveness and inclusivity of these accommodations is crucial before going live with a digital product.

Changing the Narrative: Although modern medicine cannot replace the value of storytelling, connecting with others in similar circumstances, and validation in an emotionally supportive framework, I dream of a future where Greenebean is more of a bonus to AID healthcare, instead of a complete necessity. There are many reasons as to why patients remain unaware that diet can reduce symptoms associated with AID’s; there is a lack of scientific
understanding, holistic approaches, and funding. Also, gluten-free diet fads and skepticism all cloud the monumental potential diet changes hold. These are real and difficult barriers to overcome, and I am delighted to contribute my knowledge and expertise to help where I can. Still, I am frustrated for the AID community and myself. I am frustrated that modern medicine isn’t reaching their full potential when it comes to AID-management.

I developed Greenebean to fulfill a need that is missing in AID-symptom management. However, I know I cannot realistically reach and help everyone that needs educational resources, concise direction, and an emotionally supportive community that will empower and enable them to adapt to self-managed healthcare through dietary changes. I dream that this comprehensive approach becomes readily available to AID patients through traditional medicinal channels (again, with the exception of the community-based benefits). Greenebean’s creation is influenced by what’s missing in the medical field’s disease management approach. What if, in turn, the medical field is influenced by what Greenebean successfully fulfills in AID disease-management? What if an influence feedback loop could be generated? I can’t help but wonder if Greenebean (and similar platforms like it) can shed light and create pressure in the medical field, which would influence and empower them to reduce or eliminate the barriers preventing a diet-based, holistic approach in AID-management.

For example, say the prevalence of online learning skyrockets because of its flexibility and practicality, and traditional face-to-face learning begins to decline. At some point, educators must recognize the value and successes of online learning, and try to adopt certain elements and improve their face-to-face practice. The integration of learning styles would create an ideal learning model. Greenebean exists to fulfill a need not readily found in the AID medical field, but what if its value becomes recognizable to the point where the medical community responds
and improves its sub-par management-approach? It is a very “dreamer” point of view. Still, it would be ideal if Greenebean were so successful at influencing others to adopt to a self-managed diet that significantly reduces their symptoms, that similar diet-based communities started up and did the same. Then, the value could no longer be ignored in the medical field. It may be difficult or perhaps impossible to spread the sphere of influence that far, but I do hope that one day diet becomes a staple in medicinal AID-management. Perhaps Greenebean can help contribute to accomplishing this feat by merely operating effectively for an extended (and unknown) period of time.

Adapting A User-Centric Approach

Good quality research is generated with the hopes others will adapt and adopt what has been done to continue the cycles of relearning and rethinking through new perspectives. Continued inquiry is also the intention behind explorations in CCT and accepting that there is always more to learn and reflect on (Taylor). Although the prototype I have created is very specific to the AID community, the slow, audience-centric development style can be applied to any topic or audience as needed. It’s challenging to translate audience needs into actual website material. Therefore, it takes a deep understanding of the specific audience first, then prototyping organization and design second to create a purposeful product.

User-centric development also requires the creator to shelve their own personal design styles, ways of presenting information, and methods of communicating to others, which can be challenging to adopt. For instance, I honestly struggled with limiting the amount of text in the prototype because, perhaps it’s been noticed, I am wordy by nature. I also didn’t want to have a presence on the website at all - no profile, no story. My desire to remain incognito was
outweighed by the plethora of suggestions to make my presence known as a means to influence and support others. Therefore, the user-centric decision was to be present, despite what I may have wanted. I see it as being like an interior designer. Clients don’t want a house designed in my style; they hired me to understand their wants and translate that into something concrete for them. If I can fulfill their wishes and desires, then the job is accomplished. Therefore, when adapting the user-centric prototype model I have discussed, I highly suggest an evaluation of the creator’s wants and urges as they occur over time and how it directly aligns or conflicts with the needs of the product being created.

B. Reflection

My Practice

When reflecting on my experience as a researcher and a producer of original, creative content meant to influence a specific audience, I feel grateful for the lessons and practices taught in the CCT program. Methods I didn’t fully-appreciate then were the driving force behind this whole synthesis. For example, the simple post-it grouping exercise guided me out of two very complicated areas, as mentioned above. Simple in scale, this practice can help a researcher sort through a lot of sprawling ideas, notice gaps, and organize complex ideas. Another CCT practice is the proposition and counter-propositions argument building exercise. Since skepticism runs high and because there is so much junk on the internet to cause doubt, it was essential to always be questioning my assumptions when creating the prototype. By playing devil’s advocate and continuously doubting what I was creating (whether with intention or not), I was able to rethink my assumptions, alter the plan, and better validate the user-centric rationales and decisions I made through argument-building.
The last CCT tool I was grateful for during this synthesis is the Strategic Research Design (Taylor). I loathed this several semesters ago when it was first presented because I couldn’t quite understand how to show metacognition with words. Articulating a research design plan seemed more impossible than just sitting down and attempting to do it. However, there were at least three occasions where I sat to work on the prototype or type this synthesis, and I would accomplish virtually nothing after several frustrating hours. I would try making to-do lists, but “research more” and “create prototype” were hardly directional or helpful tips. Eventually, I started keeping a digital to-do list that over time, looked nothing like the type-A products I make. There were sprawling notes, lists of priorities ranked by time and need, colored schedules, and different fonts and sizes that genuinely encapsulated the madness within. I didn’t even realize I had made a CCT- Strategic Research Design plan at the time. However, it became my bible, and over time the notes decreased, the schedules ran out, and the madness subsided. Now, the list of priorities reads like the “next steps” of the section above.

Although there is still a lot of work to be done, I am thrilled to eventually fulfill a need that I didn’t have available to me years ago. I do genuinely like helping others, which has been a helpful reminder when venturing into less-desirable areas like disclaimers and website domains. So far, other than myself, I have helped three people overhaul their diet, and admittedly, I do feel a sense of pride when they check in with their low blood pressure numbers or tell me they were able to pick up running again because of reduced joint pain. That feeling is what got me interested in this research, and that is what continues to drive my passion. It feels odd, writing these closing sentences, as if I’m saying goodbye to the CCT program. Yet throughout my graduate career, I have learned significant methods and resources that will continue to drive this self-managed, AID, diet-based support community until it comes to fruition. Lastly, like a true
CCT-er, I will never feel satisfied with what I already know and will continue to learn with curiosity, inquiry, and in collaboration with others.
Works Cited


Rose, James. “Create a Website Design Questionnaire (Includes Template).” Content Snare, 7 Jan. 2020, contentsnare.com/website-design-questionnaire/.


Appendix 2

Daily Symptom Tracking Sheet

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<tr>
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<td></td>
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Appendix 3

Site Map
Appendix 4

Greenebean: Homepage
Appendix 5

Greenebean: Start Here

A DIET GUIDE FOR THOSE WITH AUTOIMMUNE DISEASE

I DON'T KNOW ABOUT AUTOIMMUNE DISEASES AT ALL

I KNOW ABOUT AUTOIMMUNE DISEASES, BUT I DON'T KNOW ABOUT THE DIET CONNECTION

I KNOW ABOUT AUTOIMMUNE DISEASES, AND THE DIET CONNECTION, BUT I DON'T KNOW WHAT DIET TO FOLLOW

I HAVE TO FOLLOW A SPECIFIC DIET, BUT I HATE COOKING

WILL IT WORK FOR ME?

HOW DO I COOK FOR MY FAMILY IF MY DIET CHANGES?

SOMEONE I LOVE HAS AN AUTOIMMUNE DISEASE, & I WANT TO LEARN

I DON'T HAVE AN AUTOIMMUNE DISEASE, CAN THIS WEBSITE STILL HELP ME?

WHY I THINK YOU NEED TO DO AN ELIMINATION DIET

Disclaimer
Appendix 6

Greenebean: Q & A

Q: How long does it take for symptoms to start decreasing if you’ve found a food irritant?
A: For me, with gluten, it started within a few days and things continued to rapidly change for about four weeks. I started losing weight immediately and that continued the whole time. Arthritis, inflammation, fatigue, and muscle aches are so much better now! It happened so gradually that it was hard to notice at first. After a month I was like, oh wow, something’s happened!!

Q: What brands of gluten-free pasta do you like?
A: Some of your current favorite brands have great options - Barilla, Prince, etc.
A: I highly recommend rice noodles - not for marinara - think more Pad Thai
A: chickpea pasta
A: I usually buy Barilla in the store, but you can order your favorite in bulk on thrive.com

Q: I’m traveling to Boston next month for work, any GF restaurant suggestions?
A: Puro, Barcelona
A: for on-the-go meals, check out “by Chloe”, Poke Works, or Grainmaker
A: findmeglutenfree.com will give you a list of all restraints! And it’s based on ratings so you can really guarantee you’re going to the right place
A: Even though it’s a chain, Legal Seafood locations have dedicated GF Fryers!
Appendix 7

Greenebean: Recipes
Appendix 8

Greenebean; Recipe Example
Appendix 9

Greenebean: Meal Prep

Meal Prep

WHEN IN DOUBT, DO THE 1-2-3: PROTEIN + CARB + VEGGIE
(SUB 1 AND 2 FOR MORE 3)
otherwise, mix it up

RAMEN JARS

1. Pick a Base - hoisin, chili paste, bouillon paste, peanut sauce, curry paste, gochujang, lemon pepper sauce
2. Add finely chopped veggies - bell chay, peppers, snow peas, mushrooms, zucchini, edamame, napa cabbage, optional: small pieces of cooked protein/ tofu - beans, lentils
3. Add your noodles - uncooked rice or vermicelli or par cooked spaghetti
4. Lock it up - green onions, thai basil, chopped spinach
   • top with hot water, seal for 5 minutes
   • want a little crunch on top? nuts, crispy onions, fried veggies, seeds, fried noodles
   • don't use a 'regular-mouth' jar - you want wide-mouth

RAINBOW VEGGIES

Roast together and divide in to different meals w/ variation for the week
1. Slice a ton of veggies
2. Arrange on sheet, toss in EVOO, S&P and bake 15 minutes on 400
   • Divide and add to pasta, rice, quinoa, beans, (sweet) potatoes
   • can add protein but not necessary
   • Pick a sauce/seasoning to match

HEALTHY SNACKS

Snacks aren't something you think to prep, but that's where a lot of slips happen
1. Fill jars with - hummus, salsa, guacamole, favorite dip, sour cream/Greek yogurt, + any seasoning, peanut butter, yogurt, chocolate hummus (yes, it's a thing!)
2. Fill cups with various dippers - pretzels, carrots, cucumber slices, granola, strawberries
Appendix 10

Greenebean: Autoimmune Diseases

Autoimmune Diseases

A normal immune system produces antibodies to attack harmful bacteria and viruses. If there is nothing harmful to attack, the immune system doesn’t act.

An Autoimmune Disease mistakes safe cells for harmful cells and begins to attack some part of the body.

For more information on the immune response, click the image.

Some Facts:
- There are about 100 of these complex diseases
- The autoimmune response may attack your skin, a single organ, or a whole system
- They can cause symptoms all over the body
- 75% diagnosed are women

For a list of autoimmune diseases, click the image.

Common Symptoms:
- fatigue
- joint aches
- inflammation
- hair loss
- skin rashes
- digestion issues
- muscle aches
- brain fog
- numb extremities

These varied symptoms make it difficult to get a diagnosis.

If you feel you may have an autoimmune disease, schedule a visit with your doctor.

Write down your symptoms ahead of time.

Insist on testing.

Note: The resources on this website won’t be helpful without a diagnosis.

Disclaimer

References
Appendix 11

Greenebean: Autoimmune Disease & Diet

Autoimmune Disease & Diet

**Leaky Gut**
It's thought that Autoimmune Diseases are caused by tiny holes in the intestines. This releases food particles into the body, which causes the immune system to react.

**Inflammation**
Autoimmune Diseases cause inflammation in various parts of the body. Eating anti-inflammatory foods reduces the attack, response and in turn, reduces inflammation.

**Will it help me?**
Do you have an Autoimmune Disease? Then most likely, YES!

You won't know until you try
We have everything you need

**There is evidence that the**
- Paleo diet,
- Autoimmune protocol diet and the
  - Low FODMAP can all reduce symptoms

**So what does that mean?**

**You Need to take the good from each**
& make your own diet

**What can you do?**
1) Find your food irritants
   Click here: Elimination diet
2) Eat nutrient-rich, natural foods
   Click here: Recipes
Appendix 12

Greenebean: My Story

My Story

I used to be perfectly healthy before. Then trauma struck and something rusted in my body, permanently. My head was stapled and my tooth replaced, but something deep down rewired my system and how I processed pain. I felt sick 24/7. I would sleep 11 hours a night and couldn’t keep my eyes open during the day. I was nauseous all the time and threw up a few times a week. I couldn’t digest, my nails were falling apart, and my hair falling out. My muscles were sore head to toe, my joints were on fire. I was dizzy, bloated, in a constant state of heat-hum, and my skin looked like paper left in the sun too long. I was gaining weight despite eating a low-processed, vegetarian diet... keep reading

Disclaimer
Appendix 13

Greenebean: Elimination Diet

What is it?
You remove foods from your diet for a short time, then reintroduce them in small amounts while monitoring symptoms.

Why would I do that?
By monitoring your symptoms, you are able to indicate food irritants commonly associated with autoimmune diseases.

What will that do?
For more info on the autoimmune disease-diet connection, click here. Once your food irritants are found, you may help heal your gut, reduce inflammation, and eliminate or decrease your symptoms.

Should I do it?
Yes

Do you want to feel better?

What’s next?

Join the elimination diet course
Download elimination diet

Disclaimer References
Appendix 14

Elimination Diet Example 1

The following example is not my own. This example is provided by Shah. I will use a likeness of this in the creation of my own.
Appendix 15

Elimination Diet Example 2

The following example is not my own. This example is provided by Dr. Oz. I will use a likeness of this in the creation of my own.

**SHOPPING LIST**
- Filtered water (Aim for 6-8 glasses/day)
- Fish: Sardines, herring, wild salmon, black cod, sole and cod (4-6 oz twice a day)
- Lean white chicken breasts (4-6 oz twice a day)
- Fresh or frozen non-citrus fruits: Blueberries, raspberries, strawberries, blackberries, grapes, melons, apples, kiwis and cherries
- Fresh or frozen green vegetables: Leeks, broccoli, cabbage, kale, collard greens, Brussels sprouts, bok choy, spinach, arugula, asparagus and celery
- Low-sodium vegetable broth
- Brown rice
- Nuts and seeds: Almonds, walnuts, pecans, macadamia nuts, and pumpkin seeds
- Spices: Rosemary, cilantro, ginger, garlic, turmeric, curry, or sea salt

**FOODS TO REINTRODUCE AFTER CLEANSE**
- Soy: Tofu, soybeans
- Citrus: Fruits and juices
- Dairy products: Milk, butter, yogurt and cheese
- Eggs
- Corn
- Nightshades: Tomatoes, eggplants
- Gluten and wheat

**DAILY FOOD MENU**

**Breakfast:** 7-9 a.m.
- 1 cup green tea
- 1 cup hot rice cereal
- 1 tbsp of almonds
- 1 tbsp of pumpkin seeds
- 1 cup of strawberries

**Morning snack:** 10-11 a.m.
- 1 oz of almonds
- 1 cup of low-sodium vegetable broth
- 1 apple

**Lunch:** 12-1 p.m.
- 4-6 oz of chicken breast, cooked
- 2 cups lightly sautéed green vegetables (with 1 tbsp of olive oil)
- 1/2 cup cooked brown rice

**Afternoon snack:** 2-3 p.m.
- 1 cup of low-sodium vegetable broth
- 1 oz of almonds
- 1 cup of raspberries
- 1 cup of green tea

**Dinner:** 5-7 p.m.
- 4-6 oz of salmon, cooked
- 2 cups of lightly sautéed green vegetables (with 1 tbsp of olive oil)
- 1/2 cup cooked brown rice
- 1 cup of low-sodium vegetable broth
Appendix 16

Disclaimer Example

The following disclaimer example is not my own. The example is provided by *Spring*. I will use a likeness of this disclaimer in the creation of my own.

THRIVING ON PALEO DISCLAIMER

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