This is to certify that the
dissertation entitled

PERCEPTIONS OF WEIGHT-RELATED HEALTH IN AFRICAN AMERICAN FAMILIES: A PHOTOVOICE STUDY

presented by

AMY KRISTEN FOSTER

has been accepted towards fulfillment
of the requirements for the

Doctoral degree in Family and Child Ecology

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11/19/09
Date

PERCEPTIONS OF WEIGHT-RELATED HEALTH IN AFRICAN AMERICAN FAMILIES: A PHOTOVOICE STUDY

By

Amy Kristen Foster

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Family and Child Ecology

2009

ABSTRACT

PERCEPTIONS OF WEIGHT-RELATED HEALTH IN AFRICAN AMERICAN FAMILIES: A PHOTOVOICE STUDY

By

Amy Kristen Foster

In this qualitative study a phenomenological approach was used to explore the lived experiences and perceptions of weight-related health in African American families with an overweight or obese child. The goal of this study was to provide a forum for African American families to voice their experiences in order to highlight areas of influence on their weight-related health as well as their preferences for weight-related programs. Six African American families with a child diagnosed as overweight or obese (i.e. BMI equal to or greater than the 85th percentile) were interviewed with a total of 18 participants. All families completed a demographic questionnaire and were guided to use cameras to photograph factors relevant to their weight-related health using the Photovoice methodology (Wang & Burris, 1997).

The theoretical framework for the study was based on human ecological and social constructionist theories. Data were collected through semi-structured interviews and each family provided visual data. Interview questions were designed to capture stories of family experiences with weight-related health in addition to family perceptions of weight-related programs. Family photographs were used to support and clarify personal stories about weight-related health, hence allowing for triangulation with qualitative interviews.

Data analysis revealed several key findings relative to weight-related health experiences in African American families. First, families found health professionals, such as physicians, to be helpful in their understanding of weight-related health. Second, family was viewed as a strong source of support for living a healthy lifestyle. Third, weight-related health programs were seen as valuable because they provided a sense of normalcy and community support. Lastly, challenges to following weight-related health recommendations were perceived as being due to limited income.

This study has implications for professionals working with African American families who seek obesity treatment. The findings of this study suggest that it is essential for family therapists to have cultural competence training in order to gain knowledge and skills to effectively work with African American families. In addition, health care providers, such as physicians and program facilitators, are encouraged to collaboratively work with African American families in order to develop interventions that are both relevant and effective.

Acknowledgments

I would like to thank my family for their continued love, support, and encouragement during my graduate studies. It is because of you that I was able to accomplish this goal. I love you all so very much. To my husband Steve, your support over the last several years has been unbelievable and very much appreciated. I will always remember your words of encouragement, the occasional celebratory dance as this process was nearing the end, and your willingness to help me with whatever I needed during this process. I look forward to our future as Dr. Foster^2. To my Dad, thanks for the intellectual conversations and your beautiful laugh and smile. I have always known how proud you are of your girls and that is something I will always cherish. To my Mom, thank you for always checking up on me and for sending care packages. The littlest things you do bring a smile to my face. Also, I believe this calls for "play a lot and study very little". I have definitely earned it! To my amazing "sissy" Dawn, you are one of the dearest people in my life and I am forever grateful for your love and words of encouragement. You definitely know how to make me laugh and enjoy life.

There are not enough words to express my thanks to my doctoral committee. If it were not for Dr. Marsha Carolan and Dr. Lorraine Weatherspoon this dissertation would not have been possible. These two women are absolutely amazing and have contributed the most to my graduate studies. I thank you both for helping me through this process and helping my dissertation come to fruition. I truly do not know where I would be without your support. To Dr. Adrian Blow, you have probably contributed the most to my growth as a clinician. I am grateful for the many co-therapy experiences we have shared. It has been fun to work

with you and I am glad you were a part of my graduate school experience. To Dr. Deborah Johnson, thank you for your words of encouragement and the contributions you have made to my dissertation. You helped make this dissertation better than I could have imagined.

To the families who shared their time and stories with me during this study, I thank you for welcoming me into your homes and for making this dissertation possible. I learned so much more than I expected from each of you and I hope this dissertation and future publications will extend your voice to other families. I know the opportunity to share your stories was a way for you to give back and I am honored to make that possible. I hope that what you have taught me and other researchers will help improve the obesity problem in other African American families.

To all my MFT friends, this is an experience no one else can understand! I have grown as a therapist and as a person because of all of you. I will cherish the time we had together in the classroom, at clinic, at conferences, and outside school. I wish you all the best as you complete your graduate studies and move on in your professional careers. Yes, you will complete your PhD as well!!

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CHAPTER ONE

INTRODUCTION

Background of the Problem

Currently, obesity treatments seek to empower obese youth and families by helping them explore and make changes relative to the individual and environmental factors that influence their health (Campbell, 2003; Dietz & Gortmaker, 2001; Golan & Weizman, 2001; Kitzmann & Beech, 2006). Researchers have commonly identified factors that influence obesity development, but have had limited consideration for cultural factors. Based on these findings, researchers have developed treatments to address these factors with youth and their families. However, obesity treatments to date have had limited effectiveness. The lack of treatments with long-term effectiveness, complicated by growing disparities in obesity across ethnic groups, speaks to the need for tailored treatments that address the unique make-up and environments of all ethnic groups.

In particular, African Americans have one of the highest prevalence rates for obesity in the United States, which has been complicated by their unique experiences (e.g. slavery, poor medical care history, segregation) (The Obesity Society [TOS], 2008; Centers for Disease Control and Prevention [CDC], 2006; Ogden, Carroll, Curtin, McDowell, Tabak, & Flegal, 2006; U.S. Department of Health and Human Services [DHHS], 2000). Overall, the literature shows that physical activity, nutrition, parent involvement, and various environmental factors are significant to childhood obesity. However, the meaning and significance of

these various factors on the health of African American children and their families has not been considered in treatment development. This study sought to inquire about weight-related health of African American families.

This study specifically focused on the experiences and perceptions of weight-related health in African American families who have at least one overweight or obese child. It should be noted that across the literature on childhood obesity the terms "overweight" and "obesity" are used interchangeably despite having the same Body Mass Index (BMI) range (Flegal, Tabak, & Ogden, 2006). BMI is a measure of weight relative to height and age. For this study, at least one child in each family was either overweight or obese (i.e. BMI equal to or greater than the 85th percentile).

The families in this study participated in the Healthy Kids, Healthy Families program through the Kent County Michigan State University(MSU) Extension office. This program was developed as a collaboration by university departments in human nutrition (Dr. Lorraine Weatherspoon) and family ecology (Drs. Marsha Carolan and Kathleen Jager) to address childhood obesity in the state of Michigan. The goal was to integrate parent involvement in the treatment of childhood obesity. Research demonstrates parent and family influence on child health as well as the successful treatment of child health problems such as obesity (Campbell, 2003; Davison & Birch, 2001; Dietz et al., 2001; Golan, Weizman, Apter, & Fainaru, 1998; Golan et al., 2001; Harkaway, 2000).

Families were recruited through a local pediatrician's office. The pediatrician identified children who met the criteria for overweight or obesity (i.e.

had a BMI equal or greater than the 85th percentile) and subsequently referred them to the Healthy Kids, Healthy Families program. Selected staff from the Kent County MSU Extension office were involved in the enrollment process and program delivery. The Healthy Kids, Healthy Families program provided weight-related health education to families over a period of 3 months. The program consisted of 4 home visits and 6 multi-family group sessions. During the home visits and group sessions, families were educated on the effects of nutrition, physical activity, family involvement, and mental health on the development of obesity. The overall goal of Healthy Kids, Healthy Families was to educate families on weight-related health as well as encourage them to work together to improve the health of the overweight or obese child and perhaps the overall family.

Obesity and the African American population

The prevalence of obesity in youth and adults has more than tripled in the last 30 years (Flegal et al., 2006). A closer examination of obesity rates reveals that it is more prevalent in ethnic minorities such as African Americans, Mexican Americans, and Native Americans (TOS, 2008; CDC, 2007; Ogden et al., 2006). In regard to African Americans, 35.1% of youth are obese (i.e. BMI equal to or greater than the 85th percentile) in comparison to 33.5% of Caucasian youth. In adults, 45.0% of African Americans are obese compared to 30.6% of Caucasians (Ogden et al., 2006). Obesity is associated with a greater likelihood of developing obesity-related health problems such as type 2 diabetes, heart

disease, hypertension, and sleep apnea (CDC, 2007; Glenny, O'Meara, Melville, Sheldon, & Wilson, 1997).

The disproportionate rates of obesity and lack of successful long-term treatment has contributed to the current trend in exploring environmental factors as potential contributors to obesity development. It is postulated that accounting for environmental differences will enhance our understanding and subsequent treatment of obesity (Dietz et al., 2001; Egger & Swinburn, 1997; Geronimus & Thompson, 2004; Hill & Peters, 1998; DHHS, 2000)

Ecological Perspective on Obesity

With health initiatives like Healthy People 2010 (DHHS, 2000), the exploration of environmental factors that contribute to obesity development has increased in obesity research. In addition, such initiatives and researchers are taking an ecological approach to understanding the interrelationships between various individual and environmental factors. By examining obesity from an ecological perspective, researchers and health professionals have a chance at accurately understanding obesity contextually and hopefully its treatment.

A substantial amount of obesity research comes from examining factors in the microsystem (i.e. the individual) because traditional obesity research focused on the direct association of nutrition and physical activity on weight. In addition, researchers at this level have attempted to find a genetic link to obesity; however, no single gene has been associated with obesity development (Egger et al., 1997). Treatment attempts to only address nutrition and physical activity in overweight and obese individuals have not always met with success, which is

why attention has shifted towards understanding how a person's environment contributes to their weight-related health.

There are a variety of environmental factors that have been associated with obesity in the African American population. In this aspect, many researchers have taken a historical and contextual look at African American health. It is strongly believed that the history of slavery, medical mistreatment, and lack of quality health care has resulted in poorer health outcomes for many African Americans today (Byrd & Clayton, 1992; Northington-Gamble, 1993; Outterson, 2005; Savitt, 1982; Smith, 2005; Williams & Collins, 2004). In addition, these historical events have directly or indirectly affected other environmental factors that are associated with health and obesity.

The passing of the Civil Rights Act in 1964 brought about needed reform for the African American community, but lingering effects of segregation and discrimination has placed many low income African Americans in communities with little opportunity for managing a healthy lifestyle (Williams & Collins, 2001). Even today, these communities have limited access to quality medical care, schools with limited resources, a higher number of convenience and alcohol stores than supermarkets, lack opportunities for physical education (e.g. playgrounds), have few well paying jobs, and are often in less safe neighbors (Hill et al., 1998; Wells, Ashdown, Davies, Cowett, & Yang, 2007; Williams et al., 2004). All of these factors are associated with obesity. In particular, the literature points to the noticeable effect that socioeconomic status (SES) has on obesity. A person's income influences health insurance, access to medical

treatments, ability to purchase healthy foods, and the ability to access recreational activities (Wells et. al, 2007; Wickrama, Wickrama, & Bryant, 2006).

Lastly, there is a paucity of research that examines cultural influences on obesity and health. Much of this literature reflects on the general finding that African Americans are minimally influenced by Western ideals regarding beauty (i.e. thin is beautiful) (Allan, 1998; Freedman, Carter, Sbrocco, & Gray, 2004; Ge, Elder, Regnerus, & Cox, 2001; Kumanyika, Wilson, & Guilford-Davenport, 1993; Miller & Pumariega, 2001). Some may characterize this as a hindrance to treating the obesity problem; however, from a non-deficit point of view this can be seen as a strength of the African American community. Furthermore, most of the current health initiatives are promoting maintenance of a healthy weight, which is not determined by a number on a scale. This idea is more congruent with African American beliefs about weight. Another aspect of culture that has been touched on is food preference. Research by Airhihenbuwa, Kumanyika, Agurs, Lowe, Saunders, & Morssink (1996) examined African American perceptions about food and culture. Overall, many of their participants felt some connection between culture and the foods they ate as well as their eating behaviors (e.g. eat with the family and eating is spiritual). Other participants felt the history of slavery probably robbed African Americans of their traditional foods.

The research to date has done well in terms of highlighting factors that have some association with obesity development. However, minimal work has been done in collaborating with African American youth, adults, and families who

are affected by obesity to obtain their perceptions on factors that influence their health.

Lack of Qualitative Data on Obesity and Families

The literature on African American beliefs and weight-related issues (i.e. obesity and type 2 diabetes) is much more limited than research on culture and obesity. As researchers "we have a limited understanding of how perceptions about weight and beliefs about the cause and treatment of obesity may influence weight loss behavior" (Allan, 1998, p. 45). Existing qualitative studies have examined adult, female beliefs about what is helpful in obesity intervention, adult beliefs about type 2 diabetes, body image in adulthood, and beliefs about food choices (Airhihenbuwa et al., 1996; Penckofer, Ferrans, Velsor-Friedrich, & Savoy, 2007; Skelly, Dougherty, Gesler, Soward, Burns, & Arcury, 2006). From these studies we have learned that African Americans welcome a group atmosphere because it is a source of support, that physician support is appreciated, learning how to cook traditional foods in a healthier way is appreciated, the development and treatment of type 2 diabetes is not well understood, and weight does not define attraction or beauty. This is all helpful information, but most of this research has been conducted with individual youth or adults, not with families.

Although previous studies have highlighted weight-related perceptions in adults, it is important to extend this line of research to understanding childhood obesity. Specifically, family perceptions around weight-related health should be explored due to familial influence on childhood obesity development. Parent

inclusion is important because children acquire health habits from their home environment (Golan et al., 2001). Therefore, exploring family beliefs is a logical first step in creating more tailored treatment programs.

Purpose of the Study

This study explored the lived experiences and weight-related health perceptions of African American families who have at least one overweight or obese child (i.e. BMI at or above the 85th percentile). These families participated in a family-based program that focused on weight-related health education. The program explored weight-related issues from an ecological perspective with primary focus on nutrition and physical activity. The aim of the program was two-fold: 1) educate youth and their parents about living a health lifestyle, and 2) encourage youth and parents to work together to maintain the healthy lifestyle. This approach moves beyond the traditional model of focusing on individual change in the child by encouraging all family members to work together.

This qualitative study provided an opportunity for African American families to share their experiences and perceptions about weight-related health. One primary area of study included perceptions about individual, familial, cultural, and environmental influences on weight-related health. In addition, the study explored family perceptions on weight-related programs. Weight-related health perceptions were explored through an ecological and social constructionist lens using photos and in-depth family interviews.

Significance of the Study

The literature demonstrates that an array of ecological factors play a significant role in the development of obesity. However, it is unclear if and how influential these numerous factors are for various populations. This uncertainty could potentially explain the lack of success in current approaches to treatment. In particular, there are two areas of study that are lacking in obesity research. First, much of the obesity research has focused on the individual (child or adult) despite evidence of familial influence on obesity development (Campbell, 2003; Dietz et al., 2001; Epstein, Myers, Raynor, & Saelens, 1998). According to Harkaway (2000), obesity research has rarely examined the family as a distinct system. In addition, it is rare for studies to explore the family's relation to other social systems. Second, obesity research traditionally focused on the Caucasian population. In the last few decades research has explored populations with higher obesity prevalence, namely African American and Mexican American populations. Research is needed to explore unique aspects of obesity in highly affected populations, like African Americans, and needs to explore first-hand accounts of obesity-related issues from such populations. Few studies have examined values and beliefs about obesity and it is suggested that ethnic customs, beliefs and preferences must be explored in order to design culturally relevant weight-related programs (Blixen, Singh, & Thacker, 2006; Blixen, Singh, Xu, Thacker, & Mascha, 2006).

In this qualitative study a phenomenological approach was used to explore the lived experiences and perceptions of African American families with an

overweight or obese child. This approach was grounded in Human Ecological and Social Constructionist theories. This study aimed to examine the experiences of these families and their perceptions regarding what is influential to their weight-related health and how influential those factors are as well as their perceptions of weight-related programs.

Major Research Questions

The goal of most weight-related programs is to educate participants about living a healthy lifestyle and to help them achieve that lifestyle. What is typically missing in such programs is the inclusion of family perspectives. Incorporating family perspectives and collaborating with families in treatment strategies has the ability to empower families, identify the challenges they face in healthful living, help family members work together to face these challenges, and facilitate collaboration with health professionals to achieve a healthy lifestyle. This study was an effort to give voice to African American families who participated in a weight-related program in order to highlight their perceptions and experiences as they strive to live a healthy lifestyle. Furthermore, the major research questions of this study were phenomenological in nature, that is, "questions of meaning that are designed to help the researcher understand the lived experience of the participant" (Dahl & Boss, 2005, p. 70).

The major research questions explored in this study were:

1) What are African American families' perceptions of weight-related health?
2) From an ecological perspective, what influences the weight-related health of African American families?

3) How do weight-related programs influence the weight-related health of African American families?
4) What challenges do African American families encounter when implementing weight-related health recommendations?

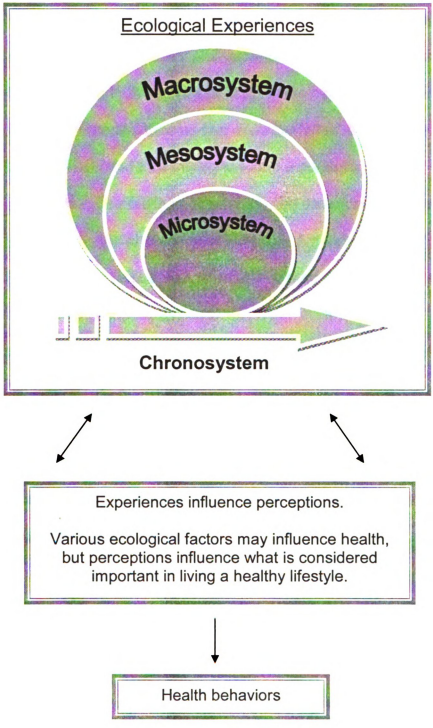
Conceptual Map

The conceptual map (see Figure 1.1) illustrates the plan of this study. The sample consisted of six families who took part in the Healthy Kids, Healthy Families program offered by Kent County MSU Extension. Families were recruited through a local pediatric office. Families who had an overweight or obese child, as identified by the pediatrician as having a BMI equal or greater than the 85th percentile, were offered the opportunity to take part in the Healthy Kids, Healthy Families program to address weight-related issues.

The purpose of this study was to explore the perceptions of weight-related health in African American families within a framework that privileged their experiences. Because this study used a phenomenological approach, my personal hypotheses and scientific findings were set aside in order to fully appreciate the knowledge and experiences that these families have (Wertz, 2005). The purpose of phenomenology is to gain understanding and knowledge, not to compare lived experiences to current literature. What I conceptualized however was that lived experiences influenced perceptions, in this case weight-related health perceptions. Subsequently, these perceptions influence how a person interprets their world and the health behaviors they engage in.

The health behaviors of African American families are hypothesized to come together through the interrelationship of experiences and perceptions. This process is dynamic. The ecological experiences of families influence their perceptions about weight-related health. These health perceptions subsequently help the family make sense of their environment and how it plays a role in their weight-related health, which will ultimately influence their health behaviors. Through an ecological perspective the literature identifies a variety of factors that may influence weight-related health. However, the family's perceptions determine the factors that are significant to this aspect of their health.

Figure 1.1 Conceptual Map



Theoretical Framework

This study takes a phenomenological approach to learning about African American families' weight-related health perceptions as they relate to the environment around them. The goal of phenomenology is to explore a particular phenomenon by bringing forth the stories of people who experience it with the purpose of discovering essential themes that describe "what" the phenomenon is (Creswell, 2007). It is believed that "reality is within a person's private perceptions – within his or her feelings, intentions, and essences" (Dahl et al., 2005, p.69). In this study, the phenomenon is African American families' perceptions about ecological influences on weight-related health and weight-related programs.

To theoretically understand the relationship between weight-related health perceptions in African American families and their environment, Human Ecological and Social Constructionist theories were used in this study. Human Ecological Theory helps explain the interrelationship between families and their environment, whereas Social Constructionist Theory attends to the beliefs and perceptions about these interrelationships.

Human Ecological Theory

Human Ecological theory has a basic premise that individuals are connected to their environment and that there is an interrelationship between them (Sallis & Owen, 2002). According to this theory the environment has several systems (i.e. layers), which directly or indirectly influence the individual, the family, and their development. "Although the family is the principal context in which human development takes place, it is but one of several settings in which

developmental process can and [does] occur" (Bronfenbrenner, 1986, p. 723). In total, there are five systems that influence development: 1) microsystem, 2) mesosystem, 3) exosystem, 4) macrosystem, and 5) chronosystem.

For the purpose of this study the microsystem, mesosystem, macrosystem, and chronosystem were explored. The microsystem involves the interaction of the developing person in an immediate setting or context. This includes the biological and psychological aspects of the individual. The next system, mesosystem, involves relationships among the various settings or contexts in which the developing person finds himself or herself (e.g. school, work, church, or family). The macrosystem encompasses the overarching institutional patterns of one's culture. This consists of general values, beliefs, or ideologies that influence the way institutions are organized. Lastly, the chronosystem accounts for historical events that have occurred over time.

These four systems were included in this study because they are commonly found in obesity research. Human Ecological Theory attends to the fact that the relationship between these systems is fluid and dynamic. It portrays how the more distal environmental factors (e.g. SES and culture) trickle down through the more direct systems (e.g. school, work, and family) to influence the health and development of the individual. As previously mentioned, the research has pointed to a variety of ecological factors that are associated with obesity; however, it does not indicate which factors are most influential on family weight-related health, particularly in African American families.

Social Constructionist Theory

Social Constructionist Theory was introduced through Berger and Luckmann's *The Social Construction of Reality* (1966). The basic premise from this text was "if some thing, event or process is social in origin, it is not given or established by nature" (Hibberd, 2005, p. 2). Therefore, if something is not from nature it is not of absolute truth. Research using Social Constructionist Theory is not judged as true or false because the data is gathered from actual accounts of participants and is not measured by instruments.

According to Burr (2003), the social constructionist approach can include any of the following assumptions: (1) a critical stance toward taken-for-granted knowledge, (2) that history and culture influence understanding, (3) that knowledge is sustained by social processes, and (4) that knowledge and social action go together. This theory encourages us to be critical of the idea that our personal observations in life reveal the true nature of life. This challenge welcomes the idea of multiple realities and encourages the exploration of lived experiences. In addition, our perceptions and subsequent behaviors are influenced by the daily interactions we have with people, which is similar to the interrelatedness of systems in Human Ecological Theory. These daily experiences contribute to the dynamic nature of our perceptions and behaviors.

The incorporation of Social Constructionist Theory into the study of obesity can yield rich information that is missing from the current literature. The application of Social Constructionist and Human Ecological theories to obesity research will contribute in-depth information about the connection between weight-related health perceptions of African American families and their

ecological experiences. Subsequently, this detailed information will help develop applicable treatments for African Americans who are affected by obesity. As previously mentioned, there is minimal research on the connection between beliefs regarding obesity and how those beliefs influence health behavior (Allan, 1998). Therefore, exploring weight-related health perceptions at various ecological systems can help create a more holistic treatment that is customized for African American families.

Theoretical Map

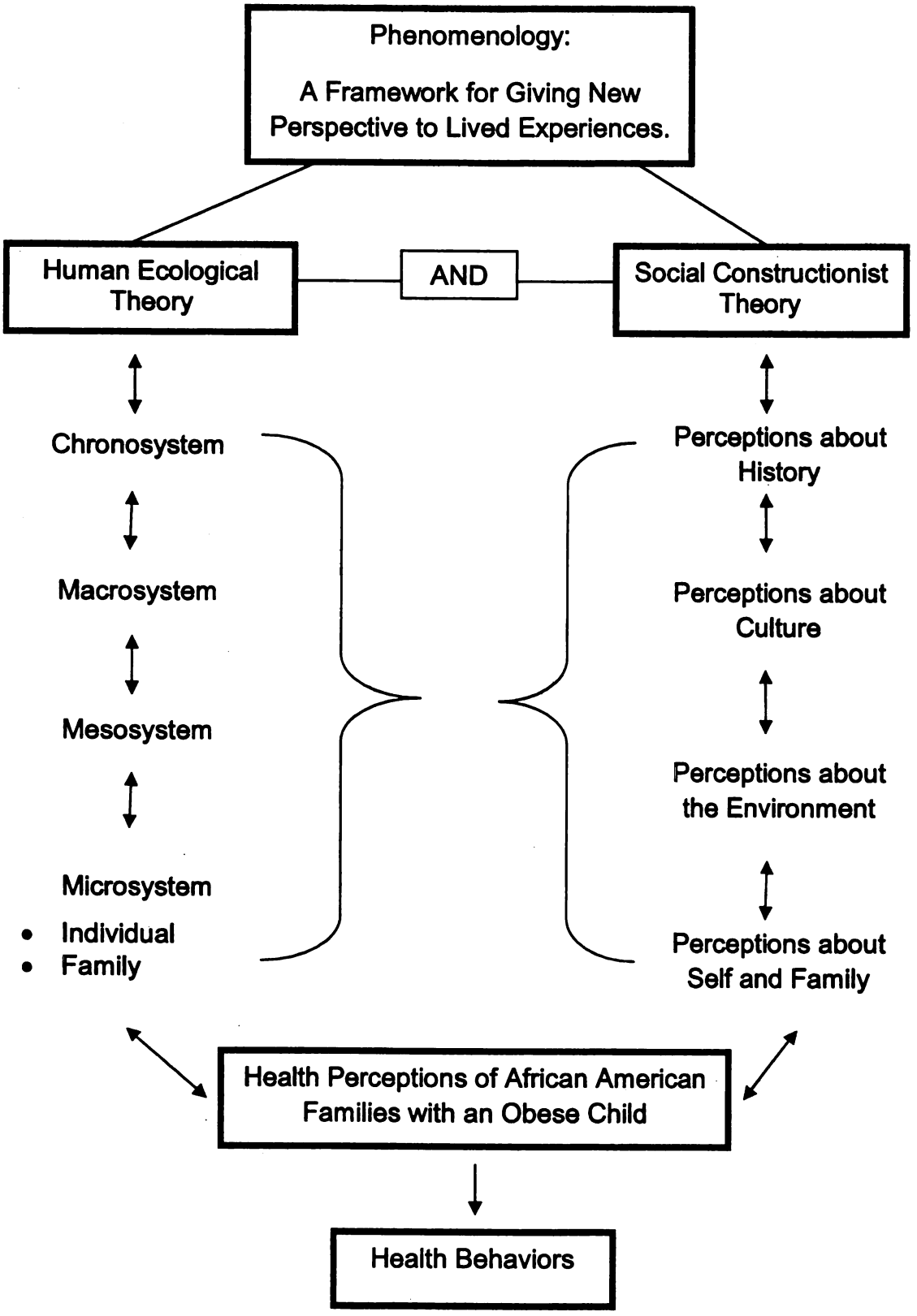
Figure 1.2 demonstrates the integration of Human Ecological and Social Constructionist theories as informed by a phenomenological approach. The map displays the interrelationship of systems in Human Ecological Theory as well as the interrelationship of belief processes through Social Constructionist Theory. In this map, Social Constructionist Theory assumes perceptions are influenced by the interactions a person has with his or her surroundings. Therefore, interactions with each of the ecological systems will influence a person's perceptions about how those systems influence weight-related health. The systems considered here include: chronosystem, macrosystem, mesosystem, and microsystem.

For example, interactions with the microsystem have initial and consistent influence on perceptions about the self and family. However, it is also possible for interactions with other systems, and perceptions about those systems, to trickle down and influence these microsystemic perceptions. The interrelationship of perceptions ultimately forms a complex belief system.

Subsequently, the weight-related health perceptions that result from these experiences will also influence health behaviors. Because experiences can change on any day it is possible for weight-related health perceptions and weight-related health behaviors to also change.

This study provided a forum for African American families with an overweight or obese child to share their perceptions about what influences their weight-related health. From the phenomenological approach, this study sought to understand "what" this phenomenon is without bias. Furthermore, the use of Social Constructionist Theory helped explore this phenomenon by inquiring about the lived experiences (i.e. perceptions) these families have regarding what ecological factors influence their weight-related health. It is through the use of Human Ecological Theory that lived experiences and subsequent perceptions can be placed in a clear format for interpretation. The overall goal of this study was to hear the perceptions of African American families regarding ecological influences on their weight-related health as well as their perceptions on weight-related programs with the hope of providing new information for the development of obesity treatment programs.

Figure 1.2: Theoretical Framework



Definition of the Terms

1. Perceptions

Theoretical: Perceptions are the reality of some being or phenomenon especially when based on examination of evidence (i.e. lived experience).

Operational: Participants will report their perceptions through the use of photos and in-depth family interviews.

2. Environment

Theoretical: The environment is considered the space outside of the individual (Sallis et al., 2002). This space may constitute the family, school, work, church, culture, government, health care system, history etc.

Operational: As defined by Sallis et al. (2002), the environment will be considered any context or space that is outside of the individual. Participants will report what their environment is.

3. African American

Theoretical: African Americans or Black Americans are citizens or residents of the United States who have origins in any of the black populations of Africa (US Census Bureau).

Operational: Participating families will self-report if they identify as African American.

4. Obesity

Theoretical: Obesity is determined when a person has excess body fat. Body fat is excessive when it is not within a normal range that is appropriate for the height and gender of the individual.

Operational: One of the participating children has been classified as overweight or obese by the child's pediatrician. This determination is made according to BMI results. Having a BMI above the 85th and lower than the 95th percentile for age and gender is considered overweight in children, whereas BMI equal or greater than the 95th percentile is considered obese.

5. Family

Theoretical: There is no universal definition for family. In African American families the term family may include extended family members or fictive kin.

Operational: Participants are informed that this a family-based study, which requires participation with immediate family members. The process of identifying immediate family members is determined by the participants.

6. Youth

Theoretical: Youth refers to both children and adolescents who participate in this study. This includes individuals who fall within the ages of 7 to 16.

Operational: Child and adolescent participants indicate their ages at the start of the study.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

This literature review begins with a discussion on obesity in the African American population and related treatment modalities. This chapter focuses on obesity in African Americans because it is occurring at a rate that is disproportionate compared to the majority population (i.e. Caucasians). The second half of this review demonstrates how historical and ecological factors influence the development of obesity in African Americans. Furthermore, the interrelationship of these factors are presented. It is postulated that lived experiences influence African American weight-related health perceptions and behaviors.

Obesity in African Americans

The typical test for determining overweight and obesity is to measure a person's Body Mass Index (BMI) (see Table 2.1). BMI is associated with the amount of body fat a person has and is categorized by age (i.e. youth or adult) (CDC, 2009). In adults (persons 20 years old or older), BMI is determined by weight and height (Hedley, Ogden, Johnson, Carroll, Curtin, & Flegal, 2004). An adult with a BMI ranging from 25.0 to 29.9 is considered overweight and a BMI greater than 30.0 is considered obese (CDC, 2009). In youth (children and adolescents 2-19 years of age), body fat is also determined using BMI. However, BMI for youths is determined based on age and sex. Because youth are constantly growing, their BMI is compared to the BMI of children of the same sex and age (Flegal et al., 2006). Youth who fall between the 85th to 95th

percentile are considered "at risk" of overweight, which is similar to an adult being considered overweight. Youth who are equal to or greater than the 95th percentile are considered overweight, which is similar to an adult being considered obese. The following statistics reflect the traditional terms of "at risk" of overweight and overweight in children (CDC, 2009).

Table 2.1: BMI Chart

	BMI Range	Weight Considered
YOUTH	85th to 95th percentile	At risk of Overweight
	Equal to or greater than 95th percentile	Overweight
ADULT	BMI between 25.0 to 29.9	Overweight
	BMI 30.0 or greater	Obese

Facts and Figures

In the Untied States, the prevalence of obesity has significantly increased across all ages in the last 30 years (TOS, 2008; Flegal et al., 2006; Hedley et al., 2004). The rates are highest among the United States' ethnic minorities, in particular African Americans, Mexican Americans, and Native Americans. According to the CDC (2006), the United States has the highest prevalence rates among the developed nations; however, this growing trend is not exclusive to the United States. The most detailed statistics on overweight and obesity across major ethnic groups in the US were reported in 2006 (Ogden et al., 2006).

From 2003-2004, 33.6% of youth were at risk of overweight or overweight and 66.3% of adults were overweight or obese. Further exploration into these percentages shows the disparity in overweight across ethnic groups in the US.

In youth, 33.5% of Caucasians, 35.1% of African Americans, and 37.0% of Mexican Americans were at risk of overweight or overweight. In adults, 64.2% of Caucasians, 76.1% of African Americans, and 75.8% of Mexican Americans were overweight or obese.

A brief, updated report on obesity in the United States from 2005-2006 was presented in 2007. According to this update, no significant changes in obesity prevalence in youth and adults have occurred from 2003-2004 to 2005-2006 (Ogden, Carroll, McDowell, & Flegal, 2007; Ogden, Carroll, & Flegal, 2008). However, obesity continues to be more prevalent in African Americans and Mexican Americans.

Lastly, individuals who are obese are at greater risk for developing a variety of health problems. Obesity is associated with increased risk of several conditions, such as type 2 diabetes, heart disease, hypertension, high cholesterol, stroke, gallbladder disease, arthritis, sleep disturbances, high blood sugar, and some cancers (Freedman, Dietz, Srinivasan, & Berenson, 1999; Glenny et al., 1997; Kitzmann et al., 2006). In addition, obesity is related to social stigmatization, discrimination, and psychological problems (e.g. depression, disturbed body image, and low self-esteem) (DHHS, 2000). In general, obesity is related to "all-cause" morbidity and mortality (Ogden et al., 2007).

History of Obesity Treatment

In order to address the obesity problem, researchers have worked for several years to find an effective solution. Early obesity research focused on

basic elements of achieving a healthy lifestyle: nutrition and physical activity (Baker, Kelly, Barnidge, Strayhorn, Schootman, Struthers, & Griffith, 2006). It seemed logical that individuals needed to focus on healthier eating and improve physical activity in order to maintain a healthy weight. This research consequently resulted in the development of seemingly effective obesity treatments. Unfortunately, the positive effects were typically not sustained. The inability to find a long-lasting treatment led to a shift in exploring other ecological influences.

Currently, researchers are encouraged to use an ecological approach in exploring the contribution of macrosystemic factors (e.g. socioeconomic status and social norms), mesosystemic factors (e.g. neighborhoods and health care system), and microsystemic factors (e.g. individual behaviors, beliefs, and genetics) on the development of obesity (Baker et al., 2006; Blixen, Singh, Xu, et al., 2006; Dietz et al., 2001; Egger et al., 1997; Schnittker & McLeod, 2005;). Using an ecological approach will also help identify how the interrelationship of these factors influences the development of obesity (Baker et al., 2006). Preliminary findings from studies that use an ecological approach support the current belief that obesity is caused by a complex interaction between genetics, lifestyle and environment (DHHS, 2000).

By focusing on ecological factors, researchers have also begun to explore how these factors contribute to different rates of obesity across ethnic groups within the United States. The difference in obesity rates, and other health outcomes, across groups are commonly referred to as health disparities.

Braveman (2006) describes health disparities as being "potentially avoidable differences in health...between groups of people who are more and less advantaged socially [which] systematically place socially disadvantaged groups at further disadvantage on health" (p. 180). It is believed that the ineffective correction of health disparities in the United States is due to inadequately exploring the inequalities within our social structure that produce them (Airhihenbuwa & Liburd, 2006; Geronimus et al., 2004; Kumanyika & Morssink, 2006;). Therefore, it is important to examine the social context across all ethnic groups in order to understand why some groups have more negative health outcomes and difficulties in addressing them than others.

Government initiatives are currently in place to address and correct health disparities within the United States. For example, Healthy People 2010, encourages researchers to use an ecological approach to understand health disparities. One of the goals of this initiative is to improve access to quality health services, reduce or eliminate overweight across all ages, and reduce or eliminate type 2 diabetes (DHHS, 2000). At this time, the following is known about health disparities in the United States: (1) overall access to health care has improved, but unequal treatment within the health care system continues to exist, (2) the biological characteristics of ethnic minorities in comparison to Caucasians does not explain health disparities, and (3) many of the treatments to-date have negative implications for African American health because they are biased towards the norms and behaviors of Caucasians (Dressler, 1993; DHHS, 2000; Geronimus et al., 2004). In summary, these findings support the need to explore

the social context of all ethnic groups to understand why health disparities, such as obesity, persist.

Current Treatment

Despite a greater understanding of obesity development, researchers continue to struggle with developing a treatment program that is successful. Harkaway (2000) supports the current trend in exploring obesity from an ecological approach to find a solution; however, she notes that researchers do not know what they are looking for or how to find it. Researchers have learned that there are a variety of factors that can influence obesity and as such they are currently working on determining the combination of factors that are significant for successfully treating obesity. One area of growing interest in obesity research is determining the role of family in the development and treatment of obesity. This is not to say that the family is always a factor, but from an ecological approach the role of the family is considered central and should be examined. Campbell's (2003) review of the literature on families and health concluded that families have a powerful influence on health, particularly the emotional support of the family. Even though research demonstrates an influence of family on health, it is rare for studies to examine the family as a distinct system and to examine its interaction with broader systems (e.g. family relation to the medical system) (Harkaway, 2000). Aside from the importance of family, research concludes that treatments should continue to focus on modifying eating patterns and exercise behaviors. Research on child and adolescent obesity has concluded that family-based interventions are more successful

(Davison & Birch, 2001; Dietz et al., 2001; Golan, Weizman, Apter, & Fainaru, 1998; Golan et al., 2001). Family-based interventions refer to treatment modalities that include the parent as an integral part of the change process. According to Golan et al. (2001), children acquire healthy lifestyle behaviors and attitudes early in life from their parents and families; therefore, treating the family as a whole is more likely to have a positive outcome. The inclusion of parents is reasonable because the child is typically dependent on the parent for food, opportunities for exercise, and support for weight loss efforts (Epstein et al., 1998; Golan et al., 1998). In comparison, the traditional approach to treating childhood obesity used the child as the agent of change and expected the child to take responsibility for their own health. As for adolescents, treatment is still more effective with parent inclusion. However, it appears that treatment is more successful when adolescents and parents receive treatment in separate groups (Glenny et al., 1997). The use of separate parent and adolescent groups supports the adolescent's increasing ability to care for their own health while receiving less support from their parents. Overall, the prevention and treatment of childhood and adolescent obesity needs to address the social context in which youth reside (e.g. family, school, and community) while applying interventions that address opportunities for physical activity and healthy nutrition.

As for adult obesity, there is no clear answer on how to effectively treat it. For example, there are mixed results on whether the inclusion of a partner or family is important to successful treatment. It is possible that the mixed results are due to differences in research that included spouses who were supportive

versus spouses who were forced to participate (Glenny et al., 1997). This is a factor that needs to be more closely examined. It does appear however that community-based groups and monetary incentives are helpful in preventing and treating obesity (Glenny et al., 1997). Just as in treating childhood and adolescent obesity, treatment for adult obesity needs to incorporate interventions which address opportunities for physical activity and healthy nutrition.

Ecological Influences of Obesity in African Americans

This section will briefly examine factors that are believed to influence the development of obesity in African Americans.

Chronosystem: African American History

The current status of health disparities, such as obesity in African Americans, can be traced back to the history of health care for the African American population (Outterson, 2005). This history is tied to slavery, the lack of rights to equal care, and medical mistreatment of African Americans. Subsequently, the current health status of African Americans has some origin in this history.

Slavery Era

Dating back to the slavery era (i.e. 1700s), the health of African Americans has been disproportionately worse than that of Caucasians. In order to receive medical care, freed African Americans paid for their own health care, which did not mean equal care, whereas slaves received medical care at the discretion of their owner. During this era African Americans were excluded from medical establishments, but were used for medical training and experiments (Fisher,

1968; Savitt, 1982). Subsequently, these conflicting messages contributed to early suspicions of Caucasian medicine.

Prior to the civil war, human dissection was illegal in many states; however it was rarely questioned by authorities. Therefore, African Americans became prime candidates for medical experimentation because of their lack of equal rights. Information that was gained from medical experimentation on African Americans was viewed as applicable to the health of Caucasians. However, research findings and teachings said otherwise and were used to support the alleged inferiority of African Americans and their suitability for slavery (Northington-Gamble, 1993; Savitt, 1982, Savitt, 2007).

Reconstruction

It was during Reconstruction (1861-1933) that the first step in health reform was made. In the early years of Reconstruction the Freedmen's Bureau was established to provide better health care to former slaves; however, this program was ineffective at meeting the health needs of African Americans (Byrd et al., 1992). The program was discontinued after three years at which time African Americans had to go to local governments or charities for health care. Despite this initial effort to improve health access, African American health was of little interest to public health agencies and their use in medical experimentation continued (Outterson, 2005). In response to this lack of health care, an African American health care system was created primarily by African American physicians and at its peak had 200 hospitals in the 1920s and 1930s (Northington-Gamble, 1995; Smith, 1999).

The New Deal and Hill-Burton

In the 1940s new programs were developed to provide equal health benefits to African Americans. These programs marked the first significant federal assistance since the Freedman's Bureau in 1865. Just as African American citizens were struggling for equal treatment in the medical community, African American physicians were struggling with similar issues. In segregated hospitals, African American physicians were treated unequally, were discriminated against into the 1960s, and were challenged with making quality health care available to all Americans (Morais, 1970). The efforts of African American physicians created pride in the African American population and gained the respect of many Caucasian physicians (Byrd et al., 1992).

In 1948, President Truman requested a report on the nation's health. The National Health Assembly found health disparities within the African American population and called for government action. The most noted action taken as a result of this report was the endorsement of the American Medical Association for a proposal made by Senators Listor Hill and Harold Burton (Outterson, 2005). The Hill-Burton Act sought to increase access to medical care by increasing the number of hospitals (Williams et al., 2004). Hospitals were assisted at the federal and state level through this program. In all, the Hill-Burton Act gave more than $13 billion in federal funds. A major flaw of this Act was that states were given authority in determining the needs of their population, which allowed for continued discrimination through means of segregation (Outterson, 2005). It was

not until 1964, nearly twenty years later, that Hill-Burton funded medical facilities were prohibited from acts of discrimination.

Title VI and Medicare/Medicaid

By 1966 practically all forms of legal segregation ended in hospitals. This was in large part due to the passing of the Civil Rights Act, which ended health care disparities in federally funded health programs (Smith, 2005). Programs such as Medicare and Medicaid provided federal funding to medical facilities and with the passage of Title VI of the Civil Rights Act these facilities were prohibited from acting in a discriminatory manner (Outterson, 2005). These efforts made it possible for African Americans to access decent health care. This era, known as the second Reconstruction, improved African American health for 10 years, but this plateaued by 1975 and has not improved since (Byrd et al., 1992).

Current History

Continued disparities in African American health is a testament to historical patterns and speaks to the need for making more serious changes in our society. According to Outterson (2005), health disparities are due to societal inequalities such as residential segregation, income disparities, lack of investing in public health initiatives, and employment disparities. Furthermore, the distrust of medical personnel has also contributed to health disparities among African Americans (Eiser & Ellis, 2007). To correct these societal inequalities research is needed to examine these factors more closely and to help identify appropriate solutions.

Macrosystem

The macrosystem consists of societal factors that have an indirect influence on an individual and family. This section will focus on SES and discrimination as two aspects of this system. These two factors are presented because they are the only macrosystemic factors commonly found in obesity research.

Socioeconomic Status

SES has been identified as a major contributor to racial differences in health (LaVeist, 2005; Sue & Dhindsa, 2006; Williams et al., 2004). Individuals from low-income families consistently have poorer health than more affluent families (Chen, Martin, & Matthews, 2006; Fleury & Lee, 2006; Wickrama et al., 2006; Williams & Collins, 1995). In relation to obesity, SES influences a person's ability to seek and maintain quality health services, to buy quality foods that are nutritious, and to participate in recreational activities.

In the United States, African Americans are three times more likely to be poor than Caucasians (Williams et al., 2004). Subsequently, the lack of income has a negative effect on the health of African Americans. Even if African American economic status improved, it does not appear that racial disparities in health would dissolve. According to Williams et al. (1995), racial disparities are only reduced, not eliminated, when SES is adjusted. Therefore, African Americans at each level of SES typically have worse health than Caucasians. Some may subsequently argue that race or ethnicity is the remaining factor of racial disparities; however, current research is unable to make such a conclusion.

Others argue that health disparities remain after controlling for SES because racism affects health (Williams et al., 1995). Racism involves ideologies of superiority, negative attitudes towards ethnic groups, and differential treatment of those group members. As previously discussed, racism within the medical community is not a new experience for the African American population and current research demonstrates the lingering effects and continuation of racist perceptions within the medical community (Franks, Muenning, Lubetkin, & Jia, 2006; Spector, 2004; van Ryn & Burke, 2000). For example, research has shown that some physicians perceive and treat African American patients differently. According to Williams et al. (1995), racism can restrict access to quality health care services.

Racism and Discrimination

Research on racism and discrimination is growing in the health literature. As previously discussed, overt racism in the past clearly demonstrated the effect of racist acts on the health of African Americans. The denial of equal access and quality health care has subsequently left the African American population in poorer health in comparison to Caucasians (Williams et al., 1995). Furthermore, racism, past and present, has left a history of distrust between the African American population and the medical community, which further perpetuates racial differences in health outcomes (Williams et al., 1995; Williams, Neighbors, & Jackson, 2003). Despite continued racism, overall access to health care has improved for African Americans and other ethnic minorities (Dressler, 1993).

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Mesosystem

The mesosystem is the system just outside of the individual and family. It includes environmental factors that the individual and family has frequent and direct contact with. In obesity research, this system has received a lot of attention. These environmental factors can have a significant influence on health and obesity development because individuals and families spend much of their time outside of the home engaging in various interactions with their surroundings (Whittemore, D'Eramo Melkus, & Grey, 2004).

Social Support

According to McLeroy, Bibeau, Steckler, & Glanz (1988), health behaviors are influenced by relationships with family, friends and other social networks. Contact with family and friends reinforce individual attitudes and behaviors regarding weight and healthy living, such as eating patterns and physical activity. For example, parent intake of fat, fruits, and vegetables is associated with children's intake of the same items. In adolescents, parents and siblings influence energy and fat intake whereas fruit and vegetable intake is associated with parent education (van der Horst, Oenema, Ferreira, Wendel-Vos, Giskes, van Lenthe, & Brug, 2007).

The influence of families and social support significantly contributes to participation in physical activity regardless of age. For African American women, the support of a spouse, family, and friends is a significant motivating factor for their engagement in physical activity (Fleury et al., 2006; Haughton McNeill, Kreuter, & Subramanian, 2006). Although there is less research on parent contribution to adolescent engagement in health-promoting behaviors, it is

reported that supportive families contribute to increased physical activity in adolescents. Adolescent girls in particular are also more engaged in physical activity when they have support from their peers (Cooper & Guthrie, 2007).

Segregation and Neighborhood

The immediate neighborhood or community where an individual resides can be a source of support or challenge for those who want to engage in healthy behaviors. In particular, African Americans continue to disproportionately reside in low-income neighborhoods, which typically lessen their ability to engage in healthy behaviors. Many researchers have examined the lingering effects of segregation and how it has influenced the current state of many neighborhoods that are predominately African American. The term segregation refers to "...the physical separation of the races by enforced residence in restricted areas" (Williams et al., 2004, p. 983). Overall, segregation negatively affects the health of African Americans because it shapes the socioeconomic status of households and the community (Geronimus et al., 2004; Williams et al., 2001; Williams et al., 2004). Segregated communities tend to have low economic mobility (e.g. fewer jobs, lower educational opportunities, and fewer high paying jobs), services that are poorer in quality and cost more, fewer supermarkets, and more venues for alcohol consumption (Wells et al., 2007; Williams et al., 2004). With the lack of services, it is no surprise that SES affects initiation and maintenance of health promoting behaviors. Living in such disadvantaged communities adversely affects health and increases all-cause mortality because community members are isolated from accessing necessary resources for maintaining a healthy

lifestyle (LaVeist, 2005; Schulz, Williams, Israel, & Lempert, 2002; Wickrama et al., 2006).

Necessary resources for encouraging community members to be physically active include having a safe area to exercise, local resources for physical activity in the environment (e.g. sidewalks and lighted streets), and convenient facilities for activity. In addition, the ability to see others exercising in one's community is positively associated with resident engagement in physical activity (King, Castro, Wilcox, Eyler, Sallis, & Brownson, 2000; Ainsworth, Wilcox, Thompson, Richter, & Henderson, 2003). Seeing community members engage in physical activity creates a sense of connectedness, which may provide access to resources and material goods that support physical activity (Haughton McNeill et al., 2006). Community settings that are able to provide education and prevention information have a greater ability to reach disadvantaged populations. Furthermore, community leaders can make such interventions more culturally relevant to the area. Overall, community interventions tend to have less individual impact, but they have greater reach (Glasgow, Wagner, Kaplan, Vinicor, Smith & Norman, 1999).

Nutrition and the Food Industry

It is clear that when the food industry is examined at the community level, particularly with disadvantaged communities, its effect on obesity is clearly problematic. Poorer communities typically have convenient stores rather than supermarkets as well as more fast food restaurants, all of which can lead to poorer nutrition (Wells et al., 2007; Williams & Collins, 2004). These convenient

stores typically offer limited healthy food choices that are sold at unaffordable prices, which leave many families opting to buy cheaper foods that are typically unhealthy. A significant problem with the fast food industry is its promotion of larger portions (Hill et al., 1998). Children are particularly at risk for obesity in this situation because they have less independence in making food choices (van der Horst et al., 2007). In wealthier neighborhoods, it is typical to find significantly more supermarkets, which offer healthier, more affordable foods. Furthermore, the ability to access a local supermarket has been shown to increase consumption of fruits, vegetables, and juice (Wells et al., 2007).

In addition to the food industry, the history of food has played a role in the current nutrition of African Americans. Dating back to slavery, African Americans food choices were limited and typically of lower nutritional value. According to Whitehead (1992), African American food is a product of various factors: foods brought by slave ships and other elements created by African servants, the integration of African, European, and Native American foodway systems, the tendency for foods to meet needs other than nutrition, and persistent economic and political marginality of African Americans. Much of this was seen in how slaves adapted cooking methods. Often times slaves were given the less desirable parts of hogs (e.g. chitterlings, maw, tail, and hocks) and to make such meats more desirable the food was fried, boiled, cooked in a large pot with vegetables and fat, and cooked with lots of spices, sugar, and salt (Bailey, 2006; Whit, 2007). Although not nutritionally sound, these cooking methods were adaptive to working long hours in the plantation fields (Whitehead, 1992). Food

had to be prepared for easy consumption (e.g. quick to cook or cook all day and not require utensils) and have high caloric content to help them refuel. Even though these cooking methods are not as adaptive to today's needs, many African Americans continue this cooking tradition. Coupled with less physical activity, these cooking methods have more negative consequences to one's health.

A study by Airhihenbuwa et al. (1996) found that African Americans believe there is some cultural and societal link to their current food choices. Their sample consisted of African Americans ranging in age from late teens to over age 65. Many participants did not know if there was any African American influence on the foods they ate. However, many felt the lack of knowledge was attributable to slaves being robbed of their culture, including their food practices. Overall, the participants reported being more comfortable with eating at home because it reduces judgment and allows eating to be an intimate or spiritual practice that should be shared with family. In relation to soul food, participants felt that unhealthy aspects of soul food should be modified, but there was concern that modification would be expensive. Lastly, the authors express that the traditional model which views food as being isolated from the social context of eating may have limited effectiveness with African Americans. Therefore, the social context around food consumption and traditional meal choices should be considered when addressing nutrition with African Americans (El-Kebbi, Bacha, Ziemer, Musey, Gallina, Dunbar, & Phillips, 1996; Airhihenbuwa et al., 1996; Whit, 2007).

Physical Activity

Physical activity has been explored in both the microsystem (e. g. personal motivation) and mesosystem. It has been included in the mesosystem because it incorporates aspects of both systems. At the individual level (microsystem), "motivational variables, such as knowledge, attitudes, and beliefs related to the health benefits of physical activity, have been associated with initiation and maintenance of physical activity across populations" (Fleury et al., 2006, p. 132). It is possible that when a person believes physical activity is beneficial to their health they are more likely to engage in such activity. On the other hand, feeling a lack of energy or motivation, not having enough time, or having low self-efficacy can act as a barrier to engaging in physical activity, even in spite of knowing the benefits of such activity. According to Hill et al. (1998), children are more likely to participate in physical activity if it is fun and parents participate.

Another challenge to being physically active is attributable to the growth in technology. Advances in technology have greatly limited the need for physical activity on a daily basis (Hill et al., 1998). Such advances were made to lessen the burden on working individuals; however, the negative consequences of technology are becoming more visible. In particular to obesity, the use of television, electronic games, and computers has created a sedentary society (Wells et al., 2007). Combined with the increase in high fat, large portion meals, individuals are experiencing a real challenge in maintaining a healthy weight. In conclusion, researchers suggest that we need a greater understanding of social

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and contextual influences on physical activity, particularly before recommendations are made (Fleury et al., 2006; Haughton McNeill et al., 2006).

School

Schools have an important influence on children's nutrition and physical activity since they are in school almost eight hours a day. In recent years, the ability to engage in physical activity within schools has been reduced, even eliminated in some areas. School is generally a safe and regular place for children to engage in physical activity. However, cutbacks in physical education programs have contributed to the decline in children's physical activity. When physical education is available it is typically taught by untrained individuals, involves little physical activity, and does not focus on the fun aspects of being physically active (Hill et al., 1998). This is unfortunately sending a message to our youth that physical activity is not important. In addition, the availability of unhealthy drinks and foods from school vending machines has many parents and adults questioning whether they should be available to children (Faith, Fontaine, Baskin, & Allison, 2007). According to Whittemore et al. (2004), school-based interventions are almost essential at this point since physical activity programs have decreased and unhealthy food choices have increased in school lunches.

Microsystem

Research on the microsystem focuses exclusively on aspects of the individual that may influence his or her susceptibility and behavioral response to obesity. The majority of obesity research has focused on individual factors and behaviors because they are significantly associated with the development of

diseases such as obesity and diabetes. (Whittemore et al., 2004). Personal factors that are commonly explored in obesity research include biological, psychological, and body image. In addition, research is beginning to explore the influence of personal attitudes and beliefs on health.

Genetics

In terms of biological factors, obesity research commonly looks for genetic markers that identify an individual's likelihood of developing obesity. In 1994, the identification of the obesity gene and its product, leptin, created hope that the cause of obesity and subsequent cure was to follow (Egger et al., 1997). However, no definite effects of this or any other single gene has been identified. Research has demonstrated that this gene, like many others, can exist in multiple members of a family and become part of family health histories.

In addition, individual factors such as age, gender, and hormones influence body fat levels. An example of this is typically seen in females with early onset of puberty. Puberty onset is often marked by weight gain, particularly fat, in various places throughout the body. Furthermore, early onset of puberty is more commonly seen in ethnic minority girls.

Psychological Factors

Research on psychological aspects of obesity is limited, but is most likely similar to those found in individuals with type 2 diabetes. This is a probable consideration because type 2 diabetes is strongly associated with excess weight (i.e. overweight and obesity). Psychological problems associated with type 2 diabetes include reports of depression, anxiety, and anger (Penckofer et al.,

2007). Depression negatively affects management of diabetes and is associated with poor diet, poor medication adherence, functional impairment, and higher health care costs. In terms of anger, Penckofer et al. (2007) found that women were angry toward themselves for not properly managing their health and towards family members who criticized their health status without trying to understand the situation. Furthermore, psychological problems can be influenced by the demands and frustrations of managing one's weight and other diabetic-related issues (e.g. checking blood sugar, regular medical check-ups, possible administration of insulin injections, etc.).

In terms of treatment plans and interventions, mental health issues are typically not incorporated in obesity program curricula. It is important to address emotional issues because "[behaviors] are the result of complex psychological factors, including habits, emotions, attitudes, beliefs, and cognitions..." (Egger et al., 1997, p. 479). The inability to address mental health issues will likely set individuals up for relapse because their basic perceptions regarding health and obesity have not been treated.

Body Image

There is a considerable amount of literature on body image, obesity, and ethnicity. During puberty the body typically begins to produce more fat. Body fat is produced more in females and this normal bodily change typically puts them at greater risk for deviating from Western standards of female desirability (i.e. thin body type). There are societal beliefs regarding obesity, however, "subjective evaluations of weight may vary according to gender, ethnicity, and class..." (Ge

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et al., 2004, p. 364). Furthermore, excess weight or obesity is found to be more stigmatizing for females than males. These weight changes during puberty typically have different meanings in African American and Caucasian populations.

Research has repeatedly shown that African Americans have a more accepting view of weight (Miller et al., 2001). In adolescence, African Americans report greater comfort with their bodies and have less risk of developing depression and low self-esteem despite perceptions of being overweight (Ge et al., 2001). At this time it is unclear if these perceptions also apply to higher income African Americans. Typically, the desire for being thin is more commonly emphasized in higher income social groups. Overall, Ge et al. (2001) states that African American youth seem to be less sensitive to matters of weight gain and more impervious to media standards favoring a slender body type. Therefore, the physical changes associated with puberty have less negative psychological consequences for African American youth.

Many of the aforementioned beliefs persist into African American adulthood. Overall, the African American community does not view overweight as synonymous with being unattractive. Kumanyika et al. (1993) found that African American women who viewed themselves as overweight were interested in losing weight because they understood the health risks of obesity, not because they felt unattractive. These women typically determined if they were overweight using subjective cues (e.g. how they looked in the mirror). In addition, Allan (1998) reported that African American women rarely mention poor self-image,

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emotional, problems, low energy, or limitations on social interaction as consequences of overweight.

In regards to African American men, research has generally found them to be more accepting of larger body sizes for women as well. It is thought that this acceptance of larger body sizes may protect African American women from developing negative body image (Freedman et al., 2004). However, recent research is showing a potential shift in African American men's preference for women of a smaller body size (Freedman, Carter, Sbrocco, & Gray, 2007; Ricciardelli, McCabe, Williams, & Thompson, 2007). It is suggested that this shift is attributable to the growing acculturation of African Americans to Western ideals.

The fact that African Americans are less affected by obesity stigmas is an admirable attribute that should be valued more than it is currently. Our society should find balance in valuing a healthy weight, not one that is based on numbers (e.g. scale number or clothing size). Of concern is whether all groups in our society adequately understand weight-related health problems. For example, Franks et al. (2006) found that African Americans may perceive less dysfunction regarding their weight and subsequent health status, thus underestimating health complications. Rather than talking about "ideal" weight or attractiveness to African Americans, health care providers should focus on the health benefits of maintaining a healthy weight.

Health Beliefs

According to Allan (1998), beliefs are not consciously formed, may change over time, and are influenced by one's environment, ethnicity, and experiences with illness. In particular to obesity research, Blixen, Singh, & Thacker (2006) reported there have been few studies on attitudes and beliefs regarding obesity. Furthermore, it is unclear what individuals believe about the causes and effective treatments for obesity (Allan, 1998; Skelly et al., 2006). More research is encouraged in this area of health beliefs because attitudes and beliefs strongly influence behaviors (Egger et al., 1997). Therefore, in order to develop effective treatment plans for obesity, it is essential to gain an understanding of health beliefs from various groups before attempts are made to change behavior. In addition, such research is encouraged to examine cultural beliefs around health (Diaz, Mainous, & Pope, 2007; Skelly et al., 2006; Sue et al., 2006). As ethnic diversity continues to grow it is important for health professionals to understand the unique health beliefs of varying ethnic groups in order to improve health communication and develop treatment plans that are culturally sensitive so quality care can be provided (Airhihenbuwa et al., 2006).

Summary

This chapter reviewed the literature on obesity in African Americans and the various ecological factors that are believed to contribute to obesity development. The literature demonstrates the unique challenges that African Americans face in leading a healthy lifestyle. The focus on obesity in African Americans and their unique ecology is congruent with the need for more

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culturally sensitive research. The literature has demonstrated a variety of ecological factors that may influence obesity development; however, research is limited in exploring the beliefs of African Americans regarding if and how influential these factors are. At this time it is unknown how influential the aforementioned ecological factors are in the lives of African Americans who are living with obesity. Health researchers can begin to develop more tailored treatment plans that are subsequently more effective once it is determined which ecological factors are more influential on obesity development in African Americans.

The next chapter will outline the measures that were taken in this study in order to gain an understanding of weight-related health perceptions in African American families.

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CHAPTER THREE

METHODOLOGY

Introduction

This chapter describes the research methodology used in this study. The topics addressed in this chapter include the research design, rationale for qualitative methods, sampling, data collection, reflexivity, data analysis, and trustworthiness.

Research Design

This qualitative study included the use of multiple sources of data to explore the lived experiences of African American families who have an overweight or obese child. The aim of this study was to grasp the essence of African American perceptions regarding ecological influences on their weight-related health as well as their perceptions on weight-related programs. To obtain the essence of lived experiences, phenomenological research methods are typically conducted, this includes the use of in-depth interviews and possibly other forms of qualitative data (Creswell, 2007). This study specifically used in-depth interviews and photographs using photovoice (Wang & Burris, 1997) to obtain African American families' experience with weight-related health.

The research process involved two meetings with each family in order to explain the study, collect data, and discuss the family's experiences. The meetings incorporated the use of a demographic questionnaire, photovoice (Wang & Burris, 1997), and a semi-structured interview. In the first meeting consent was obtained, demographic questionnaires were completed, the family was oriented to this study, and the family was asked to photograph specific

aspects of their experiences with weight-related health for the purpose of guiding future discussion. The second meeting involved an in-depth, semi-structured interview with the family about elements of their ecology that were portrayed in their photos and their perceptions of weight-related health and weight-related programs.

Rationale for Qualitative Research

The research problem addressed in this study was best examined through qualitative research methods. Qualitative research privileges the multiple realities of human experience, gains cultural descriptions of various phenomenon, and is beneficial for studying little-known phenomenon (Davis, Nakayama, & Martin, 2000; Marshall et al., 2006). Since obesity research has minimal literature on African American families and even less on their lived experiences regarding their weight-related health, the use of qualitative methods was an appropriate framework from which the data could emerge.

Historically, obesity research has examined this problem as it exists within the Caucasian population. Subsequent findings from obesity research have been used to develop treatment programs, which would attempt to treat obesity across populations. Unfortunately, treatment programs to-date have not been effective in the long run and are not generalizable. Therefore, it was appropriate to study obesity as a phenomenon that is unique to each population.

The lack of knowledge on African Americans has created a calling for the use of qualitative methods in ethnic research (Sue, 1999). This is encouraged because a substantial knowledge base is necessary before theories can be

developed on how to best treat obesity and other health problems. The use of qualitative data enlists the help of the participants in the creation and presentation of findings. Subsequent reporting of participants' stories helps reveal multiple realities and dispel previous research findings, which may be stereotypical (Davis et al., 2000). In addition, the information gained from these stories is beneficial to developing treatment plans that are tailored and culturally appropriate.

Sampling

According to Dahl et al. (2005), the phenomenological approach supports the use of small samples because it requires an in-depth description of the participant's experiences. It is recommended that three to four focus groups, of four to five individuals, with any one type of participant (e.g. only African American families) be conducted to explore the phenomenon of interest (Krueger & Casey, 2000). The purpose of this sample size is to assist the researcher in discovering patterns that emerge from the descriptive data. Furthermore, such information provides a breadth of knowledge on the under studied phenomenon, which will allow the essence of the participants' experiences to emerge.

The sample for this study was recruited based on past participation in the Healthy Kids, Healthy Families Program through MSU Extension in Kent County. These families were identified by a pediatrician as having a child with a BMI equal to or greater than the 85th percentile (i.e. overweight or obese) and were subsequently recruited to participate in the Healthy Kids, Healthy Families

program. This program addressed nutrition, physical activity, self-esteem, and other ecological factors known to influence weight-related health.

Over 40 families participated in the Healthy Kids, Healthy Families program and twelve of these families were African American. Multiple methods of recruitment were used to increase participant response rates. Participants were mailed a flyer (Appendix B) and contacted by phone. Due to dated contact information only nine of the twelve families were reachable. Of these nine families, six completed the study. Three families were unable to complete the study for various reasons. Two of the families had participated in the first meeting, signed consent forms, and were given cameras. These two families later withdrew from the study for the following reasons: (1) the biracial son of a Caucasian mother decided he did not want to participate and (2) the family was unable to return the camera after several reminder phone calls. The mother of the third family was open to participating and had spoken to the researcher on a few occasions; however, the family was unable to participate due to having a busy schedule.

Demographic information for the participants in this study is listed in Table 3.1. Participants from each family included the mother, the youth(s) who was identified as overweight or obese, and in two cases, siblings of the recruited child. Youth participants ranged in age from 7 to 16. Fathers were present in two of the households; however, for unknown reasons, they did not participate in the study. The majority of the mothers in this study were single and had an income below $20,000. In addition, according to reports given by the mothers, a

family history of weight-related medical problems was present in most of the families. Lastly, while all families had been recruited by the Healthy Kids, Healthy Families program they had varying degrees of program participation ranging from attending initial home visits to completing the three month program. In both cases where families only participated in the initial home visits, the mothers cited moving as the reason they had been unable to continue the program. Furthermore, half of the families had participated in additional weight-related programs prior to participation in this study (e.g. program at local community center, saw nutritionist, diabetes group).

Table 3.1: Demographic Information about Participants

Family Name (pseudonym)	Ages of participating children *overweight or obese child	Parent status	Parent education level	Income	Family history of weight-related medical problems
Smith	13*	Single	High School	>$20,000	type 2 diabetes
Harper	10*	Single	High School	>$20,000	High blood pressure
Gray	11*	Divorced	College	$30,000 - $40,000	type 2 diabetes
Ward	16*, 15, 14, 12*	Single	College	>$20,000	None
Hall	10, 9*, 8	Co-habiting	College	$30,000 - $40,000	Sleep apnea, high blood pressure, pre-diabetes
Parker	7*, 7* (twins)	Single	High School	>$20,000	Low blood sugar, asthma

Confidentiality

During the first family meeting, participants were given an informed consent form (Appendix A). This form introduced the participants to the purpose of the study, described the study protocol, and informed them of their rights. Participant consent was obtained for study participation, the use of audio tape during the interview, and the researcher's ability to use their photographs for publication. In addition, children signed separate child assent scripts to denote their consent to participate. Upon signing the informed consent forms the family was given necessary materials (i.e. disposable camera and photo release forms) to prepare for the second meeting. To ensure participant protection, the procedures used in this study were reviewed and approved by the Michigan State University's – University Committee for Research Involving Human Subjects.

The primary researcher identified and recruited eligible families. The participants' identities remained anonymous through the process of coding identifying information and reports of research findings did not associate participants with any specific findings. Photos that had the potential to reveal a participant's identity were only published with participant consent. Furthermore, this process extended to the photographing of non-participating individuals and institutions. In regards to audio taped interviews, only the researcher listened to and transcribed the tapes.

Data Collection Procedure

Data was collected through the use of photographs and semi-structured family interviews. In addition, a basic demographic form was used for identifying sample characteristics. Visual data was discussed and supported with data gathered from the semi-structured family interviews. All data was collected over a period of five weeks and consisted of two meetings with each family.

Demographic Questionnaire

Participating families received a demographic questionnaire (Appendix C) at the first meeting. This questionnaire inquired about family members' age and ethnicity, parent education attainment, marital status, income, and family history of weight-related medical issues. This questionnaire was used for identifying sample characteristics.

Photovoice

"Photovoice" is a photographic technique that was developed by Wang et al. (1997) for individuals to discuss the everyday forces that influence their lives via photographs that are taken by the individual. According to Wang et al. (1997), "[photovoice] recognizes that...people often have an expertise and insight into their own communities and worlds that professionals and outsiders lack" (p. 370). The use of photos when interviewing children is beneficial to accessing their perspectives and encourages a form of expression that is not commonly used with children (Cappello, 2005). In addition, "audiotaping people's narratives about their photos can capture the breadth and nuances of people's stories" (Wang et al., 1997, p. 375). Therefore, using photovoice to

understand the lived experiences of any person or group is a worthwhile endeavor.

In this study, families were introduced to the concept of photovoice at the first meeting. The researcher explained the purpose of the camera was to capture (1) aspects of their lives that influenced their health, good and bad, and (2) what it means to be healthy. That is, photovoice was only used to answer 4 out of the 16 interview questions. In addition, this process was described as a family project, thus encouraging equal participation by all family members. Each family was given one disposable camera, which allowed them to take up to 27 photos. The family was given at least one week to go through their weekly routine and photograph aspects of their lives that influenced their weight-related health and represent health. Lastly, the family was informed that after the photos were taken and developed, there would be a discussion about the photos.

Because photographs can be an invasion into people's private lives, the ethics on photography were explained (Wang & Redwood-Jones, 2001). At the beginning of the first meeting, participants were asked if they wished to consent to being included in any photographs that are taken by the family for this project. In addition, participants received release forms for non-participating subjects (e.g. extended family members) to sign prior to being photographed (Appendix D). The participating family was made aware that photos of non-consenting individuals would not be used for discussion or publication.

Family Interviews

An in-depth, semi-structured family interview took place during the second meeting with each family. The purpose of this type of interview was to describe a phenomenon that several people, in this case several families, shared (Marshall et al., 2006). During this meeting, the family was asked open-ended questions regarding the photos they took and their thoughts on weight-related health. Because this is a family interview, rather than individual interviews, this interview process resembled the structure of a focus group. During this process general areas were explored to uncover the family's perceptions while respecting how they, as a family, framed their responses and viewed the content of their photos (Krueger et al., 2000). In addition, including children in the interview process was supported because their perspectives were just as relevant and provided insight into their world (Marshall et al., 2006).

Interview questions were developed to address each research question and allowed the lived experiences of these families to emerge. Table 3.2 displays the photo and interview questions as they correspond to the four research questions proposed by this study.

Triangulation

The combination of multiple methods, known as triangulation, was performed in order to strengthen the study and some of its findings (Patton, 2002; Marshall & Rossman, 2006). In this study two sources of data were used to understand the participants perceptions of what it means to be healthy (i.e. how do they define healthy) and what influences their weight-related health. The

technique photovoice (Wang et al., 1997) was used to obtain visual data which supported the realities of the participating families in regards to these aspects of weight-related health. Prior to the second meeting, the researcher numbered each photo for easy identification during the interview. At the start of the interview process the family was asked to sort their photos according to the following: (1) what helps you be healthy, (2) what makes it difficult to be healthy, and (3) what does it mean to be healthy. After the family sorted their photos, the digital recorder was started and the interview began by examining one stack of photos (e.g. what helps me be healthy), discussing what was photographed and how that answered the interview question(s). The researcher wrote the photo number and took brief notes while the family discussed each photo. This process was continued with the other groups of photos until all were discussed. Once the family shared their experiences in relation to their photos the interview process moved forward to questions that were not associated with photographs (see Table 3.2).

Table 3.2: Research and Interview Questions

Research Questions	Photo Questions	Interview Questions
1. What are African American families' perceptions of weight-related health?	1. Which photos show what it means to be healthy?	1. What does it mean to be healthy? 2. How do you know what it means to be healthy? 3. What do you see in this photo that portrays being healthy? Probe: Do you feel that you and your family are healthy? Probe: How did your family respond to being told your child is overweight?
2. From an ecological perspective, what influences the weight-related health of African American families?	1. Which photos represent something that helps you be healthy? 2. Which photos represent something that makes it difficult to be healthy?	1. What is in the photo that helps you be healthy? 2. What is in the photo that makes it difficult to be healthy? Probe: How does this influence your health? Probe: What influences your health the most? Probe: Is there anything else that influences your health that you were unable to photograph?

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Table 3.2 continued

3. How do weight-related programs influence the weight-related health of African American families?		1. How do programs like Healthy Kids, Healthy Families influence the weight-related health of your family? 2. What topics are important to you when learning about weight-related health? 3. How do you think these programs should be structured? Probe: What are your overall thoughts on weight-related programs?
4. What challenges do African American families encounter when implementing recommendations of weight-related programs?		1. Are there any challenges you face when trying to follow health recommendations? Probe: How should weight-related programs respond to the challenges you face?

Reflexivity

An important element of qualitative and phenomenological research is to reflect on the researcher's own history and perceptions as they pertain to the research topic. In particular to phenomenological research, this process of bracketing off the researcher's experiences from those of the interviewees is termed *epoche*. In this process the researcher sets aside her own experiences, as much as possible, prior to data collection in order to take a fresh look at the studied phenomenon (Creswell, 2007; Marshall et al., 2006). Furthermore, the process enhances the researcher's awareness of whether her biases influence data interpretation.

Personal and Professional Experience

When I began graduate school I was working on finding my interests of study. At the time I had an initial interest in ethnic research. This interest emerged from my own experiences as a biracial woman. On a daily basis, and particularly at family gatherings, I am aware of the two, sometimes different worlds, from which I was raised. It is at family gatherings that I am able to clearly witness and live varying experiences of weight-related health between my families. Subsequently, my lived experiences as African American and Caucasian have benefited me in seeing the multiple realities within my own family. I believe my personal experience with multiple realities spurred my interest in privileging the multiple realities (i.e. beliefs) of other people. It was through witnessing the differences between my African American and Caucasian families that I became interested in both ethnic research and belief systems.

In regards to health, I have had a lifelong interest in the topic, which was further influenced by my husband's career as a physician. However, my interest in health research really took off when I was given the opportunity to work as a research assistant on an obesity project over 4 years ago. As a research assistant I helped develop family based programs aimed at living a healthy lifestyle. In addition, part of my job included facilitating these groups, leading focus groups, and transcribing data. In particular, I facilitated five groups over the course of two years with a nutrition student and Dr. Kathleen Jager. During these groups, children and parents were educated on various topics of weight-related health: nutrition, physical activity, self-esteem, goal setting, and working together as a family to address weight-related issues. It was this experience that bridged my interests in health and ethnicity. From this experience I learned more about weight-related health, the lack of research on obesity in African Americans, the lack of research on the family system and health, and the lack of exploring the lived experiences of those who live with obesity. It is through this combination of missing research that I decided to explore the lived experiences of African American families affected by obesity and to give them a forum to express what goes on in their lives that contributes to their weight-related health. I chose to explore this topic not for personal gain, other than to complete an important educational requirement, but because over time I saw that this was missing from the literature and wanted to find a way to contribute. It is my hope that this study will not only contribute to the literature, but more importantly provide new information to fellow researchers who continue to devise treatment

programs so they may be better informed on health and obesity in African American families.

Experience with Qualitative Methods

As previously mentioned I have had some experience with qualitative methods. In the last few years I conducted five focus groups with children and adults and transcribed the data from those groups using manual methods. I feel that this experience gave me a good foundation to conduct interviews for my own research. In addition, it gave me valuable experience to working with families, large and small, in a community environment.

Expectations

I expect the use of photographs in combination with some of the interview questions to be beneficial in interpreting the data, presenting the findings, and determining if there is new information for the field of obesity research. In particular, I expect the use of photos to add a unique element to the literature on understanding what influences the weight-related health of African American families. Furthermore, I expect some influences of weight-related health to reinforce previous findings, but anticipate interviews with the family system will add new influences to the literature. By interviewing the system it is likely that more information will be gathered than what is typically found in individual interviews (e.g. parents recognizing influences on their child's weight-related health and vice versa). I expect this study to highlight the family process in understanding weight-related health and how that information is transmitted through generations. Lastly, I anticipate this study will provide new information

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on what is needed in improving the relevancy of weight-related programs to African American families. By interviewing the family system, this study will be able to draw attention to elements of weight-related programs that are important to children of all ages and parents. This information is particularly important considering the familial influence on obesity development and treatment (Campbell, 2003; Dietz et al., 2001).

Data Analysis

According to Dahl et al. (2005), the purpose of analysis in phenomenological research is to describe and understand the experience of the participants. To accomplish this, an important element of this analysis is for the researcher to stay connected to the participants' experience. This occurs through a 5-step process which goes from collecting data to the final report on the essence of the phenomenon (Creswell, 2007). To complete data analysis, the researcher used qualitative analysis software.

The first step in the analysis process, *epoche*, was accomplished through bracketing or reflecting on the researcher's own experiences prior to data collection. This enabled the researcher to go into the data collection and analysis process with a clear and open mind to better understand the experiences of the participants. This researcher examined her personal experiences with weight-related health and in particular the differences she sees between her Caucasian and African American background. In addition, the researcher's experience as a research assistant and group facilitator was explored prior to data collection.

The second step of analysis known as *horizonalization* entailed the researcher immersing herself in the data to become familiar with it. Following transcription, the researcher listened to each audiotape while reviewing corresponding photos and field notes. It was during this process that significant sentences or quotes that gave understanding to the participants' experience were highlighted. The photos which corresponded to the significant statements were also highlighted to give the visual representation of what was said by the participant.

Once the significant statements and corresponding photos were identified, the researcher developed *clusters of meaning* from the significant statements and photos. Next, the clusters were categorized into themes based on their corresponding interview question. After the themes were created, *textural and structural descriptions* of the data were made. This step described what the participants experienced (textural description) and the context or setting that influenced how the participants experienced weight-related health (structural description).

The final step of data analysis was constructing the *essence* of the phenomenon from the textural and structural descriptions. The essence focused on the participants' common experiences and was a reduction to the essential elements of the experience. This final description left the researcher with the feeling that she had a better understanding of weight-related health in African American families.

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It was through this process of identifying and coding the descriptive narratives to their corresponding photos that the researcher understood the participants' underlying weight-related health perceptions and how their ecology influences their health.

Trustworthiness

The researcher has taken various steps to enhance the trustworthiness of this study. Trustworthiness is the term most commonly used that resembles the terms reliability and validity in quantitative research. Methods of creating trust or credibility include aspects of self-reflection, methods of data collection, and data analysis.

Theoretical Sensitivity

In summary, theoretical sensitivity refers to the quality of the researcher. The researcher's quality was influenced by both personal and professional experiences and how these experiences influenced the analysis process (Strauss & Corbin, 1990). Personally, I have become more aware of what influences my own health, which is why I chose Photovoice over photo-elicitation as a visual method. This method removed my bias in what visual data was used for the study, thus allowing the participants to photograph their views of reality.

From my professional experiences I realize that over the years I have gained an in-depth understanding of the literature and what can influence obesity development and weight-related health. Learning the literature and being a systemic thinker was helpful when it came time to develop the Healthy Kids, Healthy Families program. Hence, I am familiar with the group my sample was

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recruited from as well as what the sample was taught during their participation in the group. Because I am familiar with the literature and the Healthy Kids, Healthy Families program it means I had to put forth extra effort to make sure my experiences did not limit my interpretation of the data.

My experiences were helpful in that it gave me some basic understanding of this phenomenon, but it could have also come with a price. The downside was that my experiences could have restricted my ability to examine the data for what it really was, which may differ from what I had learned. As previously mentioned, becoming immersed in the data and stepping back to reexamine it at various points during analysis helped me explore potential variations and differences from what my experiences told me. This process also included my continued examination of whether the data supported my interpretation. Furthermore, I took this one step further through the process of bracketing.

Sample Selection

To ensure the credibility of this study and subsequent findings it was important to carefully select the sample. The focus of this study was to explore perceptions of weight-related health and weight-related programs in African American families with an overweight or obese child. The significance of including families with an overweight or obese child was attributed to the need for finding effective solutions for treating obesity and, in particular, obesity in populations with higher rates of prevalence, such as African Americans. The inclusion of African American families who previously participated in a weight-related program was also important because it is hypothesized that program

participation increases family awareness about health, what influences their health, and what information should be included in treatment programs. Specifically focusing on African American families with an overweight or obese child and those who have participated in the same community-based weight-related program increased the comparability of these families and their reports.

Review of Transcripts

Prior to coding and forming themes from the data it was important to immerse myself in the data. In this study, this referred to the researcher reading and re-reading transcripts to become familiar with the narratives, as well as viewing the corresponding photos. This process put all data on an equal level before patterns were sought. Becoming intimately familiar with the data made it easier to discover patterns that emerged. These patterns were subsequently coded and put into general themes for which specific statements were categorized. During the process of developing and organizing themes the researcher continuously stepped back to reexamine the data and assessed if her themes accurately reflected the data.

In addition, the researcher explored if alternative interpretations could explain the data. Once all significant statements were categorized under the appropriate themes the information was reduced to its essential points. Essential points refer to the "core meaning of the thoughts, feelings, and behaviors described in [the] texts" (Ulin, Robinson, & Tolley, 2005, p. 144). Completing this thorough process of data reduction resulted in an accurate understanding of the phenomenon and its essence.

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Summary

This chapter described the specific methodology used in this study to address the research questions. It included the research design, participant confidentiality, procedures, data collection, data analysis, and trustworthiness. The following chapter presents the study's findings along with corresponding photographs.

CHAPTER FOUR

RESULTS

This study explored the experiences and perceptions of weight-related health in six African American families with an overweight or obese child. In total, 6 mothers and 12 children participated in the study. These families discussed their perceptions of weight-related health, what influences their *weigh*t-related health, their thoughts on weight-related programs and the challenges they encounter trying to be healthy.

Table 4.1 displays an overview of the research questions and themes as they emerged from the interview questions. Visual and oral responses to interview questions were then categorized into themes and subthemes within four thematic sections: Weight-Related Perceptions, Weight-Related Influences, Weight-Related Programs and Weight-Related Challenges.

The results are presented within the four thematic sections. The first section, Weight-Related Perceptions, focuses on the families' understanding of weight-related health, including their own, and reactions to having a child diagnosed as obese.

Weight-Related Perceptions

Defining Health

At the beginning of the interview, each family was asked to describe what it means to be healthy and how they acquired that knowledge. In addition, they were asked how this description was captured in their photographs. Three major sub-themes emerged from these descriptions: engaging in healthy

behaviors, feeling healthy and emotional well-being. Interestingly, the majority of the child participants mentioned various physical activities they engaged in or healthy foods they ate to describe what it means to be healthy. Subsequently, their photos captured some of these behaviors.

Table 4.1 Overview of Research Questions and Themes

Research Questions	Interview Questions	Themes	Sub-themes	Thematic Sections
1. What are African American families' perceptions of weight-related health?	1. What does it mean to be healthy? 2. How do you know what it means to be healthy? 3. What do you see in this photo that portrays being healthy? Probe: How did your family respond to being told your child is overweight? Probe: Do you feel that you and your family are healthy?	Defining health Current family health Overweight diagnosis	Engaging in healthy behaviors Feeling healthy Emotional well-being Same health Work in progress Engaging in healthy behaviors	Weight-Related Perceptions
2. From an ecological perspective, what influences the weight-related health of African American families?	1. What is in the photo that helps you be healthy? 2. What is in the photo that makes it difficult to be healthy? Probe: How does this influence your health? Probe: What influences your health the most?	Positive influences Negative influences Most influential factors	Physically active Nutrition Medical Emotional Other Significant positive factors Significant negative factors	Weight-Related Influences

Table 4.1 continued

	Probe: Is there anything else that influences your that you were unable to photograph?			
3. How do weight-related programs influence the weight-related health of African American families?	1. How do programs like Healthy Kids, Healthy Families influence the weight-related health of your family? 2. What topics are important to you when learning about weight-related health? 3. How do you think these programs should be structured? Probe: What are your overall thoughts on weight-related programs?	Program evaluation Program topics Program structure	Increase knowledge Beneficial Demonstrate compassion Basic knowledge Nutrition Physical activities Cost-effective meals Length Format	Weight-Related Programs
4. What challenges do African American families encounter when implementing weight-related health recommendations?	1. Are there any challenges you face when trying to follow health recommendations? Probe: How should weight-related programs respond to the challenges you face?	Challenges Help with challenges	Time Using healthy foods Limiting choices Self Income Teach healthy recipes Support system Financial assistance Program continuation	Weight-Related Challenges

Healthy behaviors that were mentioned by the children included drinking water, jumping rope, exercising, eating healthy choices, running, getting a fresh start to their day by walking and maintaining doctor appointments (see Figure 4.1, Figure 4.2, Figure 4.3):

Figure 4.1. "Running. I think is what I think it means to be healthy and having motivation."

Figure 4.2. "Showing that you know, getting up early with the morning getting that fresh air, that morning air, that makes a lot of difference."

Figure 4.3. "Keeping your regular visits."

Ms. Gray's 11-year-old daughter expanded her view of being healthy to include the act of monitoring whether a person is engaging in healthy behaviors:

> Well I think what it means to be healthy is that you keep a track of...what you're eating. Or if you're being active or are you being lazy or sometimes or if you don't wanna do something that you just sit back and not...get out there and do something ... What it means to be healthy is that you're outside trying to do something or you're in the house moving like cooking or something like that.

Participating mothers gave more in-depth descriptions, which focused on internal feelings of health rather than healthy behaviors. Ms. Gray described health in relation to how one physically feels:

> I would say being healthy is being...to the point to where you don't exhaust yourself. Healthy, you know, you'll be able to do just the basic activity and be able to be comfortable with doing that...test yourself to the limit and still be able to do that.

Mrs. Hall had a similar description, which included feeling safe:

> I'm thinking...what it means to be healthy too is whenever...you don't have difficult times bending over or picking things up or can't button your

pants up. So stuff like that that's what I think. You feel, yeah, you feel it. You can see it. You can feel it.

On the other hand, Ms. Smith described health being related to one's emotional well-being and discussed how her emotional well-being was influential to her daughter's health and well-being:

> How I define healthiness is...joy. I wanna define it as joy. Yeah, I say about loving yourself. The healthiest thing is loving yourself. That's the reason I say joy. If you can look in that mirror and say I love me...okay, I'm a say it this way. In order to help my daughter with her health problem I got to love myself. And if I love myself I can help someone else. And if I'm not loving myself and not happy within myself how can I help her. And to me...once I started being happier with more of a laugh, if ain't nothing but sitting in the room watching the TV, laughing I notice it got to giving me energy. So I had to start learning things that made me laugh and feel more joy. That's the reason I say joy.

Ms. Smith's 13-year-old daughter expressed a similar sentiment regarding health and how it applies to her own life:

> Maybe I would say feeling good about yourself. Don't let other people put you down. Think positive about yourself. Somebody put you down, just...words don't hurt you, just walk away. That's the main thing to being healthy to me about your happiness. To me it doesn't matter about the number on the scale cause if you feel happy about yourself, you like the way you look, some people...sometimes when I look in the mirror I don't like the way my clothes fit on me, but hey...I just gotta keep trying.

A few different sources of knowledge were mentioned when the families were asked how they knew the meaning of health. Many of the younger participants attributed their knowledge about weight-related health to what their parents or family had taught them. It appeared that these family role models helped educate the children at a young age about what it meant to be healthy. Some of the older children and parents stated they learned this information

from various health professionals (e.g. doctors, health teachers, program facilitators). In addition, Ms. Gray noted the influence of television on sending healthy messages to today's youth:

> And a lot, I think it played too, far as like young kids is that they can see it on Nick Jr. or you can see it on...you know because it's a commercial with a little boy, Carlos. It's a little commercial where Carlos is like, "Carlos, which one do you wanna do Carlos...to stay healthy?" "Do you wanna have the candy bar or do you want to have the yogurt?" And when I saw that it kinda surprised me. You know a lot of that TV does play into being healthy. You know especially for kids. It's catching them where they see it, you know, in that cartoon.

In regards to her own knowledge, Ms. Gray stated that learning what it means to be healthy is something you are taught through life experiences, which may include witnessing your own health decline.

Current Family Health

After eliciting information about the participants' definition of health, the interviewer asked about the family's present health status. Having a baseline understanding of how the families defined health was important to understanding their perceptions about their own health.

There was an even split among the families in viewing their health as the same, a work in progress, or improved. The Ward and Parker families viewed their health as needing improvement. A child in the Ward family expressed needing someone to motivate and encourage her to be healthier and support her in her efforts. In the Parker family, Ms. Parker reported the whole family was obese.

The Harper and Hall families viewed their health as a work in progress.

Ms. Harper stated:

> We're working on it. We need a lot more work, but we've started working on it. We just gotta keep at it...and get more active, more walking, more exercising...eating not fried foods. We need to have boiled, baked, grilled. We need to do more of that.

In the Hall family, all members expressed that they have made some health improvements. Ms. Hall said: "We're working on it. It's a work in *pro*gress and I think this is a starting point and that in anything you have to start somewhere so this is where we start."

Lastly, the Gray and Smith families reported making noticeable improvements in their health and continuing to engage in healthy behaviors to maintain their new healthy lifestyle. Ms. Gray's 11-year-old daughter reflected on her past health and motivation for getting healthy:

> Like in the beginning...when I was eating a lot. I feel that I wasn't...healthy, slouchy and stuff like that. And then I got to the point when I was like okay it's time for me to get up and be more active. And then now I see that my mother...she was active and stuff like that so I wanted to try something to be active like that so I just went along and played basketball and that made me feel that, like, I can do stuff like really good.

Ms. Gray stated that since their participation in the Health Kids program her daughter is no longer in the 85th percentile for weight and noted the visible changes she has seen:

> She's no longer in that category. I believe...we just went recently for her well-child checkup. (The pediatrician's) like, "oh, you know, look at the chart here", you know. "She's outta that range now". I'm happy about it, you know. She's doing really good. And you can tell the difference in her from the first day we started by looking at her, you know. I can and I just stare at her a lot because I can see the difference.

In the case of the Smith family, the mother attributed their improved health to living in a better neighborhood as well as working with her teenage daughter to improve her health:

> ...but after we moved over here I feel like it's more healthier that I'm making a healthier start again. I'm not just a mother sitting back. I'm out participating in it as well for both our health. Not just saying Cierra you get out and walk down there to that bus stop cause you need to lose this weight. No, I'm doing it with my daughter. I wanna do it with her. I wanna be with her.

Obesity Diagnosis

Once information was gathered about the family's evaluation of health, they were asked to recall their experiences of being informed that their child was overweight or obese. Some of the children shared that they were surprised, whereas others were not. Ms. Gray's 11-year-old daughter said: "I was like, wow! Like I was really scared that something could happen to me if I wouldn't lose weight or something like that."

The mothers had a wider range of experiences to being informed their child was overweight or obese, including not being surprised by the news. More notably, parents recalled raising concerns prior to diagnosis, uncertainty of what the diagnosis implied, and surprise.

Both Ms. Hall and Ms. Smith pursued medical concerns with their child's pediatrician prior to the diagnosis and felt it was beneficial to receiving timely care:

Ms. Hall said:

> Well I don't recall the doctor actually telling me, but I actually inquired about it and asked them, "you know, how can I...I need help with this". "This is a little bit difficult." Yeah I went to the doctor and he never said

anything to me about it. I always, whenever I went to the doctor they always asked, "do you have any concerns?" And it was always one of my concerns because on her father's side they all have diabetes and I was really concerned about that because I seen the neck changing and she was thirsty all the time and so that was really my concern. And then they...I had to be more proactive pretty much to ask them, you know, well what does that mean and what does this mean and what does 85th percentile mean. You know it wasn't clear to me what that actually meant. I knew I had my own perception of what it meant, but I needed more.

Ms. Smith's pursuit began out of concern for her daughter's poor breathing as a young child. She was proud that she kept her daughter's doctor appointments and pursued her concerns:

We...not just leaving it to the doctor. We trying to also improve ourself as well, like I said, by the walking. I think why Cierra diabetes got more [diagnosed] because of me pressurin' the doctors. So all we could do is watch and see what was going on, but basically by me staying up on my appointments I think we kinda caught it...on time. And I remember taking her to a eye doctor appointment. And the eye doctor told me that he feel like she got diabetes. Taking her to the doctor for the...I said you a little late. You a little late. I had already start doin' that and...that kinda made me happy. It kinda made me happy because I was constantly on it about the way she was breathing.

Similar to Ms. Hall's story, Ms. Gray was unsure what overweight and obesity really meant in terms of her daughter's health:

Yeah and when we found out...we didn't realize what actually played a part into that, you know, 85th percentile or that obesity, you know. A lot of things that was going on with Shawna, we didn't realize it and I believe that once we found out that that's what they categorized her as they actually took a look into see what's causing this problem. And we found out that she has diabetes, you know, so we found out a lot of things that were played an importance with her health, you know. It made me more aware what I was allowing her to do.

A few mothers were surprised that their children became overweight or obese. Ms. Harper was surprised because her 10-year-old son was very active and she worked on controlling his diet. In addition, she experienced a collaborative relationship with her son's pediatrician to determine the cause for his weight gain:

> At first it was kind of a shocker because he wasn't overweight. Then he just sort of started gaining and gaining and seemed like every time we go to the doctor's office he'd gained more weight. And I was wondering, you know, why. He was real active. He was always playing outside. He was riding his bike. He was....like he said playing soccer, playing in the park, but he was still gaining the weight. I don't think his doctor believed me that he...didn't sit around watching TV...cause she kept mentioning it and I'm like, "okay, but he doesn't sit around watching TV." He's the only kid I knew that had a video game hooked to a TV and didn't play it often. She (the pediatrician) also thought it was emotional. That his overeating was emotional. So she recommended he see a counselor which we got that started and see what's going to go from there and... She suggested it might be...I guess from some things I told her or whatever that it could be emotional.

Unlike the other mothers, Ms. Hall reported feeling her child's pediatrician was insensitive to her concerns about her 9-year-old daughter's weight:

> Well, yeah until I brought it up and then... I got some feedback from doctor, "well you know, you the one that buy the food." And you know, kinda like scolding me for it and I'm like, "well I know that, but I'm asking you for help and what can I do because it's..." To me I looked at it generational. This is what I knew to eat. This is what I fed 'em. I was on a very fixed income and I'm gonna give her what I have to eat and so...I felt like, wow he's really on top of me for this so I need to do something. So then he sent me to the social worker or whatever, but... I was surprised that they didn't...wasn't more sensitive to it. Yeah whenever I brought it up it was, "well you, you shouldn't feed her that." "You shouldn't...", but it goes way beyond what I'm feeding. You have to look at the economical part of it too and I didn't feel like that they were looking at that. And that the programs that they had were expensive. Everything

I couldn't afford. I needed some help from somebody else to say, "well how 'bout trying this" or, you know, helping me to brainstorm different things that I could do or other options. I wasn't really surprised. I was just surprised at how unsensitive they were. Yeah they were unsensitive and I'm like, wow at least I'm trying. Give me an E for effort, you know, because I do identify that there's a problem but how can I...how can we be a team.

Weight-Related Influences

The next line of questioning explored ecological factors that were influential to the weight-related health of participating families. This thematic section highlights visual and oral experiences which positively and negatively affect family weight-related health. In summary, the most influential factors were also reported by each family.

Due to limited time for taking photos, families were asked to discuss positive weight-related health influences that they captured in photos in addition to other factors that they were unable to photograph. Once that was completed the interview explored negative weight-relatedhealth influences in the same manner.

Positive Influences

Several positive weight-related influences were mentioned by the families. The main themes that emerged were: Physical Activity, Nutrition, Medical and Emotional.

Physical Activity

A wide variety of factors were mentioned when it came to helping the participants be physically active.

Family

Four of the families noted the significance of being physically active with family and its influence on weight-related health. Ms. Gray and her 11-year-old daughter, Shawna, commented on how they are physically active with Shawna's, aunt, and cousin. This included working out a few times a week to a work out video (see Figure 4.4).

Shawna said:

> ...when I exercise with my family and we just...we get out there and we have healthy shakes, like we'll have a strawberry shake and then the next day we wouldn't have one and then the next day well have a mango shake or something like that. I think most families need to learn how to do it cause it's fun.

Similarly, two of the Ward sisters photographed each other as they took part in their daily walk (see Figure 4.5).

Figure 4.4. "I think we like doing it cause we're all doing it..."

Figure 4.5. "That was early in the morning at like...9. We was gonna walk."

Although unable to photograph family outings, Ms. Gray and Ms. Smith's 13-year-old daughter also noted the significance of being active with family.

Ms. Gray:

> A lot of things we do, we do it as a family and her aunt was just here and her cousin was here and she wanted to take a picture of them before she left because that is something that helps her be healthy too. You know, family plays a big role in a lot of decisions that we make because if one do it then the rest will want to do it.

School

When it came to being physically active at school, children from the Gray, Harper, and Hall families commented on organized sports and gym class as helping them be active. In particular, Ms. Gray noted that her daughter played an entire game of basketball and was able to keep her energy level up.

Ms. Gray's 11-year-old daughter stated: "It's like I wanted to be in the game. Like when I had got to sit...I just was like, oh, is it my turn to get back in?"

In the case of the Harper family they were unable to take a picture of gym class, but the 10-year-old son commented on how much he enjoyed gym by saying:

> I didn't get to take a picture at school when I was playing volleyball. I wish we could have it everyday cause I like it...and I help the gym teacher after I'm done with...class. Then I help the little kids cause sometimes they don't know how to like...they have like a little ball they gotta bounce it up and do tricks. So I gotta help them with that.

Ms. Hall's 10-year-old son participates in some organized sports and she took a picture of him performing push-ups, which is part of his football and basketball practice regimen (see Figure 4.6). In addition, he plays tag with his friends.

Figure 4.6. "I'm doing push ups."

Limiting TV and Video Games

In regards to television and video games, two children mentioned different factors that help them be healthy. In Ms. Harper's household she sets a time limit on when her son can watch DVD's and television. She sets this

limit because she wants her son to be active and she knows he would watch television all day if he could.

In the Hall household, the oldest daughter (age 9) commented on how video games help her be healthy: "...and today the Wii (video game) helped me be active cause I was playing the Wii. I was playing tennis."

Weather

Ms. Gray was the only person to mention how weather positively influences the weight-related health of her family:

> And I think the weather plays a big part in that. You know that would've definitely been a good thing that help us be healthy and also can make it difficult. When you're out in the summer, I mean every single day we're doing something. Whether that's going, leaving out of the house after dinner and then taking a walk, you know, or we go to (local school's) track and we do it as a family.

Community Centers

Two families shared how local community centers helped them live a healthy lifestyle. Ms. Harper's 10-year-old son attends a local community center every day after school where he plays games and enjoys a snack (see Figure 4.7). In addition, his cousin attends the center with him. Ms. Harper also discussed how they received free passes to the local YMCA from the pediatrician:

> It's not might, we're gonna go to the Y. They gave a family pass. His doctor gave it to me. We got five passes and then they're gonna help us...join so we can have a membership.

Figure 4.7. "I took a picture of my cousins running and hugging." "This is the place that we go to, (community center)."

The Hall children also attended a program sponsored by their local YMCA. Each week they did different physical activities and learned about healthy living. They captured this experience in two photos (see Figure 4.8 and Figure 4.9).

Figure 4.8. "We could bounce on 'em or play a game." "We had to bounce on it like a basketball and go around and hit peoples."

Figure 4.9. "We're dancing." "It's Zumba."

Playing Outside

Playing outside was one way to be physically active and help a person be healthy. No one clearly explained why being outside was healthy, but it was viewed as helpful by many of the families. Ms. Hall photographed her 10-year-old son and other children playing outside (see Figure 4.10).

Figure 4.10. "That's when y'all was running and playing with the bubbles." "Being outside is good."

Ms. Gray's 11-year-old daughter articulated that working in the yard was helpful for her health:

> "I did want to take a picture of like a tree outside and how it helps me to be healthy when I'm outside and trying to build a tree and dig a hole for the tree to sit in or a flower to sit in..."

In the Parker family, the 7-year-old twin boys spend much of their time outside playing with the ducks at a nearby pond. When asked how the ducks help them be healthy one of the boys replied: "...when they run we run with them. When...they be swimming we be walking."

Various Physical Activities

Five of the families photographed and commented on several physical activities that they enjoy doing, including skating, playing with the family dog, playing sports, swimming, and riding their bikes. Three of the families, Hall, Harper, and Ward, have dogs and stated that walking and playing with their dog keeps them active. Ms. Harper's 10-year-old son articulated it the best (see Figure 4.11).

Figure 4.11. "Um, running and chasing my dog around." "Then he can get exercise and I can get exercise."

The Ward family mentioned going to the local community center, roller skating, swimming, and riding bikes as the physical activities they enjoy. Ms. Ward stated: "We all just get together on our bikes. Just go ride."

Ms. Parker's twin sons enjoy riding their bikes and scooters the most. Pictures were taken of both of these activities and one of the 7-year-old sons described why he enjoys these activities (see Figure 4.12 and Figure 4.13):

Figure 4.12. "Riding my bike makes me be healthy because I love it and...our mom said it burns calories."

Figure 4.13. "I love it and it good and healthy cause I stand up and then peddle."

Nutrition

Different aspects of healthy nutrition emerged from participant stories as being helpful to weight-related health. Most participants mentioned healthy eating (e.g. eating healthier foods and controlling portion size). A few families also reported the influence of external factors such as schools and programs.

Healthier Choices

Ms. Gray's 11-year-old daughter learned how to read nutritional labels due to participating in weight-related programs and to this day she is mindful of what she eats. She captured this information by photographing her cereal and stating the following (see Figure 4.14): "Some healthy cereal. The um…how much fat or how much sugar was in it and um…was it less calories or more calories in it."

Figure 4.14. "She's been watching...the calories, the intakes, the sugar and all that..."

Ms. Harper and her son took a few photos of what their family ate and had discussed how each meal had some items that were healthy (e.g. vegetables, bake foods, noodles) and others were not as healthy (e.g. fried food and meat sauce). Ms. Harper's 10-year-old son was photographed eating

a healthy meal, which included drinking water with the meal (see Figure 4.15). Ms. Harper commented that the water was to help her son get full so he wouldn't eat too much.

Figure 4.15. "It was rice and um...steak."
" I had a glass of water right next to me, but I drunk that before."

The Ward family was unable to photograph some of the healthy foods they ate, but talked about eating fruits, drinking water and transitioning to milk with lower fat content. Ms. Ward said: "Well, you know what, I alternate the milk when I buy it. From like whole milk to like...two percent."

Similarly, the Hall family took several photos of their healthy choices (see Figure 4.16). One notable commonality of their photos was that they photographed vegetables they enjoyed, which enhanced the likelihood of actually eating such foods. In addition, they found healthy ways to make certain vegetables more enjoyable, like putting peanut butter on celery.

Figure 4.16. "It's because they not...it ain't got no sugar in it and stuff and they regular Cheerios." "They not Honey."

The Hall family also consumes more water and for different reasons. Ms. Hall switched to water in order to "start somewhere." Ms. Hall's 9-year-old daughter stated: "I started drinking more water cause I need to lose weight." Whereas her son said: "I started drinking water so I could be more active and run faster..."

In the Smith household, Ms. Smith gave an example of how they turn a sometimes unhealthy food, in this case burritos, into a healthier choice (see Figure 4.17): "Well you make 'em healthy like a lot of lettuce, tomatoes. I'm trying to make more healthier foods."

Figure 4.17. "Homemade burritos."

Portion Control

The Smith family was the only one to discuss how they control portions as a way to eat healthier (see Figure 4.18). Ms. Smith also noted that you can still eat not-so-healthy foods, but they need to be eaten in smaller portions in order to be healthy choices:

> ...you can't say, "well I'm not going to eat no chicken, I'm not going to eat no french fries," so what we tries to do is when we eat those things we try to break 'em down in small portion. Smaller portions instead of you know eating a big portion of it and...we still trying to say everything is still good for you, but certain foods you bring down in portion.

Figure 4.18. "You can still eat...great tasting food with not eating too much."

School

When it came to school and nutrition Ms. Gray and her daughter talked about the improvements they've seen in the school lunch menu. As a family, they have also incorporated some of the lunch menu items into their choices at home. Ms. Gray said:

> I noticed that menu cause I was like, wow...for them they making sure that they have their vegetables, their fruit, their bread and their meat. So they have that every single day. It kind of surprised me when I saw it. I've had to use that menu for us to have.

Programs

Ms. Gray's 11-year-old daughter commented on how helpful various health programs have been on the development of her healthier lifestyle. In addition to learning more about nutritional labels, as previously mentioned, attending those groups gave her and her mother more ideas on healthy recipes and meals that they could make at home.

Medical

A few families shared how taking care of their health through medical means was also beneficial to their weight-related health.

Health Education

Ms. Smith's 13-year-old daughter has type 2 diabetes and shared that as her daughter learned of her diagnosis and became more informed of diabetes she was subsequently more comfortable with herself and her body:

> So it's learning your body. It's learning your body and learning how to take care of your body. And once, I feel like, once she learn her body and feel secure with her body and knowing that she got diabetes I think it will be a lot easier to fight it than being depressed. And I know as we going through it, the more and more she's listening and hearing about

the diabetes and...she's going through it...I see a [dramatic] change that, "ok, I got to do this, I'm coping with this."

Doctor Appointments

In addition to learning about diabetes, Ms. Smith expressed the need for parents, especially low-income African American parents to take care of their child's health:

> So now I think it's very important as a parent...stay on the doctor's appointments. For low-income Black kids..., Black parents, they should stay on it. I mean don't say, "okay, okay this and this." "Oh she got diabetes." No, don't just dismiss it.

Self-care

In regards to self-care or managing health, Ms. Harper mentioned the importance of taking medication and how it was beneficial to weight-related health:

> We forgot to mention taking our medication too. We stay healthy by taking our medication. It keeps him from having a asthma attack and me from my blood pressure going up. Trying to lose the weight to get my blood pressure down is a good thing I need to do.

Emotional

The last theme to emerge regarding positive influences on weight-related health was emotional factors. In particular, these factors were important to the Smith and Hall families.

Desire to be Healthy

Ms. Hall has noticed a strong desire in her children to live a healthy lifestyle and she feels this is a positive contributor to improving their weight-related health.

Ms. Hall explained:

> Um...what helps us to be more healthy is that they're adamant about wanting to be, or their receptive to it and I guess we can't take a picture of that, but just something...that they wanna be healthy and the desire. Yeah, I think the desire is really important.

Faith

Ms. Smith expressed that despite having limited income, in addition to medical problems within her family, she felt that God had blessed them and was optimistic that future blessings were coming their way. A recent example was they recently relocated to a more relaxing and safer neighborhood, which allows them to go outside and be more active. In addition, the new neighborhood has reportedly improved their mental health.

Ms. Smith stated:

> Everything I got, the biggest amount of money went to just trying to keep a roof over our heads...and I hide from her a lot. She found me one day and I tried to not show what was going on with me and...like I'm about to break down now, but I told her I say, "you know what Cierra, hold on," you know. I said "yeah I been crying, but I been praying." I said, "hold on. God gonna bless us one day. He gonna bless us very well. You know he gonna bless us. You know, you gotta hold on to your faith as well with it." I keep telling her and I keep telling myself, you know, even with the Lupus that...it was years that I stayed sick, back in the hospital, but with my faith and then like I keep telling her with her faith, believing in God and standing on that faith saying I'm gonna be whole one day....you will because...with me standing on top of God I look at how he done just blessed us. We in a better place. I'm able to pay the bills. It don't take everything just for the rent.

Family Support

Being physically active with family was previously mentioned, but the Smith family also shared how having family support is beneficial to their emotional well-being. It also helps Ms. Smith's teenage daughter cope with her diabetes.

Ms Smith:

> Yeah it's something that helps us be healthy. I feel like it's healthy. I think it's very important for you to stay um...active with your family, grand kids...sisters and brothers... In order to stay healthy also...laughter. I mean, you depressed so family, being around family, being with family is a healthy...a healthy goal by keeping you laughing. I mean, when you can sit down and talk about, "okay, Cierra you got diabetes...," you know. And can laugh about it instead of feeling depressed with it, you know. And....showing that other person love. I mean that helps a lot, that's what makes it healthy.

Negative Influences

When it came to discussing negative influences on weight-related health, the families had several factors that hinder this aspect of their health, such as being inactive, unhealthy eating, medical issues, and emotional factors. Some of these factors were also captured in photographs.

Physical Activity

When it came to being physically active, all of the families mentioned at least one factor that makes it occasionally difficult for them to be active.

Inactive

Many of the families shared that just being "lazy" was something that negatively influenced their weight-related health. Ms. Harper shared her struggles with getting her son to go outside and be more active:

> Actually getting out there doing it. I encourage him to go play outside a lot to keep him out there. To actually get him to do it on his own which he used to do it on his own. It was getting him in the house that was a problem now it's getting him outta the house.

Ms. Harper's 10-year-old son acknowledged his lack of engaging in physical activity. He had also recalled being more active at their last residence, but could not identify why things had changed: "Sometimes I say I'm doing it…I'm gonna do it, but I don't end up doing it."

Ms. Ward has admitted to occasionally driving to the local store instead of walking, which she usually does when her children are with her: "Like the store down the street. We'll drive instead of walking. Or…like Family Dollar's right across the street and if the kids ain't here instead of me walking over there I might drive."

Ms. Hall's 9-year-old daughter acted like she was sleeping in order to demonstrate how sleeping inhibits physical activity (see Figure 4.19). Ms. Hall's 10-year-old son explained: "And this is her sleeping. When you sleep you can't exercise."

Figure 4.19. "Sleeping."

TV and Video Games

A few families shared that watching television or playing video games contributed to their lack of physical activity. In the Harper household, the grandmother, mother, and son were all guilty at times of being inactive due to playing video games. Ms. Harper's 10-year-old son commented on a photo of himself (see Figure 4.20): "This one I was being lazy playing my DS (video game). See...I was being lazy. Didn't want to do nothing."

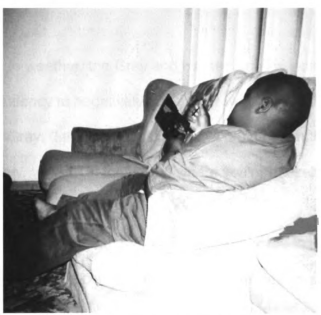

Figure 4.20. "...not wanting to do nothing but sit and play the DS."

Ms. Ward took a picture of her 14-year-old daughter playing computer games and also expressed: "You can be doing something...just hours. They sit and play games and play music. Just sittin'."

Figure 4.21. "Sittin' around."

Weather

In regards to weather, the Gray and Harper families indicated cold weather had a tendency to negatively affect their weigh-related health. According to Ms. Gray: "I think the weather plays a big part in that. You know cause in the winter…you get in that mood where you're housebound and don't want to do anything."

Ms. Harper expressed that her family will go outside to be active throughout the year, but the cold winter weather limits how much they venture outdoors:

> Usually we're outside more when it's warm outside. We're outside more than when it's cold. We go out when it's cold, but not a lot. When it's cold, I just can't. I'll go out, but not as quick as when it's warm.

Neighborhood/Environment

Living in a new neighborhood or environment, which may not be very welcoming, has made it difficult for some of the families to be outside more. Ms. Harper recently moved to her neighbor hood and said: "I have yet to

venture down to the store, but it doesn't have anything with not wanting to exercise. I'm afraid a new neighborhood and everything I just haven't got the guts to walk down there yet."

Ms. Smith recalled her previous place of residence and how it wasn't enjoyable due to her landlord. At this time Ms. Smith and her teenage daughter have relocated to a new neighborhood where they feel better, which has helped improve their physical activity.

Ms. Smith stated:

> Sometimes the environment you are in make it difficult to want to be healthy... I can say for the environment of being right there on Tibbs. It was like miserable. Your living conditions were like miserable. Not only that my grandkids can come over. I wanna get out on the field and play kickball with them. "I don't want anybody on the grass!" And see that make it hard for kids... If you feel that way why rent to people that got kids? So the environment.

Unhealthy Eating

The majority of the families discussed how the nutritional choices they make are not always the healthiest. In most cases, the children were able to identify why certain food and drink choices were not healthy for them.

Unhealthy Choices

Ms. Gray's 11-year-old daughter reflected on the first time she had a sports drink for her basketball game. She felt the drink slowed her performance and subsequently requested her mother just give her water. She stated:

> When we had the first game that I had...my mom had bought me a Kool-Aid, a Powerade...drink and I just drunk it before the game. Then when I started getting tired in the game and it wasn't right so I just told her to start buying water and stuff because then when you drink the sugar stuff it makes your motivation go down.

Ms. Harper and her son listed a few items that are difficult for them to not eat, which they described as unhealthy. For Ms Harper, she acknowledged having a "weakness" for ice cream whereas her son enjoys "bags of chips" and juice and pop.

Ms. Hall's children photographed several items within their house that they believed had a negative influence on weight-related health. They photographed condiments, such as mustard and mayonnaise, and sugary foods. Ms. Hall's 10-year-old son explained why mustard was not healthy: "It could be healthy…but we put it on stuff that's not healthy." He also articulated why oatmeal cookies were not healthy (see Figure 4.22): "Cause it got sweets…I don't know if oatmeal is good but it got a lotta sugar in there makin' the oatmeal sweet."

Figure 4.22. "...that's cookies and it got all that sugar."

Portion Control

During the interview, Ms. Harper explained that her son has a tendency to eat more than one serving of certain foods and tried to explain to him that that was unhealthy. Her 10-year-old son appeared to understand, but expressed a difficulty with limiting foods that he really enjoyed. They discussed this struggle in relation to one of their photos, which had a couple pizza rolls and fish sticks that a cousin brought over to share (see Figure 4.23). Ms. Harper said:

> (It's) not too healthy cause you like to eat more than a couple. It would be healthy if you're gonna eat maybe...five at the most. But you want to eat more than five. Yeah, makes it difficult because you want to eat too many. That's why I don't buy pizza rolls.

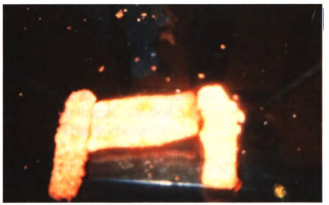

Figure 4.23. "When she buy pizza rolls they go like this (snap sound)."

Lastly, the Ward family tried to photograph a hamburger that one of the daughters was eating. Unfortunately the burger didn't show up in the photo, but was explained in the interview by other family members. They described it as being greasy and having several items on it: lettuce, tomato, ketchup, mustard,

miracle whip, cheese and pickles. To the family this burger was more than the 14-year-old daughter should have eaten.

School

Only one child mentioned the negative effect school can have on weight-related health. Ms. Ward's 16-year-old daughter, who is in high school, mentioned having cravings for a certain kind of chip and shared that the school provided those chips and other unhealthy items at school. She said: "Then they sell them at our school so that just make it even worse. Fifty cent a bag...and they got vending machines and stuff at our schools."

Cooking Style

Ms. Hall and Ms. Ward discussed how their traditional way of cooking also had a negative influence on their family's weight-related health. Ms. Ward explained:

> Yeah the way we cook. Make it difficult to be healthy. We be like...well we be cooking unhealthy...like sometimes like we be fryin' chicken and we could bake it, you know. Or boil it or broil it or somethin'. And...we use a lot of butter. That's cholesterol...

Ms. Hall saw the traditional cooking method and unhealthy eating as being generational in nature: "...and I guess it's generational too. This is the way I knew how to cook. There was no other way. This is the way we always ate, big meals. Portion size wasn't really...until now till we see the problem."

Restaurants

In regards to eating out, the Harper family had a lot to say about the struggles they face when trying to eat healthy when eating outside of their home. For them it appeared to be a double-negative in that the restaurants

offered several unhealthy options along with multiple servings. Ms. Harper's 10-year-old son explained this struggle when they occasionally go to a local buffet-style restaurant:

> Me and mom when we go out we just...we just go. We just poof. Yeah, because they...we do eat vegetables, but when we go to Fire Mountain. Yeah, it's just hard…because they have like chicken, steak, um...potatoes, french fries, shrimp.

The children in the Hall household also discussed the negative effects of eating at restaurants. According to their explanations, if you ate at restaurants regularly you had a high chance of dying prematurely due to the limited nutritional value in restaurant foods (e.g. high fat content).

Medical

A few medically related issues were mentioned by families as having negative effects on their weight-related health. These topics ranged from being ill-informed about proper health maintenance, treatment for medical issues, and the presence of medical issues.

Health Education

Ms. Hall expressed a feeling of regret for not learning about healthy living before her 9-year-old daughter developed weight-related problems. It seems she felt that acquiring such knowledge earlier on would have put her children in a better place, health wise. She stated: "What makes it difficult at the time is that I wasn't aware of, you know, how I was really hurting my children by not learning more."

Equipment and Care

Ms. Smith's 13-year-old daughter struggled at times with appropriately monitoring her blood sugar. As previously mentioned, she has type 2 diabetes. Here she explains her struggle:

> Cause sometimes I forget about it or...when it pokes you it just...sometimes I poke it in the same finger constantly and like my finger is throbbing and it hurts so much. Sometimes I just don't want to do it but I have to. I switch fingers every once in a while, but it's like every time I look at my hand I can always see little dots from where I poke myself at. Sometimes I end up poking myself...inside my finger like over here somewhere cause it hurts so much.

Health Issues

A few family members mentioned the health problems they have, which have affected their weight-related health. In the Parker family, Ms. Parker expressed that one of her sons had asthma, but in recent months he has had few symptoms. Both mom and son reported that he use to get winded when physically active, but now Ms. Parker wonders if he has outgrown the asthma.

Ms. Hall was photographed sleeping by her 9-year-old daughter (see Figure 4.24). When ask to explain what was in the photo that made it difficult to be healthy she explained her mother's sleep apnea affected her mother's health. She stated that when her mother slept she stopped breathing, which isn't healthy. Ms. Hall was surprised at her daughter's awareness of this matter and said the following: "Well it is bad for you and it could be due to overweight and I know it is due to being overweight, but it's funny that she even know that."

Figure 4.24. "Because when you sleep, you stop breathing. She was snoring."

Emotional

Being mentally prepared and focused on engaging in healthy behaviors was admittedly a challenge at times for some participants. They found it most difficult to be motivated and at times got frustrated from trying.

Desire to be Healthy

Ms. Gray talked about how people can sometimes be their biggest obstacle to making healthy choices. In addition, she viewed herself as a role model to her daughter and if she wants her daughter to be healthy then she needs to model healthy behaviors for her. Ms. Gray said:

> Look at it as…I can be my biggest enemy and I cannot be my biggest enemy, you know. So I think it has a lot to do with me mentally and us mentally cause if I don't wanna do it she's not gonna do it cause I don't want to.

Ms. Harper described this factor as more of her willpower to make healthier choices. As her example, she talked about the difficulty in going to a restaurant, especially a buffet-style restaurant, and only choosing healthy

options. She also felt this was a similar struggle of willpower for her son. Ms. Harper stated:

> Cause I just eat maybe a couple...which is the fried chicken which is probably, I shouldn't eat it, but I eat the fried chicken and I eat the macaroni and cheese... I do sometimes get a vegetable, but I love the macaroni and cheese and I love the chicken...but if they don't have the fried chicken I would pick a baked piece. So it's basically me having the will power...

Emotional Well-being

At times it can be frustrating to implement healthy changes into a person's lifestyle. Sometimes the frustration can lead to moments of giving up, like Ms. Gray's 11-year-old daughter said she experienced at her basketball game:

> What makes it difficult is...just passing (the basketball) and then when you get confused to what you're supposed to do. You get a little angry, but you gotta keep your head in the game... And then you just forget about it and wanna sit out so that makes it difficult because then you're not getting your exercise...you're just sitting down.

Other

Lastly, Ms. Smith commented on how a lack of transportation to medical appointments can have negative consequences for weight-related health:

> A lot of us don't have transportation... it's still kinda hard getting to doctor's appointments when you don't have transportation then not only that you don't even have the money to catch the city bus ...

Most Influential Factors

After questioning families about all the factors that influence their weight-related health, they were asked which factors were most influential.

Significant Positive Factors

The families narrowed their most influential positive factors down to being physically active, the support of their family and making healthy choices.

Physically Active

A few of the families recalled the physical activities or sports they enjoyed doing, which increased their chances of engaging in those activities. Ms. Ward said: "I'm a say the kids skate all the time. I'm a say that make it easy to be healthy."

Family Support

The Smith and Gray families shared that the support of their families played a significant role in their health. Ms. Gray's 11-year-old daughter shared: "Yeah being with my family mostly and how we just get together to exercise and being healthy with each other..."

Healthy Choices

Lastly, the Hall family recalled that eating their preferred vegetables and drinking Vitamin water helps them be healthier. The 9-year-old daughter said: "I like corn and it's good. And I like eating corn because corn...not got a lot of sweet sugar in it and it's really healthy for you."

Significant Negative Factors

All of the families were able to name at least one negative factor as being very influential on their weight-related health.

Physically Inactive

The Harper and Parker families felt it was difficult at times to be active due to not wanting to exercise and being tired. Ms. Smith expressed the limits that low income children have when it comes to being physically active:

> Kids like that...well, not just kids with diabetes, low income kids, giving them something to do. When they outside it's always a complaint about the kids running around yelling and screaming. Or you got a neighbor complaining about it.

Desire to be Healthy

Both Ms. Gray and her daughter felt that at times it can be very difficult for them to find the motivation to engage in healthy behaviors and that they are sometimes their own obstacle to being healthy. Ms. Gray acknowledged that the "opportunity is there" to be active, but it was just a matter of doing it.

Unhealthy Choices

Limiting unhealthy foods was a significant struggle that many of the families experienced. Ms. Harper expressed that: "It's hard just staying with the healthy stuff." And her 10-year-old son shared a similar sentiment: "If you're used to junk food, you just eat all junk food."

Income

Lastly, Ms. Smith expressed that having a limited income is a major factor in trying to be healthy:

> Like I was just feeling to say...by being low income, getting to the doctor, that'd be my strong point. It's difficult to get to the...you got appointments and if you can't get to 'em and you don't cancel them in time a lot of them drop you from the program. So that'd be my big difficult problem with struggling with income.

Weight-Related Programs

The next part of the interview process explored the families' experiences and thoughts on weight-related programs. This questioning was done to discover how programs can be more suited to their needs. With limited information on weight-related programs for African Americans, it is important to hear what is important to this population when it comes to supporting their efforts in living a healthy lifestyle. Therefore, this section will explore three aspects of weight-related treatment programs: program evaluation, program topics and program structure.

Program Evaluation

To a varying degree, most families had some participation in weight-related programs. A few families had participated in the initial meeting for the Healthy Kids, Healthy Families program, but after moving they were unable to complete the program; therefore they spoke about the benefits of weight-related programs.

Increased Knowledge

The Gray family had a lot to say about how their participation in weight-related programs enhanced their knowledge of living a healthy lifestyle. Upon starting their first program, Ms. Gray stated she did not take it too seriously, but within a few meetings her and her daughter began to learn a lot and became more invested in learning. Ms. Gray reflected on how it's helped her family:

> You know, like I said growing up I was never taught on portions or what's good and what's not good, you know. We didn't grow up on having a square meal. When I got into that program and it taught us different things to do, you know, my mind is always hamburgers, hot dogs and

> french fries. You know we learned a lot of different recipes. We learned what that nutritional guide mean. We learned far as like portion, what a portion is actually considered and you know. So, yeah...it made us more aware.

Ms. Gray's 11-year-old daughter reflected on how significant these programs have been in helping her make a healthy change in her life:

> I think it did a lot for me...it would help me and teach me more about being healthy and life skills and stuff like that. And when we go by...day by day you just gotta take it. Take it in and so I think it was, like, a really helpful programs. I would thank the programs for helping me in being healthy.

Beneficial

All members of the Hall family expressed that weight-related programs are beneficial to their health and that they enjoyed the programs. Ms. Hall felt the programs helped her family stay motivated and accountable for making healthy choices:

> I think it holds us all accountable and I think accountability is really important cause sometimes...almost with anything you have to have some kind of accountability to yourself and to others...

Although they were unable to participate in the full Healthy Kids, Healthy Families program due to relocating, the Harper family felt that participating in weight-related programs would benefit their family. Ms. Harper said:

> To help um...give us some decisions on some healthy things to eat. And um...help encourage him to exercise and get outside and...ideas on different things...to stay healthy, get healthy, and stay healthy.

Demonstrate Compassion

Ms. Smith was very appreciative of being able to participate in a weight-related program with her daughter. Having programs seek her out and on

occasion come to her home was very meaningful to her and showed her that people cared. Ms. Smith explained:

> Yeah, yeah they come and influence the health of the family. That makes me feel like someone out there care. Trying to make a different...make a difference in our life. Overall on those type of programs...I think they're really good because the peoples come out to the home environment. I liked that even like sitting here talking to you right now. Listening at what's going on, you know, with the kids. Trying...that shows we trying to figure a way to help 'em. You trying to help us. Cause they don't...you, I mean, really didn't have to get out and try to get us into these programs. "Oh she just got diabetes" and left it alone, but no I feel like the programs are really good. And programs like this is helping us to cope and make us feel like we are people. We are part of this world.

Overall Thoughts

Ms. Gray felt that the programs she has participated in have been wonderful and could not think of anything she would change. Overall she was grateful for what the programs have done for her and her daughter. Ms. Gray said:

> Seriously I wouldn't and I'm not saying that because, you know, you're here. I'm actually saying that from my heart because it has changed my family tremendously. You know not just for them learning something. It was me learning something as a parent, you know, and what I was teaching my child or how I can encourage her or how I can, you know, get her motivated and she motivate me.

Ms. Hall was happy to see that I had come to her home to learn from her family about what can be done to help African American families live a healthy lifestyle:

> We just don't have enough people of color to help children of color and like you said, when you first came, that it's geared more toward African Americans cause that's whose pretty much obese right now and the Hispanic side. And we don't have enough people helping in that field so

> that I think...you start building trusting relationships, people will start opening up to you, but you have to build that relationship first.

Lastly, Ms. Smith felt it was very important for weight-related programs to reach out to families, especially low income families who are often overlooked. She has seen how her daughter's emotional health has improved from learning more about her weight-related health and type 2 diabetes. Ms. Smith stated:

> So I feel like that's very important. That reach out, I mean, the programs that reach out. Trying to, you know, understand what peoples are going through with they health and all...especially with the low-income people because a lot of 'em feel like because I'm poor they gonna let me die through the system anyway. You know, but...I think that help positive a lot of young women that's out there looking for those type of help and don't know where to go and know how to get there.

Program Topics

The families mentioned a range of topics that should be included in any weight-related program. Some of these topics, nutrition and physical activity, are typically included in such programs.

Basic Knowledge

Ms. Gray shared during the interview that learning basic elements of being healthy is important because in some cases that information may not be known by all group participants. She shared her personal example:

> I would say basic things that we have already learned. Like, for example, we found out that having the TV on and eating makes you want to...drive you (to) eat more. We didn't realize that, you know. So stuff that I don't know or don't think that's important or plays a factor in it, you know, like the nutritional guide. Whereas before I wouldn't read that and actually I know what it is and what to actually look for when I look at it, so those were something that when I went there was unexpected.

Nutrition

In regards to nutrition, a few of the families expressed a desire to learn healthy recipes. Furthermore, learning healthier cooking methods was suggested to be beneficial. Ms. Harper said: "Yeah recipes too because there is different ways to cook things that make it taste better."

No one specifically mentioned learning healthier ways of cooking traditional African American dishes; however, Ms. Hall expressed the need for more cultural sensitivity when it comes to weight-related health, which extended to teaching families about healthy eating.

Physical Activity

Learning different exercise regimens or options was viewed as important to some of the families. Ms. Harper would like programs to provide information on different exercise programs. Whereas Ms. Ward's 16-year-old daughter wanted help with creating a workout schedule or information on how long she should workout.

Cost-effective Meals

Learning to cook healthy, cost-effective meals was viewed as beneficial to many mothers. Ms. Hall said: "For me I would like to have something for the parents...especially the working parent is to...quick meals or inexpensive meals and 30-minute healthy meals or something like that."

Support Groups

Incorporating a support group atmosphere within weight-related programs was seen as helpful to Ms. Hall and Ms. Smith. Having support

groups for parents and children provides opportunities to share stories and brain storm ideas.

Ms. Hall explained:

> And just ideas of, and I know about planning, so just enforcing that a little bit more and how...cause you can say plan, but actually teach a technique or brainstorm some kind of ideas with other parents as to what they do and get the parents together to try and have support groups for the kids too.

Program Structure

After discussing topics that the families would like to cover in weight-related programs, the interview moved to asking about the structure or format of such groups. Families were asked to share their thoughts on the length of weight-related programs and what group meetings would look like (e.g. group format, open discussion, using the Internet).

Length

Programs are offered in a variety of timeframes from weeks to months and on occasion year-long. Families were asked how long they think these programs should be. One mother, Ms. Gray, suggested that the program be at least six months. She explained why:

> I would say at least do six months...or you know because you don't want it to burn yourself out and then your like," ugh", you know. You get...I would say six months be good, you know, cause then...the other six months you can do things as a family and take in that information and bring it on to the next, you know, relative or whoever.

Long-term

The majority of families felt that programs should be offered year-round. This timeframe would provide more opportunity to learn information and put that information into practice. In addition, it helps establish community supports.

Ms. Hall's 9-year-old daughter explained why she thought programs should be offered for longer periods of time: "I want it where you can come and go everyday. Cause if people got things to do and the other day they don't, then they can come."

Ms. Hall saw the problem of obesity requiring a long-term commitment for lifestyle change to occur; therefore, program meetings should be readily available. In addition, she thought it would be beneficial to develop tiered programs based on how far along a person is in their lifestyle change. She said:

> And ongoing, not just for six weeks program cause it's a lifestyle change its not something that a diet, and I hate the word diet, and I'm trying to get Tamia to...not to use that, but cause it's a lifestyle change, but something ongoing. Like they have AA and NA and it's long term and it's something that they have to live with everyday and this whole thing, I mean obesity is huge. It's huge and I think its something that I think needs to be ongoing and not stop it. It's always available and that you can talk and continue...and that the kids that has graduated from the program maybe get a....offspring of another program. You know, say "okay now here's one tier, now we're gonna move you up to another tier." So kinda tier it a little bit.

Ms. Smith expressed a similar point:

> Yeah, it not quite a tough one cause they'll be days, you know, where you don't feel like going. Then there'd be days you would wanna go you would like to get more information so um...I would say you could extend it a little longer. I think it should be a ongoing thing. I think...just like her diabetes. It's not gonna go away. So I think that should be an ongoing thing.

Format

When asked about the format of weight-related programs, all the families felt it was at least helpful to have group meetings. Some appreciated home visits or one-on-one time with program facilitators as well. Overall, they wanted to learn from other families who were experiencing the same thing. This provided a sense of normalcy and support.

Home Visits

Providing home visits was appreciated by some of the families because it gave them time to talk with program facilitators about issues that were unique to their household. In addition, it allowed the families to develop a relationship with the facilitator. Ms. Gray said: "And I do like the home setting too. It's because you get to meet someone and you get to know them on a personal level, you know."

Groups

When asked about the group format, participants had various preferences. The following formats were mentioned: multi-family groups, separate parent and child groups, and a combination of the two. Ms. Gray enjoyed the group format because it gave a chance to brainstorm with other families.

Ms. Gray said:

> Yeah and I think it would be better with a group setting because you can hear other people and what they're going through. And maybe give advice to them and they can give advice to you. I love the group setting cause you meet different people who are in the same situation as you as well...

A few other mothers felt it would be enjoyable to meet in separate parent and child groups before meeting in family groups. These mothers felt the family groups would be a time to offer support to one another and to discuss any matters of concern that they want to share. In addition, Ms. Smith felt the child group would give her daughter some time to talk with other girls and provide a sense of normalcy and comfort with sharing her concerns.

Ms. Hall expressed that if parents are to be in separate groups from the children than they should at least join as a larger group for demonstrations and group activities.

Topics with Open Discussion

A few participants expressed their desire for programs to have pre-selected topics for the group to learn, but to also incorporate time for open discussion. It seems this would allow group members to make the program more fitting to their needs and include them as co-facilitators of the program. Ms. Hall explained how this format would be helpful:

> It's a specific topic, but not to...weed out something that someone is really hurt, you know, dealin' with something. Yeah, so if we have a set topic, today is cooking on a budget this week and someone come in and say, "you know I really had a hard time getting, you know, started." "I need some help with this." You know and not to just let that go, but really foster people's feelings and thoughts because it's hurtful. It's a lotta days that I just cry because I'm like, "man I wish I...," you know, even for myself it's really, really hard.

Outside Activities

Taking the education outside of the classroom was a quality that Ms. Hall also believed to be helpful. She stated:

> You know what...I could see actually taking a trip, the whole family, to the grocery store, and maybe...one of you as a facilitator... just observing. Just kinda observing just to see our habits and see how we can tweak that, you know, because that's an entity of being healthy too because sometimes you just go in (and) be like, "I'm just gonna grab this because I don't have time to look through the grocery store."

Internet

Ms. Parker suggested putting program information on the Internet:

> Even if they could have a program like that on the Internet that'd be good. That...really be nice. That way with the Internet...you could always have access to it. Or even recipes and suggestions. And um....ways that parents could possibly interact, you know, put something on there.

Weight-Related Challenges

The fourth thematic section resulting from the interviews is Weight-Related Challenges. Families were asked about the challenges they encounter when implementing weight-related health recommendations given by health professionals. They were also asked about what would help them with those challenges.

Healthy Lifestyle Challenges

Families were first asked to identify the challenges they have experienced with trying to live a healthy lifestyle.

Time

A few of the mothers, Ms. Gray and Ms. Hall, expressed time being a challenge for them. These mothers have busy lives filled with work and managing the household. This double duty can make it difficult for them to find the time to participate in programs, cook healthy meals, and schedule appointments. Ms. Hall said:

> Time is a huge barrier, you know, we get up early in the morning I have to...see I'm not done cooking yet. You know, that's why I said those 30-minute meals or something and I wanna cook something healthy for 'em, but...at the same time I, you know, still have homework to do, good their dad was here to step up with that, but...you know, just time.

Using Healthy Foods

Ms. Smith and her daughter discussed the challenge they have with eating fresh foods. They try to consume fresh foods because they have learned it is the best choice. It has been difficult keeping fresh foods readily available at home for making healthier meals. Ms. Smith's 13-year-old daughter described the challenge and potential solution:

> Yeah because my mom sometimes we like the soups and like healthier soups and salads and stuff like that. She tries to keep fresh things in the house, but she can't because they always get spoiled or something like that. Because soon as you go to use them they spoiled. So it's hard...for us it's hard to get fresh vegetables and stuff like that to keep in the house. That's why we're thinking about starting a garden outside.

Limiting Preferred Choices

Most of the families mentioned eating healthier as being a challenge. For many, it is a struggle to give up some of the unhealthy foods they enjoy. In Ms. Ward's family this occurs when her children state they are still hungry for more. She doesn't want her kids to go hungry, but she also knows it was recommended that they fill up on more nutritious items. Ms. Ward explained her dilemma of trying to offer her children healthier foods to fill up on when they want more of the main dish they are eating:

> Yeah when the kids be still like, "I'm hungry. I'm hungry. I'm still hungry." Then you be like, they still hungry give 'em somethin' to eat. But even if I tell 'em something like this, they said like, "drink some water," or something. Or maybe eat a fruit or something. I do try that

sometimes, but that don't always work. They, "I want some more of this."

Ms. Smith's 13-year-old daughter also expressed how this is a challenge for her:

> Well sometimes...it's hard to let go of the stuff that you like really like. Yeah cause it's been a while like since my mom like kept um....like chips and ice cream in the house. That's like a good way for staying away from it cause we don't have a way to get it out, but sometimes...she like, "you have a sweet tooth", but you have no way to get there. She have... it every once in a while, but sometimes when you get to the store after you buy everything you say..."It's on sale so just get it." So it's hard to stay away from it, the stuff that you really love.

Ms. Hall experienced this challenge as well, but commented on the lack of health professionals having sensitivity to people's culture and how that plays a role in the foods they eat. She stated:

> And then you hear the doctors say, and it drives me nuts, "organic food is good." You can afford that. Everybody can't afford that and I just hate that they not sensitive to people's culture. I've ran in to that...or, "you could just do this or you could just do that." But you don't, first of all you have to know the culture and I feel like a lot of people that try to help you don't really understand or not sensitive to people's culture and their beliefs and their, you know, upbringing.

Self

Half of the families mentioned themselves as being a challenge to being healthy. This was typically associated with motivation or will power to engage in healthier behaviors.

Ms. Harper said:

> Actually getting out there and doing the walking, that's hard for me. That's a real challenge. Just sometimes...I can get out there and I do it and sometimes I'm like, "naw I'm not going to do it." Cause at one point we was like... walking almost everyday. We were walking, just taking a walk just...if it was down the block. And then at one point I got to the

point where, "ah I'll do it tomorrow" and then...just get to the habit of doing it.

Ms. Hall expressed that being a supporter rather than just telling people what to do would lead to more successful changes:

> But...the thing about that is, and I work with this with my job all the time, you're not going to get anybody to take ownership if you tell them what to do, but if you let them work out their own problems but that your more like a facilitator and helping them to get through those, you know, curves or whatever. That's how people, you know, gonna take ownership and manage their own weight or health or anything like that...

Ms. Ward's 16-year-old daughter shared Ms. Hall's sentiment that having a supporter would be helpful:

> I need someone to pump me up, "come on let's go, let's go." Cause I just be soft...be like, "I'm sad. I don't wanna". Yeah cause it's boring by yourself. Need somebody that makes you laugh and I need it to be like more funner than just exercisin'.

Income

The final challenge some families mentioned were related to income. Income influenced items such as purchasing foods and enrolling in programs. Ms. Hall experiences the challenge of purchasing healthier foods, which provide long lasting benefits, in the face of unhealthy foods being offered at sale prices:

> Money, money, money. I mean ...the long term effects...cause you can buy unhealthy stuff and you just not healthy...but then if you spend a little bit more here, right here, you gonna in the long run you gonna be okay. But the reality of it is...you have to go with what you have and so you go like that. To get the long lasting, the benefits of it you just go with what you can get and what you can afford, you know and hope that you making it healthy. It is, it is expensive. Everything that goes on sale is things that...things that goes on sale is things that's not so good for you.

Ms. Parker wants to feed her family healthier meals, but is challenged with feeding a family of five on a very limited income:

> Well I already told doctor today it's hard. I'm on a $400 budget...and that's a month for five people. That's not easy. And I'm not eligible for food stamps. So I'm struggling. I mean if they come up with a way we can eat healthy. I'm for it. Especially when they want them to eat healthier food.

In Ms. Smith's case, she sees the challenge in finding a balance between buying healthy foods at an affordable price and maintaining a balanced meal. She stated:

> Then it's also hard trying to keep a lot of the nutrition...say nutrition cereals the best, you know, for you. Cause they're more expensive than regular. If I get this one box, I can have three of these boxes, you know. And a lot of the foods they say are healthier for you, it's more expensive. You said well I can go on in here and pick up this pork chop and....for a good example, like they were showing on the TV about Kentucky Fried Chicken. A $10 meal. Okay, I thought about it. I said for a $10 meal now. (I) went in the store taking $10 to prove what $10 can buy in the store for a meal. I can go buy a pack of hamburger meat, get a thing of spaghetti string, and a jar of spaghetti sauce. That's one meal, but yet it still... that spaghetti and sauce is not a healthy...it's okay to eat, but if I go get that meal everyday it's not a healthy meal for me. So it kinda makes it difficult cause you want fresh carrots and fresh vegetables.

Help with Challenges

The final question in the interview asked how programs and health professionals can help the families face these challenges and how they can help these families in their efforts to live a healthier lifestyle.

Teach Healthy Recipes

One area where health professionals can help is by teaching families a variety of healthy recipes that they can make at home. The families desired knowledge instead of just being told to eat healthy.

Ms. Gray shared her desire for more healthy recipes:

> I know a lot of things too like when we first started out I didn't know any menus or recipes or show me, show me what I can do different. Give me some ideas on how to dress up this fruit thingy or what other fruits can I look into or what other healthy meals is out there. You know instead of having...sometimes people don't have a computer or Internet, you know. Give me like a little list of things that you think would be good for us to eat.

The Ward family felt it would be helpful to have cooking classes where they can learn hands on. They also wanted to learn how to make their traditional dishes healthier. Ms. Ward said: "Or either, yeah, like maybe... some kinda meetings that were they train us on how to cook more healthier or, you know, something like that. Or different ways to prepare, you know, the foods we like or whatever."

Support System

Families also expressed having a support system would be beneficial to helping them with challenges. Ms. Smith felt that allowing families to discuss their challenges would be helpful on its own. Ms. Harper wanted a support system that would help encourage her to be healthy and teach her what to do. She recalled how this was beneficial to her in the past.

Ms. Harper said:

> You have somebody that you...that can encourage you to do it. Just keep telling you, "ok, did you do this?" Or like give you like...tell you like

> well, walk so many...walk so many blocks this day and see if you can keep that up, you know, doing that cause I know when I was seeing a nutritionist that's what she told me to do. Yeah, somebody to support you...make sure that you keep up with what you're supposed to do.

Financial Assistance

Ms. Ward shared that it would be helpful to offer scholarships or financial assistance so families could enroll in weight-related programs. She wants her children to be able to partake in healthy activities and programs, but struggles financially. Ms. Ward stated: "Offer scholarships or something or, you know...some kind of assistance on getting in a program or something for low-income, you know, families or individuals..."

Program Sustainability

The last suggestion for helping families with their challenges was to continue making weight-related programs readily available. Ms. Hall shared that continuing to offer weight-related programs would be helpful for her family. Ms. Hall explained:

> I think to continue it. We really enjoyed...the lady coming out and cooking with us and it was quick stuff. I mean we really enjoyed that... It was healthy and I think that...I know the economy is really bad, but even just finding grant money or something to continue, you know, offering the...programs. I think those are awesome or that outings for children that...different things like expose them to rock climbing or something. Other things that's healthy for 'em too that a make 'em wanna do it later on in life cause I guess it starts now so that they it can follow, but to continue the program. Yeah, I would hope that they don't get rid of this...

The Essence

The phenomenon explored in this study was the experience of weight-related health in African American families with an overweight or obese child.

Although the sample may be small, the experiences these families shared provided valuable information for health professionals who work with similar families. The purpose of developing the essence of this phenomenon is to highlight the shared experiences among interviewed families and present the essential elements of their experience (Creswell, 2007; Marshall et al., 2006). The essence consists of two elements: textural description and structural description. The textural description describes what the families experienced and the structural description highlights the context or setting that influenced how the families experienced the studied phenomena (Creswell, 2007).

All of these families had basic knowledge regarding what it meant to live a healthy lifestyle, including what helped and hindered this process. The families described five primary factors which influenced their weight-related health: (1) physical activity, (2) nutrition, (3) medical care, (4) emotional health, and (5) income. Much of this basic knowledge was acquired through various healthcare settings, such as meetings with physicians, nutritionists and program facilitators. These healthcare settings commonly addressed issues of physical activity, nutrition, and medical care. In addition, the participants had internal health barometers, which helped them recognize if their behaviors where healthy or not so healthy. Many times they had to listen to their internal voice in order to help them engage in healthier choices and motivate themselves to follow through.

A third key context that strongly influenced the weight-related health of these families was their close bond with immediate and extended family

members. All family members were united and open with one another when it came to working on their weight-related health. Family relationships provided emotional support and teamwork (e.g. workout together). Furthermore, this context emphasized supporting its members rather than putting one another down. The overall focus for these families was to work as one in creating lifestyle change.

Another context that influenced family weight-related health was their involvement in weight-related programs. All of the families had something to share about what they experienced with weight-related programs and the challenges they faced. The families expressed a common desire and appreciation for weight-related programs and hoped to learn more from them in the future. They also hoped that such programs would be affordable and provide an ongoing source of knowledge and support as they continued on their path to a healthy lifestyle. In addition, the ability to meet other families going through the same experience provided a sense of normalcy and a larger support system. The families appreciated having one-on-one time with program facilitators, but also found it helpful to learn from other families. Programs were seen as a way to brainstorm ideas and support other families in the community.

In regards to the challenges of living healthy, families found it difficult at times to maintain healthy behaviors. This difficulty was attributed to living busy lives, not having the motivation to be healthy, having limited income and wanting to maintain a sense of African American culture while they made

healthy changes. Furthermore, the context of having limited income enhanced the struggle to eat healthy foods and enroll in weight-related programs. All of the families were eager to do what they could to make healthy changes, but their income limited their true potential to make all the changes they saw fit for the family.

Lastly, the context of culture had some implications for weight-related health in African American families. Most of the families struggled with holding on to the foods they loved and preferred, especially when they were constantly told to try healthier options. The families experienced outsiders telling them what they should eat, which at times was not reflective or respectful of their culture.

Summary

For this study, the focus of the qualitative interview was to elicit responses from African American families with an overweight or obese child about their experiences with weight-related health and treatment programs. Data from the interviews resulted in four thematic sections: Weight-Related Perceptions, Weight-Related Influences, Weight-Related Programs and Weight-Related Challenges. In addition, visual data in the form of photographs also supported these experiences.

CHAPTER FIVE

DISCUSSION

Introduction

African Americans have one of the highest prevalence rates for obesity. Unfortunately, obesity research has given insufficient attention to this growing issue in African American families. Furthermore, little is known about the connection between weight-related health perceptions and health outcomes. This study explored weight-related health experiences and perceptions of African American families using ecological and social constructionist theories. These theories allowed the researcher to explore the interrelationships between the environment and family weight-related health as well as subsequent weight-related health perceptions.

The purpose of this study was to explore the weight-related experiences of African American families who have an overweight or obese child in order to provide qualitative information about obesity influences and obesity treatment. To obtain such information, this study relied on oral interviews and visual data to highlight African American families' experiences with weight-related health.

Key Findings

The results of this study produced several key findings. First, African American families find health professionals to be helpful in understanding weight-related health. It was clear from the interviews that all of the families obtained basic knowledge about weight-related health from various health professionals, namely physicians, nutritionists, and program facilitators. It appears that interactions with these health professionals are a preliminary source of

information regarding weight-related issues. Consequently, these professionals are at the frontline for identifying weight-related problems early on and providing timely treatment. It should also be noted that health professionals need to continue their efforts on rebuilding trust with African American families in order to effectively assist them with weight-related health issues.

Second, family is a strong source of support in living a healthy lifestyle. The importance of family was consistently mentioned by participants. Family primarily provided a source of support, whether it was words of encouragement or simultaneously engaging in healthy behaviors. Working together as a family unit also provided a sense of accountability amongst family members and appears to strengthen lifestyle changes. In addition, many of the families felt family participation in weight-related programs was more beneficial than parents and children working in separate groups.

Third, weight-related programs are beneficial because they provide a sense of normalcy and secondary source of support. Weight-related programs continue to play a significant role in changing and managing health behaviors. These programs, when affordable, are a valued service and provide additional education that families are unable to obtain solely from doctor appointments. Participation in these programs gives families more time to discuss weight-related health concerns, learn hands-on skills, and enables them to connect with others in their community who are dealing with similar issues. Additionally, families valued long-term programs because it gives them more time to create lasting lifestyle change.

Finally, low income exacerbates the struggles of living a healthy lifestyle. The families in this study had very limited income and expressed the negative affect it has on their health. Limited finances inhibited many of the families from enrolling in weight-related programs or community centers. In addition, the lack of income affected the mothers' food budget for purchasing more nutritious foods, which would promote a healthier lifestyle for their family. Mothers shared that the healthier foods typically cost more, were rarely on sale, and fresh foods were hard to keep (i.e. easily spoiled).

In reviewing these findings, there was a mix of new and supportive information in relation to the current literature on obesity. Many of the ecological factors that influenced the families weight-related health was reflective of what is currently reported in obesity research in relation to African Americans. This demonstrates that some factors remain relevant to weight-related health in African American families. What is new about this information is that the family unit was able to verbalize how and why many of these factors affect their weight-related health.

Elements of this study's key findings were not as apparent in the previous literature. For example, the mothers were able to articulate how their relationship with their child's physician helped or hindered the process of treating the child's weight problem. In addition, the families' discussion around family support speaks to the need to include family members in weight-loss treatment for African American youth. The families were able to share their opinions of weight-related programs and how they could be more beneficial in addressing their

needs (e.g. teach cost-effective meals, have open discussion, and make groups affordable). Lastly, income was one of the most significant factors when it came to the families weight-related health. The literature shows that income influences the health of African Americans, but the stories shared by these families really touched on the multiple levels that low income affects their weight-related health. The information provided by the families in regard to low income should provide a deeper understanding of how powerful this factor is in the lives of African American families.

Theoretical Implications

The research questions guiding this study were phenomenological in nature because they would allow the researcher to understand the lived experiences of African American families with an overweight or obese child. To assess these experiences, Human Ecological and Social Constructionist theories was applied as a framework. These theories were chosen for their ability to explore lived experiences in an unbiased manner while supporting the idea of interrelationships between the individual and the environment. Together these theories provided a framework for discovering the Weight-Related Perceptions, Weight-Related Influences, Weight-Related Programs, and Weight-Related Challenges experienced by African American families with an overweight or obese child. The results indicate the theoretical framework provided a good fit for exploring these experiences.

The basic premise of Human Ecological Theory is that the individual is connected to the environment through various levels of interrelatedness (Sallis et

al., 2002). Consequently, the individual influences and is influenced by the environment. In regards to weight-related health, the theory takes into account the characteristics of the individual and family, the external environment, and the process involved in developing weight-related perceptions. In this study, Human Ecological Theory was useful in exploring the ecological influences on the families weight-related health in a systemic manner. Furthermore, the families experiences highlighted the fact that their weight-related health is significantly tied into their ecology or environment. The families were able to identify a variety of factors including self, family, neighborhood, culture, and socioeconomic status that were influential on their weight-related health. These factors influenced their understanding of what it means to be healthy, their perceptions of what influences their weight-related health, and their challenges to being healthy. In general, I believe Human Ecological Theory was useful in exploring ecological influences on weight-related health in a systemic manner. The theory acknowledges an association between individual development and environmental interaction, which was supported by the stories of these families. Furthermore, using this theory as a guiding framework emphasized the influential pull environmental factors have on weight-related health.

Social Constructionist Theory is focused on exploring and accepting that there are multiple realities of any given experience. Because there are multiple realities, no singular experience reveals the true nature of life. Similar to Human Ecological Theory, this theory asserts that individual beliefs and behaviors are influenced by the daily interactions people have with their surroundings. It is

through daily interactions with the environment that each person develops knowledge about the world around them (Burr, 2003). In the case of weight-related health, family interactions with their surrounding environment had significant implications for the weight-related health of family members and was worth exploring in an effort to discover effective treatment. In addition, some authors suggest that ethnic customs, beliefs and preferences must be explored so culturally relevant weight-related programs may be developed (Blixen, Singh, & Thacker, 2006; Blixen, Singh, Xu et al., 2006). Results from this study indicate that African American families' interactions with their environment helped them perceive which factors were most influential to their weight-related health and how they are influential. Furthermore, their experiences with weight-related programs contributed to their knowledge about how important these programs are to their health. Overall, the use of Social Constructionist Theory in a phenomenological study was wonderful. It provided a useful framework which gave voice to the experiences of the participating families and contributed to valuing all experiences. Because this theory and phenomenological research share a common desire in privileging all voices and experiences, I think they worked well together.

Clinical Implications

Implications for Family Therapists

As the obesity rate continues to climb, it is very likely that family therapists who work with African American families will encounter a family who has an obese member. It is also likely that few of these therapists have a sufficient

understanding of how various ecological factors play a role in the development and continuation of obesity in African Americans. This is not to say that all family therapists must know the ins and outs of obesity; however, it would be beneficial to at least have basic obesity knowledge. This basic knowledge could start in training programs. According to Campbell (2003) family therapy programs need to teach students how to work with families with health problems.

In addition, the family therapist should have some degree of cultural competence in order to appropriately work with African American families on this topic. Having some knowledge and skills which are relevant to the family are fundamental to developing cultural competency (Whaley & Davis, 2007). Such knowledge and skills include (1) having an awareness of one's culture and how it influences values and biases, (2) having some knowledge of the culturally different client, and (3) using interventions which are culturally appropriate (Sue, Arredondo, & McDavis, 1992). Cultural competency in the area of African American obesity would include self-of-the-therapist work to understand one's beliefs about obesity issues in African Americans and how those beliefs influence therapy, understanding historical ramifications of African American health (e.g. discrimination), and exploring with the family the means of support that are important to them in their quest for a healthy lifestyle (e.g. exploring programs within their church, in their community, and physician-patient relationships). Furthermore, therapists should learn how to network with other professionals in the community. Networking can improve service to families by referring them to professionals and programs that specialize in obesity treatment. In addition,

maintaining a collaborative relationship with other health professionals could be beneficial to patient treatment.

Family professionals should understand that while obesity is an individual health problem it is attributable to a variety of factors, some of which are unique to the individual or family and their culture. At the individual level, professionals should consider the presence of psychological issues or personal beliefs that may be attached to obesity (e.g. depression or assumption that obesity is only attributed to eating too much). More external contributing factors may include family eating patterns, cultural associations with food, the ability to engage in physical activity (e.g. unsupportive environment), and income.

Implications for Medical Professionals

Medical professionals, especially physicians, are typically the first to educate and treat families who have an obese member. Physicians can counsel children and parents about healthy practices and potentially change their perceptions (Kitzmann et al., 2006). In this study, all of the families indicated that health professionals gave them basic information about obesity and the families were eager to learn more. In addition, some of the mothers pursued child obesity concerns with a physician prior to diagnosis.

One area of concern, based on the data, was the variety of reactions the mothers received from their child's physician. In some cases, the mother felt supported by the physician in determining the cause of the weight gain and avenues for treatment. Unfortunately, a few of the mothers felt criticized by the physician about their child's weight and health. It appeared the physicians in

these cases had trouble looking beyond the cause of the weight gain in order to simply work with the mothers to improve the child's health. These were not cases where the mothers denied the child had gained weight. The mothers were just as concerned as the physicians about the child's weight and were seeking assistance from their primary source of medical information. It would serve families and physicians well to take a team approach to identifying and treating childhood obesity. In fact, the mothers in this study wanted to work as a team with their child's physician. When parents and physicians are working for a common goal it would benefit physicians to take a supportive and collaborative approach in working with their patients. This includes exploring parent concerns, cultural influence on knowledge and beliefs, and the family's ability to follow prescribed health recommendations (Skelly et al., 2006). Physicians should remind themselves that even though families are eager to make positive changes sometimes their income or living situation may prevent them from making all the changes they see fit. If this is the case, supporting families along the way with what resources they have will continue to foster a good physician-patient relationship. Families' inability to make all of the necessary changes should not automatically be viewed as an act of defiance. If there is a concern about following recommendations it would be best for the physician to calmly address these concerns, explore the challenges in following the recommendations, and find a possible resolution. Furthermore, according to these mothers, it appeared that physicians who were supportive rather than critical in their approach to addressing weight concerns was more beneficial. Speaking to the mothers with

respect and from a caring place seemed to make the mothers feel more empowered and supported. Subsequently, in some cases this supportive, teamwork approach appeared to improve the child's weight-related health. Lastly, physicians should refer families to outside resources such as weight-related programs. All of the families in this study were referred to various resources such as weight-related programs or were given passes to local community centers. The families were appreciative of these efforts.

Implications for Program Facilitators

Developers of weight-related programs must also recognize the uniqueness of obesity across individuals and families. The literature has shown that treating obesity is not a simple task. Although this study consisted of a small sample, it highlighted obesity factors that are significant to local African American families. Therefore, it is suggested that program facilitators spend some time getting to know the families they work with. This may include collaborating with families to discover what information is pertinent to them and subsequently incorporate that information into the program. It is possible that such collaboration will lead to more effective treatment programs that have long lasting effects. Furthermore, ensuring that programs are family-based will include parents as an integral part of the change process and foster change within the family unit (Golan et al., 1998). Many of the families also valued the group aspect of programs. Overall, meetings that consisted of separate parent/child groups followed by a multi-family group was supported by these families. The separate groups would give some time to develop age-appropriate connections,

especially for the children so they develop a sense of normalcy, and concluding the group meeting with multiple families would provide a sense of community support.

Families in this study had a variety of recommendations when it came to formatting groups so they would be more useful. The families agreed that information on nutrition and physical activity remained important to weight-related programs. However, it appeared that information on mental health (e.g. motivation), family involvement, and cost-effective solutions were also important. The families also suggested that while weight-related programs may have their own agenda set for each meeting, they would appreciate time for open discussion. Having an open forum would give group members opportunity to discuss a topic that is relevant to them at that particular moment, share ideas, and brainstorm solutions. In addition, many of the families appreciated the one-on-one home visits provided by the Healthy Kids, Healthy Families program because it allowed the individual family to develop a personal relationship with group facilitators and created time to focus on their specific needs.

In terms of program length, the families in this study supported the idea of a long-term program because it would give them more time to learn and to make the necessary changes for a healthier lifestyle. In addition, an extended program would allow families to develop a local support system with similar families, which is particularly important incase the program were to end. Establishing community supports would provide group members the opportunity to continue their efforts and potentially develop their own group within the community.

Implications for Working with Low-Income Families

The majority of these families reported a household income of less than $20,000. In addition to this report, it became apparent in many of the interviews that limited income created several challenges for these families in regards to their weight-related health. Although all of the mothers expressed a desire to make their family's weight-related health better, their limited income created a real burden. It appeared that the mothers took the information they had learned about healthy living and were doing the best they could to follow the advice of various health professionals. However, the lack of finances created a daily struggle for them to maintain healthy changes. These struggles included not being able to consistently buy healthier foods because they cost more, having limited ability to use public transportation to participate in medical appointments and weight-related programs, not being able to enroll the children or family in weight-related programs due to cost, and limited their ability to live in safer neighborhoods where they could go outside and be active on a regular basis. The mothers had a few key recommendations particularly for program facilitators to help them address the issue of low income. First, the mothers wanted more information on creating cost-effective meals and how to find healthy items at an affordable price. Second, it was suggested that program facilitators find ways to reach out to low income families because they are often unaware of such programs. One mother stated that by reaching out it shows that programs care about them and their well-being. Third, to help lessen their financial strain, make weight-related programs affordable. This can be done either through offering

scholarships or making the programs free. As a researcher and group facilitator, it is concerning that weight-related programs are not reaching the most needy of populations. Hopefully the information these families provided will create new awareness to the needs of low income African American families.

Using Photovoice with Families

Phenomenological research methods were used in this study to obtain the essence of weight-related experiences in African American families with an overweight or obese child. These methods included the use of family interviews and photovoice technique. Developed by Wang et al. (1997), "photovoice" enables individuals to discuss the everyday forces that influence their lives via photographs that are taken by the individual. Furthermore, photovoice provides an assessment of needs for its participants. This technique has traditionally been used with individuals in a focus group format to highlight the needs and strengths of the community. According to Wang et al. (1997), photovoice acknowledges that people have insight into their communities that outsiders do not have.

In this study, the technique was used to enhance the families' stories about their weight-related health. Although applying photovoice to family units rather than individuals was unconventional, the results indicated the method was applicable to exploring the needs and strengths of the community and the families as they strive for a healthier lifestyle. Family members were able to collaborate with one another in photographing their experiences and it encouraged family discussion about the factors that influence their health.

Furthermore, it created a family dialogue about the needs of its members, how the family unit can work together, and their process of understanding weight-related health.

Personal Reflections

This specific research topic was inspired by my experience as a co-facilitator of a multi-family weight-related program. At the conclusion of each group, the families shared with me what additional improvements could be made to the program. I wondered if the families would have been better served if we had taken their ideas into consideration prior to the end of the group.

When I sought more information about weight-related programs I discovered the disparity in obesity prevalence across ethnic groups. In particular, African Americans have one of the highest rates, but are not commonly studied in the obesity literature. This lack of research on a highly affected population was very concerning to me. I was concerned that as a society of researchers we had not progressed from primarily focusing on Caucasian participants and erroneously applying subsequent findings to all ethnic groups. It was this concern that inspired me to focus this study exclusively on African American families.

Research on obesity in African Americans is growing; however, a concern is how applicable the findings are to African Americans in different communities. In the Literature Review I explored a wide variety of influential factors on obesity in African Americans. While it was informative, it did not give me a strong sense that it could be generalized to the families I was working with. Therefore, the

best solution was to interview families about their experiences with weight-related health as well as their thoughts on weight-related programs. It was a privilege to learn from these families and to share their stories and photographs. The families welcomed me into their homes and were eager to share their stories. In some cases, they wanted to share their story in order to help others like them, and I am grateful that I was able to provide such an opportunity.

One of the greatest lessons I've learned from this experience is that obesity is unique to each family and each community. Therefore, if the goal of local programs is to help the community in fighting obesity, then a collaborative relationship needs to exist between community members and program facilitators.

Limitations

This study used interviews and photographs from African American families about their experiences with weight-related health, including weight-related programs. The majority of the data reflected the families' current history. This allows for more accurate information. However, some retrospective information was also obtained regarding diagnosis stories and past experiences with weight-related programs. The families' ability to accurately recall these events is uncertain since they occurred over a year ago. In regards to recalling participation in previous programs, retrospective data is acceptable because some amount of time is needed in order for the families to determine how effective the programs were in improving their weight-related health.

Another limitation to recalling experiences with weight-related programs is that the families had varying degrees of exposure to such programs. It is possible that the few families who participated in more than the Healthy Kids, Healthy Families program were better equipped to identify what information was relevant to them. In addition, it appeared that those families were able to reflect more on their evaluation of weight-related programs. The few families that had little exposure to weight-related programs could only evaluate such programs as being helpful.

Although the families did not express concern in opening up about their weight-related health, it is possible that my presence made them more apprehensive to share their whole story. Even though I am part African American, my appearance can sometimes mislead people to assume that I am only Caucasian. As the literature has shown, the ethnicity of the interviewer can influence the interview process. Although I do not think it occurred in this study, it is possible that some of the families were hesitant to fully share their experiences because of my appearance. However, it is also possible that any hesitation is attributable to me being an outsider or a researcher who was there to interview them.

Lastly, the process of sharing information about one's weight-related health in front of immediate family members may have also created a barrier to completely and honestly answering the interview questions. Although the families appeared open in sharing their story and at times identified each others struggles and efforts, it is unclear whether each member was able to fully share

his or her experience. Interviewing the family as a unit can reduce the need for all members to express their thoughts; therefore, it is also possible that some family members withheld their opinions since others were speaking.

Future Directions

Although this research has provided important information regarding weight-related health in African American families and their thoughts on weight-related programs, important work lies ahead for obesity research.

First, there is a need for more qualitative research in the obesity literature. Qualitative research will allow the literature to move beyond generalized findings towards richer information on how influential these factors are (Epstein et al., 1998). Subsequently, this will help researchers and policy makers determine where resources are needed to support or correct relevant factors. Obesity research has spent much of its early history on exclusively locating the variety of factors that play a role in obesity development. Now the focus should move towards determining which factors deserve more attention.

Secondly, if the goal is to prevent, treat and reduce obesity development, researchers and programs need to study obesity at the community level, not nationally. Existing obesity research has served its purpose in providing a basic analysis of what factors contribute to obesity development in the general population. It is time for research to progress to the next stage by determining which factors are most relevant to different communities. This research demonstrated what factors are most influential to local African American families and the same should be done in other communities. This idea of focusing on the

community level is supported by the lack of effective treatment to date, which has typically taken a more generalized approach.

Finally, weight-related programs at the community level are encouraged to include program participants as co-facilitators or co-researchers. It is likely that including community members, who the programs aim to serve, will lead to more relevant and effective programs. Including community members in the process will foster empowerment, feelings of value, and enhance perceptions of how valuable weight-related programs are to one's health. In addition, if a program has to end due to funding, it is possible that community members who also served as co-facilitators are able to continue group meetings. Therefore, the program could remain intact so it may reach other local families and build a larger support system within the community.

APPENDICES

APPENDIX A

"The Essence of Weight-Related Health in African American Families"

Parent Consent & Minor Assent Form

Project Investigators: Amy Foster, MA
(616)554-0057 or (517) 377-8798

Marsha Carolan, PhD, LMFT
(517) 432-3327

Purpose of this study

We are conducting a research study that will help us understand the life experiences of African American families who have an overweight child. The purpose of this study is to learn about your perceptions and experiences as your family strives to manage weight-related problems and live a healthy lifestyle. We expect to gather this information by asking interested families to take photos of their life experiences and share their photos with the researcher in a two-hour family interview. Ms. Amy Foster will conduct the family interview. You may decide to not participate in the study or not answer any of the questions. The family interview will be tape recorded and later transcribed and studied by the research team. To be considered for the study, you must: (a) have participated in the Healthy Kids, Healthy Families (HKHF) program in Kent County, (b) identify yourself as an African American family, (c) have at least one parent or guardian and child who was recruited to the HKHF program participate in this study, (d) be at least 7 years of age, and (e) show an interest in participating in the study. Due to time and resources, no more than 5 people in each family may participate.

What will happen

1. You will have an initial meeting with Ms. Foster to go over consent forms, answer questions, complete a basic demographic form, and receive instructions for taking pictures about your experiences over the course of 1-2 weeks using a disposable camera. As a family, you be asked to take pictures of your experiences based on the following questions: (a) What things influence your weight-related health, both good and bad, (b) What does it mean to be healthy, and (c) What challenges does your family run into when trying to live a healthy lifestyle.

2. This study involves taking photos over a one to two week period and one family interview over the course of 4 weeks. If necessary, a second family interview will be scheduled. The family interview will be audiotaped, last approximately two hours, and the interview will involve discussing the photographs taken by your family.

3. You will be asked for permission to have your photos published for the purpose of this study.

4. Two sets of photos will be developed. One set belongs to you, while the second set of photos belongs to the investigators of this research to be published and/or used for the purposes of this study.

5. You will receive a "healthy gift" valued up to $35 following your participation in this study.

6. Participation is voluntary, you may choose not to participate at all, or you may refuse to participate in certain procedure, or answer certain questions, or discontinue your participation at any time without penalty.

Why this study is being done

We want to better understand the experiences of African American families who have an overweight child and have participated in some type of weight-related program. Your feedback will be very important because we will have a better idea of the challenges you experience when trying to live a healthy lifestyle. In addition, we will have a clearer understanding about the experiences in your community and how it influences the weight-related health of your family. We want to know your family's perceptions and experiences about how you understand weight-related health.

Potential Risks

You may experience slight discomfort if you talk about issues that represent a challenge in your community and personal health (e.g. discrimination, stigma of being overweight). If you become visibly upset during the family interview, the interview will be stopped. Ms. Foster will offer counseling referrals if any follow-up services are required.

Furthermore, the use of photos has the potential of harming a person's rights to privacy. Photos will not be used in this study if they show a person engaging in illegal activity and if a person or business has not consented to being photographed.

Potential Benefits

Potential benefits from participating in this research study include gaining insight about your experiences with weight-related health (e.g. what influences your health, what is helpful for living a healthy lifestyle), and you may experience a sense of relief by having someone listen to your stories. In addition, the information you provide will be used in an effort to better understand the life experiences of African American families facing weight-related health issues.

Confidentiality

Your privacy will be protected to the maximum extent allowable by law. Because you are being asked to photograph your life experiences, as well as publicize your photos to increase awareness of your experiences, your photo may be identified particularly if someone from the community is the photo participant. If the study is published, there will be no personal identifying information reported.

Audio taping

Participation in this research study includes audio taping family interviews. The interviews will last approximately two hours each and the nature of these family interviews will involve discussing your photographs. The recordings will be transcribed and used to help researchers better understand weight-related health in African American families. Only the project researchers will have access to the audiotapes. Following transcription, the content of the recordings will be erased.

Your signature below indicates your voluntary agreement to be audio taped during the second meeting, and if necessary, the third meeting.

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

Your Rights to Participate:

Participation in this research study is purely voluntary. If you decide to participate, you are free to withdraw at any time without affecting any relationships with your group facilitator. You may otherwise refuse to participate

in any procedures, to answer any questions, or to discontinue your participation at any time without penalty.

Contact Information:

If you have any questions or concerns about this research study, such as how to do any part of it, or if you believe you have been harmed because of this research, please contact the researcher, Ms. Foster (616) 554-0057 or (517) 377-8798, smith653@msu.edu, or Dr. Marsha Carolan (517) 432-3327, carolan@msu.edu, or write to A-233 Clinical Center, Michigan State University, East Lansing, MI 48824.

If you have any questions or concerns about your role and rights as a research participant or would like to register a complaint about this study, you may contact – anonymously, if you wish – MSU's Human Research Protection Program at (517) 355-2180, Fax (517) 432-4503, or email irb@msu.edu or regular mail at 202 Olds Hall, MSU, East Lansing, MI 48824

CONSENT FOR PARTICIPATION

Your signature below means that you voluntarily agree to participate in this research study.

Signature of Parent /Guardian Date

Signature of Parent /Guardian Date

Signature of Assenting Child (ages 13-17) Date

Child Assent (ages 7-12)

I agree to participate in this study with my family. I understand that I will be asked to take pictures about my health with my family and talk about my pictures. I also understand that I may choose to not participate at any time.

Signature of Assenting Child (ages 7-12) Date

Signature of Assenting Child (ages 7-12) Date

Signature of Assenting Child (ages 7-12) Date

CONSENT FOR PHOTO PUBLICATION

I agree to be a part of this research study and give permission to have my photos published for purposes of this study.

Signature of Parent/Guardian Date

Signature of Parent/Guardian Date

Signature of Assenting Child (ages 13-17) Date

Signature of Assenting Child (ages 13-17) Date

Child Assent (ages 7-12)

I give permission to let the researchers use my photos for papers and presentations about this study.

Signature of Assenting Child (ages 7-12) Date

Signature of Assenting Child (ages 7-12) Date

Signature of Assenting Child (ages 7-12) Date

You will be given a copy of this form to keep.

APPENDIX B

Dear (Family name),

I am sending this letter to inform you about a brief, follow-up study for families who participated in the Healthy Kids, Healthy Families (HKHF) program in Kent County. This follow-up study is being performed to strengthen our understanding of weight-related health in families who have an overweight child.

You may be eligible to participate in this project if you:

1. **Were recruited by the Healthy Kids, Healthy Families program in Kent County. It's okay if you did not complete the program.**

2. **Are able to meet twice over a period of 2-3 weeks. The first meeting will last 30-45 minutes and the second meeting will last around 2 hours.**

3. **Are able to participate as a family. It is preferable that at least one parent and the child who was recruited into the HKHF program can participate.**

We are very interested in hearing what influences the weight-related health of families that participate in our program. In particular, we want to know what influences your health, what it means to be healthy, and what challenges you face when trying to live a healthy lifestyle. We hope you will share your experiences with us so we may improve our program to fit the needs of other families who join our program.

In appreciation of you time, participating families will receive a gift of their choice that is valued at $35 as well as other items. Your family may choose a gift card to Meijer, family pass to Millennium Park, or sports equipment.

Your participation in this project is completely voluntary. If you have any questions or think you may be eligible, please contact:

Amy Foster
(616) 554-0057

HEALTHY KIDS
HEALTHY FAMILIES

APPENDIX C

Demographic & Health Information

ID#_____

Ethnicity/race of parents _____
Ethnicity/race of children _____
Age(s) of child/ren in family _____

Status of parent (check one)

_____Single parent
_____Married
_____Divorced/separated
_____Remarried
_____Co-habiting
_____Life partner

Education level of parent (check one)

_____Junior High
_____High School
_____College
_____Other

Income

_____ Up to $20,000
_____ $20,001-30,000
_____ $30,001- 40,000
_____ $40,001- 50,000
_____ $50,001-60,000
_____ $60,001-70,000
_____ Over $70,001

Does anyone in your family have weight-related medical problems? (Example: type 2 diabetes, high cholesterol, sleep apnea, high blood sugar, heart disease, and hypertension).

_____
_____
_____

APPENDIX D

Photo Release Form

Introduction

This project is being conducted on behalf of researchers at Michigan State University to give individuals and families an opportunity to describe their life experiences. The findings of this research will be used to better understand and enhance services for African Americans with weight-related health problems.

This project is focused on members of the community taking photographs, sharing stories, and identifying issues to educate others about weight-related health in the African American community. Some of the photographs may include images of people. If you are asked to have your photograph taken as part of this project and agree to do so, please read the following:

Purpose of taking photographs

Your photograph(s) may be used in this project to accomplish two goals:

1) To identify issues for members of the community involved in this project.
2) To initiate social change through presentations and publications.

Your participation

1) Your participation will take less than 10 minutes. During this time, the photographer(s) may take pictures that contain images of you.
2) This project is confidential. Your name and any other identifying information will not be listed with the photographs and reports. It is good to remember that despite efforts to maintain confidentiality, there is a chance that someone may recognize you in the photographs.
3) Participation is voluntary. You may choose to not participate at all, or you may refuse to participate in certain procedures, answer certain questions, or discontinue your participation at any time without penalty.

Use of photographs

Photographs become property of the researchers of this project and may be used in presentations and publications. All photographs and information will be kept in a confidential manner. Data will be stored in a locked file cabinet. Only the researchers have access to this file.

Confidentiality

Your privacy will be protected to the maximum extent by law. Because this project requires photo taking of experiences, as well as the sharing of photos to increase awareness of the photographers' experiences, your photo may be identified. The researchers will use these photos for analysis of the study. If the study is published, no identifying information will be reported.

Risks and Benefits

1) The primary risk of this project is the risk of incrimination. This means that because this research involves taking photographs, there is the potential that a photo may be taken which places a person or building at risk to be

accused of or present proof of a crime or fault. Photos which place an individual engaged in illegal activity will not be used for this study.

2) Another potential risk includes the disclosure of embarrassing facts. For example, a picture may reveal one's physical health and/or sexual orientation, which you may not want to disclose.
3) In addition, there is the risk of being misunderstood by images. This refers to the photo not representing who you or your business is. Because this study requires the taking of photos and discussion of those photos, the photographer may have a different opinion of what the photo means or represents.
4) Lastly, you may experience slight discomfort if you give permission to have a photo taken of yourself that represents an issue to your community and development (e.g. discrimination, stigma of weight-related problems such as overweight). In an effort to prevent this from happening, no photos will be used if we do not have your permission to have your photo taken or to be published for the purposes of this study.

The information obtained from this study will be used to better understand the life experiences of African American families with weight-related health issues in an effort to develop better services.

If you have any questions

The people in charge of this study are Ms. Amy Foster and Dr. Marsha Carolan of Michigan State University. If you have any questions about this study, please contact one of the investigators, Ms. Foster (616) 554-0057, smith653@msu.edu or Dr. Carolan (517) 432-3327, carolan@msu.edu, or write to A-233 Clinical Center, Michigan State University, East Lansing, MI 48824.

Agreement Statement: By signing this consent form, I agree to voluntarily have my photograph or my child's photograph taken. I also understand and agree that unless otherwise notified in writing, the researchers of this project assumes that permission is granted to use my photograph(s) for public presentations, publications and/or other educational purposes and that no identifying information will be used. If the individual being photographed is a minor, parental permission must be provided below.

Print Parent/Guardian's Name_____

Parent/Guardian Signature_____ Date_____

Print Youth's Name_____

Youth's Signature_____ Date_____

Or

Print Adult's Name_____

Adult's Signature_____ Date_____

Photographer's Name_____

APPENDIX E

Semi-Structured Interview Questions

A. Ecological Perspective of Health

1A. Which photos represent something that helps you be healthy?
2A . What is in this photo that helps you be healthy?
3A. How does this make it easier be healthy?

5A. Which photos represent something that makes it difficult/hard to be healthy?
6A. What is in this photo that makes it difficult to be healthy?
7A. How does this make it hard to be healthy?

9A. Is there anything else that influences your health, good or bad, that you were unable to photograph?
10A. How do these things affect your health?
11A. Out of all of these, what are the top 3 that influence your health the most?

B. Perceptions of Health

1B. Describe what it means to be healthy?
2B. How do you know that's what it means to be healthy?

3B Which photo(s) show what it means to be healthy?
4B. What do you see in this photo that portrays being healthy?
5B. Do you feel that you and your family are healthy?
6B. How did your family respond to being told your child is overweight?

C. Weight-Related Programs

1C. How do programs like Healthy Kids influence the weight-related health of your family?
2C. What topics are important to you when learning about weight-related health?
3C. What are your overall thoughts on weight-related programs?
4C. Are these programs helpful?

D. Challenges

1D. Are there any challenges you face when trying to follow health recommendations?
2D. Do any of your photos show these challenges?
3D. How should weight-related programs respond to the challenges you face?

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