THE INFLUENCE OF CULTURAL BELIEFS AND ATTITUDES ON THE PERCEPTIONS OF HEALTH, BODY SIZE, AND HEALTH BEHAVIORS AMONG OVER-WEIGHT AND OBESE AFRICAN AMERICAN WOMEN

A DISSERTATION

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BY

EVERLYNE COSEY JACKSON, M.S.N.

DENTON, TEXAS

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TEXAS WOMAN'S UNIVERSITY
DENTON TEXAS

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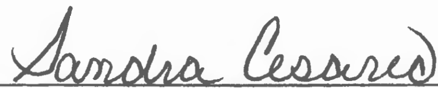
To the Dean of the Graduate School:

I am submitting herewith a dissertation written by Everlyne Cosey Jackson entitled "The Influence of Cultural Beliefs and Attitudes on the Perceptions of Health, Body Size, and Health Behaviors among Over-weight and Obese African American Women." I have examined this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy with a major in Nursing Science.



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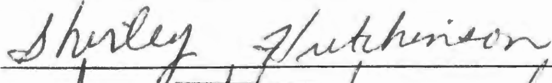

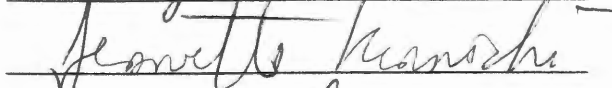

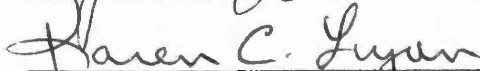

Associate Dean, College of Nursing

Accepted:

Dean of the Graduate School

DEDICATION

In memorandum of my parents, Clarence and Lula Mae Cosey who raised 11 children against unimaginable odds; my son Daryll and grandson Kaman (who left me far too soon).

To my daughters, Stacey and Danita, and my grandchildren (Terrika, Brandon, Taylor, Alex, and Srage), for allowing me the time away from them to finish this project.

To the participants in this study, I'm grateful for your willingness to share your life experiences with me. Through interaction with you and your words, I have come to understand myself.

Most importantly, I give honor and praise God Almighty.

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ABSTRACT

EVERLYNE COSEY JACKSON

THE INFLUENCE OF CULTURAL BELIEFS AND ATTITUDES ON THE PERCEPTIONS OF HEALTH, BODY SIZE, AND HEALTH BEHAVIORS AMONG OVER-WEIGHT AND OBESE AFRICAN AMERICAN WOMEN

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African American women experience extremely high rates of health disparities related to major chronic conditions such as heart disease, hypertension, and diabetes, in addition to high rates of premature mortality. These problems have been directly linked to the extremely high prevalence of overweight and obesity, approximately (80%), decreased physical activity, and a diet high calories and fat in this group. Health care professionals have little success in assisting African American women change or modify health behaviors that result in weight loss and maintenance. Culture plays an integral role in the day-to-day lives of African American women, which influences all aspects of their existence. Little is known about the unique life experiences of African American women related to culture and how those experiences influence their ability to initiate and maintain lifestyle changes.

A phenomenological study was conducted to describe the experiences of eight overweight and obese African American women over four life stages from childhood to middle adulthood. Data was obtained through a one-hour, audio recorded, face to face

interview. Data analysis was completed using Giorgi's approach, which was originated by Husserl (1859-1938). Four categories of themes emerged from the data with a total of eleven themes. Food, as an integral part of life, the universal theme category, was found to be most salient theme that ran across the three categories under study and throughout the life stages of the women. Perception of health yielded three themes. Two themes emerged under body size. Five themes were found to describe perception of health behaviors.

Leininger's Culture Care Theory was used to guide the study. Several theoretical assumptions were supported. Study findings can be useful in hypothesis testing and development, creation of teaching strategies for clients and health care professionals, and in illuminating the unique life experiences of this high-risk group. Research implications and recommendations are addressed.

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CHAPTER I

INTRODUCTION

Health disparities among African American women (AA) are among the highest of all minority groups in the United States (US), and even more dismal in contrast to their Caucasian American (CA) counterparts. African American women have the highest morbidity and premature mortality rates in the nation (Department of Health and Human Services [DHHS], 2008). A major contributor to chronic disease and premature deaths among AA women is the high prevalence of overweight status and obesity in this group. African American women have the highest rates of overweight status and obesity compared to other groups in the United States. The Center for Disease Control ([CDC] 2007) early release estimates and numbers from the American Heart Association ([AHA], 2009) indicate that the incidence of overweight and obesity among AA women ages twenty and above is nearing 80%, a full 20 points above levels experienced by Caucasian American (CA) women in the same categories. Chronic conditions such as cardiovascular and cerebrovascular diseases, hypertension, and diabetes are directly linked to overweight/obesity, decreased physical activity, and high calorie diets (CDC, 2006; DHHS, 2004). Efforts to reduce health disparities and the incidence of overweight and obesity among this group have resulted in very limited success.

Although the issues surrounding the health of AA women are complex, cultural attitudes and beliefs are thought to play a crucial role in conceptions of health and health-

related behaviors in this group (Kumanyika, 2005; Leininger & McFarland, 2002). Several research studies indicate that AA are less successful at weight loss and weight maintenance due to factors that are directly related to biological, cultural, socioeconomic, and educational influences entrenched in families over centuries (Weinsier, Hunter, Schutz, Zuckerman, & Darnell, 2002; Nies & Kershaw, 2002). Experiences unique to AA women may impede the initiation and maintenance of positive health behaviors. Pender, Murdaugh, and Parsons (2002) asserts that learned behaviors over the lifetime of an individual influence the manner in which individuals view health and make lifestyle choices. Further, Leininger (2000) proposes that cultural attitudes and beliefs influence the manner in which individuals view health and choose whether to engage in healthy behaviors.

Many AA women may not recognize the inherent health risk that obesity and lifestyles (Hughes, 2000). Myers, Kagawa-Swinger, Kumanyika, Lex and Markides (1995) contend that the lack of basic knowledge related to health promotion behavior often impedes or prevents the creation of successful health promotion programs for AA women. Additionally, several studies suggest that when planning programs directed toward increasing health promotion behaviors in AA women, individually and culturally sensitive interventions and strategies may increase the potential for success (Kumanyika, 1993; Renili, Will, Thomphson-Reid, Liburd, & Anderson, 1996; Riley, et al., 1998, Kumanyika, 2005). Information is essential regarding the influence of life experiences of AA women, and how cultural attitudes and beliefs affect their perception of health, health

practices, and body size. Health care providers require appropriate information to assist in the development of relevant, culturally sensitive and successful weight loss programs as well as measures to create strategies in assisting AA women to incorporate positive health behaviors and healthy lifestyle changes.

Purpose of the Study

The purpose of this study was to explore and acquire an understanding of how life experiences influence the perception of health, health practices, and body size among over-weight and obese AA women 35 to 54 years of age. The goal of the study was to provide qualitative data which may be used in hypothesis development and testing; and developing culturally sensitive programs to assist AA women with weight loss and maintenance and integrating positive lifestlye changes.

Rationale for the Study

Current statistics indicate that AA women have the highest incidence of obesity and obesity-related diseases in the nation (AHA, 2009; CDC, 2006). Deaths from heart disease, diabetes, and certain cancers are also high among AA females (CDC, 2006; DHHS, 2008). Additionally, Stanhope and Lancaster (2004) relate that many AA women are heads of single-parent households, and tradionally, they influence decisions related to health care choices and practices among other family members (Allen, 1995; Benin & Keith, 1995; Maynard, Galuska, Blanck, & Serdula, 2003), especially children who are experiencing obesity and certain obesity-related diseases (CDC, 2004; National Center for Health Statistics [NCHS], 2004). According to Paeratakul, White, Williamson, Ryan,

and Bray (2002) the disease burden associated with obesity increases as the severity of obesity increases (DHHS, 2004; Tilghman, 2003).

During the early 1990s national organizations acknowledged that minority populations in the United States were increasingly experiencing health conditions and premature deaths at much higher rates related to obesity than the national average (DHHS, 2004, 2008; National Institutes of Health [NIH], 2004) National goals were thus developed under the Healthy People 2000 agenda that were directed toward decreasing the health disparities in minority populations (2004). The primary goals were to increase the quality of life and decrease mortality in target populations.

Recognizing that minorities were also disporportiately not included in research studies, the NIH passed a mandate in 1993 (amended in 2001) requiring that minorities be included in research funded by governmental organizations unless there were clear and convincing evidence which existed to the contrary (Flaskerud & Nyamathi, 2000). Moreover, the report of the NIH Obesity Task Force (2004) indicated that a need existed for research studies to identify cultural factors that influence perceptions, attitudes and beliefs of high risk groups; these may be factors that contribute to obesity and can assist health care providers to understand how health education is percieved by certain groups.

This study seeks to identify cultural influences related to perceptions of health, health practices and body size among AA women by exploring the life experiences of this population. The purpose of the study is to identify valuable information for health care providers to use in planning, developing and implementing culturally sensitive programs

to assist AA women in attaining healthy lifestlye changes which may increase the potential for successful weight loss and weight management. Lastly, the study focuses on AA women between the ages of 35 and 54 because implementing healthy lifestyle changes during the cycle of middle age can be effective in decreasing the potential of developing certain diseases later in life, or at least, delaying the the onset of impending diseases (DHHS, 2004; Tilghman, 2003).

Researcher's Relationship to the Topic

This proposed topic has great interest to this researcher because of personal experience in this specific area. Born into an AA family whose female relatives were either overweight or obese and where most of them eventually developed chronic health problems related to obesity, has prompted a need to seek information that may assist in decreasing the incidence of the problem. Personal experience indicated that many indivduals within the family circle practiced health behaviors that were passed down for generations. For example, the belief that persons who are larger are healthier has persisted over time. Research has shown however, that the opposite is true and in reality, and could potentially be detrimental to health. Further, results from studies indicate that many obese babies and children grow up to be obese adults with an increased risk for chronic illness and premature death (Daniels, 2006; Flegal, Carroll, Kuczmarski, & Johnson, 1998; Gorden-Larsen, Adair, & Popkin, 2002; Kumanyika, 1987).

Theoretical Framework

Leininger's Culture Care Theory of Diversity and Universality often referred to as

the Culture Care Theory (CCT) served as the theoretical framework to guide the proposed study. Leininger began the conceptual work on the theory in the late 1950s as a foundation for scholarly knowledge development in nursing (1998). Five decades later, the CCT is currently being used as a framework to guide nursing research; nursing education; and nursing practice worldwide (Leininger, 2000). Today, Leininger's theory has evolved into a broad, comprehensive model that is holistic and culture specific, and can be used to serve as a theoretical foundation to support and guide nursing education, nursing practice, and nursing research equally. Although Leininger has often employed the ethnographic method, the theorist has conducted research using the phenomenologic approach as well. A large number of qualitative research studies using different methods such as phenomenology, grounded theory, historical, and case study (including ethnography) have employed the CCT and the transcultural care perspective has generated a wealth of knowledge on national and international levels over the previous 60 plus years (Leininger, 1997, Leininger, & McFarland, 2002, 2006).

The CCT framework was chosen to guide the study because it provides a foundation for examining cultural attitudes and beliefs among people of different ethnicities in relation to a variety of phenomena which may influence the health of individuals, families, and groups (Leininger, 1997). Newton (2005) affirms that cultures shape one's beliefs about the value of behaviors and influence decisions and actions related to diet and physical activity habits. The premise of this study is that culture could significantly impact the health of African American women because of their unique

cultural values, beliefs, and attitudes. There is a historical significance in the life experiences of African American women that may provide valuable insight into how to approach nursing care for this group. Emphasis in similarities and differences within cultural groups is an important component of the CCT theory. Leininger suggests that although not all individuals subscribe to culture practices from their respective group, the "tenacity of cultural values cannot be underestimated in understanding…the meaningful information and the justification for behaviors of the constituents" (Leininger, 1991, p. 55).

African American women are uniquely different when compared to women of other ethnic groups because of their sociocultural history; long-standing distrust of the western health care system; and their traditional beliefs; attitude; and cultural practices passed down over generations. George (2001) suggests that experiences in health and illness are unique to the individuals, and their perception of that occurrence will ultimately influence the outcome of the health situations. Research has shown that the inclusion of cultural factors in nursing result in more positive outcomes (Leininger, 1997, Leininger, & McFarland, 2002, 2006). The CCT, based on the premise of holistic nursing care, is multidimensional and focused not only discovering differences, but also commonalties among and between persons and groups. Although groups tend to have more health aspects in common than not, knowledge of significant variations are essential to safe and effective care. Leininger (1997) relates that imposition practices, cultural conflicts and stresses reflect a lack of professional and culturally congruent care.

The Culture Care Theory proposes that a number of interrelated patterns and factors engage in a dynamic force which encompasses the cultural and social structure dimensions of the lifeways of individuals, groups, and communities. Among the factors considered to influence the health perceptions, health behaviors and how body size is perceived by an individual or illness, and well-being of the person relate to (but are not limited to): social, economic, environmental, cultural, and religious values. As such, the Culture Care Theory of Diversity and Universality provides an appropriate guide to explore the phenomena of this study. Application of the CCT, affords a basis for an organized, comprehensive guide to further the understanding of cultural attitudes and beliefs of peoples from different ethnic backgrounds, which underlie health perceptions and health practices.

Assumptions

The assumptions which underlie the CCT that will provide grounding for this study are based on the following premise of culture care (Leininger, 1997, 1998):

1. *Every human culture has generic care knowledge (lay, folk, or indigenous) and practices, and professional care knowledge and practices, which vary transculturally.*
2. *Individuals' beliefs, values, and practices related to health and well-being arise from within the context of a specific culture and are grounded in all aspects of life, which include the worldview, as well as cultural and social structure dimensions.*

3. *Culture care values, beliefs, and practices are influenced by and tend to be embedded in the following: worldview; language; philosophy; religion (and spirituality); kinship; social; political; legal; educational; economic; technological; ethno-historical; and environmental context of cultures.*

4. *Culturally congruent or beneficial nursing care can only occur when an individual, family, group, community or institutional care values, expressions, or patterns are known and used explicitly in appropriate and meaningful ways.*

5. *Culturally-based care based care is the broadest holistic means to know, explain, interpret, and predict nursing care phenomena and guide nursing decisions and actions.*

Research Question

This phenomenological study will seek to answer the following question, "What are influences of cultural attitudes and beliefs related to perceptions of health, body size and health behaviors among overweight and obese AA women 35 to 54 years of age?"

Theoretical Definitions

For the purpose of this study, the following terms are defined:

1. *Influence is defined as causing an effect upon an individual or group of people indirectly, or without active participation in the process. This process may extend to organizations, communities, or entire societies (Mish, 1984).*

2. *Health is an evolving concept with multidimensional components. In this study, health is simply defined as a level or state of physical, mental, and social functioning and well-being (Pender, et al. 2002). Health is a relative measure of functioning (O'Toole, 1997) that may be defined by individuals within the context of life experiences and individual perceptions.*

3. *Health behavior relate to any behavior individuals engage in to maintain or improve their state or level of physical, social, or mental functioning.*

4. *Body size refers to the physical magnitude or dimensions of a human being and will be measured by using the body mass index (weight/height squared [Kg/m^2]).*

5. *Overweight is category used to describe the body size of a person, and is defined by body mass index which may indicate a higher risk for developing health problems compared to a person in the regular sized category. A body mass index of 25.0 to 29.9 is considered overweight (DHHS, 2004).*

6. *Obese is the body size category defined as a body mass index of 30.0 or above (DHHS, 2004).*

Limitations

Limitations of this study include the following:

Participants in the study were restricted to overweight and obese AA women

between 35 to 54 years of age. This study represents the collective experiences of AA women and therefore may not be generalizable to AA men, adolescents, and children, or AA women of different age or SES groups, or other AA women of the same group. Because of different cultural orientations, study findings may not be applicable to individuals of other ethnic groups.

Summary

The purpose of this study was to explore and describe the influence of the phenomena, cultural attitudes and beliefs on perceptions of health, health care practices and body size among AA women. A qualitative, phenomenological method developed by Giorgi (1985) was used to describe the lived experiences of AA women over four life stages. This study may be of value in providing relevant and timely information for theory development to guide practice that will assist nurses in designing and implementing culturally sensitive and effective strategies to assist AA women in adopting positive health behaviors and life style changes.

The researcher approached the study as required by the phenomenological methodology, using naive description (Giorgi, 1985; Moustakas, 1994) without hypotheses or operational definitions. A convenience sample included eight AA women, aged 35 to 54 years old. All preconceptions or judgements related to the phenomena of interest were suspended through bracketing to allow the researcher to approach the raw data without bias or prejudice.

CHAPTER II

REVIEW OF LITERATURE

A review of the literature shows that African American women (AA) experience an overwhelming burden of health disparities that is greater than that of any other ethnic group. The problem is well established by national organizations such as the AHA, (2009), CDC (2007) and the DHHS (2006, 2008) who report extremely high prevalence of acute and chronic conditions among this minority population. Many of these conditions are linked to different issues that cause African American women to see health through cultural aspects of life which does not give them a true meaning of what constitutes health.

Presently, AA women are at the greatest risk for the development of serious and life threatening disorders associated with obesity such as diabetes, heart disease, stroke, and a number of different cancers (Adderly-Kelly & Williams-Stevens, 2003; CDC, 2007; AHA, 2009). Many of these conditions are related to the high incidence of overweight status, obesity, and a sedentary lifestyle. Johnson, Saha, Arbwlaez, Beach & Cooper (2004) report that diets high in fat, due to culturally laden perceptions that larger body sizes are more acceptable. In addition living a highly stressful existence combined with low socioeconomic levels and persistent racism, are major factors involved obesity epidemic among African American women. Obesity and overweight status among minority populations is directly related to morbibity and mortality rates in the United

States and contribute significantly to the widening gap of health disparities among minority groups and particularly in African American women. (Groessl, Kaplan, Barrett-Connor, & Ganiats, 2004; NHLBI, 2002, 2004; CDC, 2006). Early release estimates and data released by the AHA (2009) indicate that the incidence of overweight and obesity among AA women aged 25 and above is much higher (almost 80%) than their European American (EA) counterparts.

Obesity among African American population is more gender-oriented; with the proportion of women who are obese are approximately 80% higher than that of obese men (AHA, 2009; CDC, 2007). Obesity is a major health hazard and is frequently used as one of the primary markers in evaluating a person's level of risk for leading causes of death and disability. According to the CDC (2007), DHHS (2006), and the NHLBI (2002) body mass index (BMI) is the primary method currently used to assess obesity status. In 2007 the CDC established the following categories for standard BMI levels: underweight = 18; regular weight = 18.5 – 24.9; overweight = 25 – 29.9; and obese = 30.0 and above (CDC, 2007). The CDC further obesity into three distinct subgroups, Class I = 30.0 – 34.9; Class II = 35 – 39.9; and 40≥ is considered a Class III (DHHS, 2004). According to current reports from the CDC, up to 80% of African American women have a BMI of 25 and above. There is also evidence that a substantial decrease in weight reduces the risk of mortality and the development of obesity-related diseases (AHA, 2009; CDC, 2007; DHHS, 2006; Tilghman, 2003).

Background

The literature was reviewed to ascertain studies, related to this subject that has been conducted previously. However, in keeping with principles of qualitative research, no in-depth review of the literature was done until after data collection was completed. Review of related literature began as stated in the research question. The variables, chosen for the study were cultural attitudes and beliefs, perceptions of health, health behaviors and body size. Subtopics may be included as necessary to ensure adequate coverage of the available evidence. Although significantly earlier studies will be included, the majority of the literature will focus on studies completed over the last five to six years.

The literature indicates that there is increasing concern for the high rates of overweight status and obesity in AA women which have existed for more than 25 years (Gillum, 1987; Dawson, 1988; Kumanyika, 1987, 2002; Wright & Whitehead, 1987). However, very little has been accomplished in reducing the incidence of overweight status and obesity among this population. Rather, the prevalence of overweight status and obesity continue to rise (AHA, 2009; DHHS, 2004; CDC, 2007).

Because most studies focused primarily on individualistic-physical explanations for health behaviors, the results have not been successful in explaining health gaps between AA women and other ethnic groups. Several cultural-based studies have found that the social system in which one lives may have a major impact on one's health beliefs and health status (Abrums, 2004; Barnes et al., 2007; Drayton-Brooks & White, 2004;

Hawkins Gorgey, Williams, & Dudley, 2007; Mastin & Campo, 2006; Schousboe et al., 2004; Tilghman, 2003; Weng, Bastain, Moser, & Ostbye, 2004). Sociological studies of obesity have also found that low-SES persons with lower levels of activity have higher rates of obesity (Braveman, 2008; Chang, 2006; James, Fowler-Brown, Raghunathan, & Van Hoewyk, 2006).

A major barrier in the management of obesity and health conditions among AA women is limited knowledge among health care providers in relation to cultural aspects of health (Jones, Cason, & Bonds, 2004; Majumar, Browne, Roberts, & Carpio, 2004). Wiginton and Baker (1997) assert that nurses often view attitudes and behaviors of clients through the contexts of their own cultural values and belief systems. Therefore, inadequate knowledge and understanding of the client's worldview greatly impairs the capacity of health care professionals to provide effective health services that meet the needs of the person in the current health care environment. Health care practitioners require specialized knowledge and skills to develop culturally relevant strategies; to communicate effectively with individuals of various ethnicities; and to provide aid and support needed to assist in weight loss and to develop a good maintenance plan over time. Kumanyika (2005) asserts that gaps in knowledge exist among health care professionals related to the understanding of what may be required to initiate major changes in weight-related behaviors such as eating and exercise among AA women in light of existing social and economic conditions.

Engebretson and Littleton (2001) maintain that health-related behaviors are based

on cultural traditions and beliefs which influence the "for whom, when, or what" an individual seeks assistance or information outside of the family structure. Generally, members of AA families maintain deeply rooted cultural ideas, beliefs, and attitudes passed down through generations regarding health and health care (Brown, 1994; Harris, 1992; Johnson, Elbert-Avila, & Tulsky, 2005; Kumanyika, Mauger, Mitchel, Phillips, & Smiciklas-Wright, 2003; Newton, 2005). Frequently, cultural beliefs and attitudes may be expressed in a number of actions or behaviors that should not easily be dismissed. For example, the manner in which various health problems are perceived, are greatly influenced by cultural beliefs and values (Leininger, 1991). Cultural beliefs may moderate perceptions of various illnesses; how one interacts with health care professionals; and actually supersedes or displaces generally accepted health practices (Majumdur, et al., 2004; Newton, 2005; Taylor, 2005).

Several qualitative studies identified that cultural attitudes and beliefs related to body image and perception of body size may impede the ability of AA women to engage in positive health behaviors (Ard, Durant, Edwards, & Svetkey, 2005; Baturka, Hornsby, & Scholing, 2000; Gore, 1999; Kumanyika, Wilson, & Guilford-Davenport, 1993). Certain beliefs and attitudes toward health and body size may actually generate negative health behaviors among specific ethnic groups. Malpede et al. (2007) and Ard, Durant, Edwards, and Svetkey (2005) contend that knowledge of culturally held beliefs and attitudes is imperative for developing interventions to assist AA women to lose weight and maintain a healthy body weight.

Culture

Since a major focus of this study highlights cultural aspects of health perception in AA women, it is therefore appropriate to define culture and its significance on this particular group of people. Culture is defined as "learned, shared, and transmitted values, beliefs, norms, and life practices of a particular group that guides thinking, decisions, and actions in patterned ways" (Leininger, 1991, p. 47). The need to address cultural beliefs, values, and health practices have been well documented in the literature (Davidhizar, 1998; Leininger, 1991, 1997, Leininger & Mcfarland, 2002, 2006; Meleis, 1996; Purnell, 2000; Schim, Doorenbos, Benkert, & Miller, 2007). Leininger asserts that if nursing care is to be relevant and meaningful, competence in transcultural nursing is imperative (Leininger, 1997). The need for cultural competency among health care professionals is supported by a large body of literature (Betancourt, Green, Carrillo, & Ananeh-Firepong, 2003; Brach & Fraserirector, 2000; Leininger, 1991, 1997, 2002; Purnell & Palunka, 2003; Taylor, 2005).

Culture has been identified as an essential component in addressing health problems and weight concerns among minority populations (Chevannes, 2002; DHHS, 2004; Leininger, 1991, 1997; Schim, et al., 2007). A major issue facing health care professionals is the lack the knowledge and skill to adequately address the unique culturally-based health beliefs and behaviors of many AA women (Black, Cook, Murry, McBride, & Cutrona, 2005; Fields, 2001, French, 2003). Until recently, culture has largely been ignored by many individuals involved in health care delivery (Bryant, 2003).

Leininger (1997, 1998) and Browne-Krimley (2004) contend that cultural needs of individuals from ethnically diverse backgrounds are little more than a discussion for many health care scholars, researchers, health organizations and public policy makers. However, several scholars and researchers such as Leininger (1988, 1991, 1997), Purnell (2000), and Davidhizar (1998) and others have been advocating the incorporation of cultural competence for health care professionals as a standard in clinical nursing for decades. None-the-less, many health care providers lack basic knowledge on cultural needs of people from diverse backgrounds and fail to recognize the inability to meet the health care requirements of the clients (Taylor, 2005). According to French (2003), deficiency in knowledge and skill renders many health professionals unable to adequately provide care for clients from a variety of cultural or ethnic backgrounds. Thus, information which can provide a better understanding of how to improve health-focused programs to address the needs of AA women and other minority groups is essential (Annunziato, Lee, & Lowe, 2007).

Kumas-Tan, Beagan, Loppie, MaCleod, and Frank (2007) suggest that "cultural incompetence stems from a lack of knowledge and exposure to people from cultures different from the personal and stereotypical biases, prejudices and discriminatory acts of the individual, "(p. 548). Cultural competence has been defined in various ways. Generally, it is defined as the ability of individuals to demonstrate specific behaviors that incorporate an awareness of sensitivity to the cultural values, worldview, and lifeways of persons of ethnicities which are different from their own (Boyle, 1999; Schim, et al.,

2007). Additionally, the Office of Minority Health defines cultural competence as the ability to recognize and respond to health-related beliefs and cultural values in a manner that enables health professionals to work effectively in cross cultural situations (DHHS, 2005). The common elements found in most definitions include the following: a culturally competent person must possess an awareness or sensitivity, knowledge and skills, understanding differences, socio-cultural aspects, socioeconomic levels, and environmental influences interact to impact the health condition of the individual. In addition, many researchers assert that behaviors which demonstrate the ability to assess and identify the needs of the individuals or group, to formulate appropriate interventions, and respond in a suitable manner are crucial (Brach & Fraserirector, 2000; Leininger, 2000; Meleis, 1999; Purnell, 2000; Taylor, 2005).

Several studies were conducted with health care professionals to ascertain the level of cultural awareness and confidence in knowledge and skills pertaining to various ethnic groups. For example, Jones et al. (2004) conducted a descriptive study of 409 health care workers. The community-based inquiry included nurses and assistive personnel, as participants. The study examined knowledge, skills, and attitudes of the personnel to provide care to three ethnic groups: AA, CA, and Hispanic clients. The study's care providers consisted of participants from four different ethnic backgrounds: AAs (31%); Asian American (11%); EAs (36%); and Hispanic (16%) with an average age of 39 years (range = 19-65 years). Assessments were carried out using the Ethnic Attitude Scale (validity coefficients for the instrument ranged from .42 to .72); the

Cultural Self-Efficacy Scale (reported internal consistency of .97); and a 12-item demographic inventory. Findings indicated that the average attitude scores toward all three patient groups were 65 (SD=8) on the AA patient portion, 64 (SD=6) on the EA section, and 63 (SD=7) on the Hispanic segment of evaluation. An interesting finding was that a one-way [analysis of variance] ANOVA with Bonferroni post hoc contrast revealed that attitudes of the EA health care providers toward Hispanic patients were significantly more positive compared to attitudes regarding African Americans ($p = < .01$).

According to study results, health care workers demonstrated no significant difference in attitudes toward other ethnic patient groups within the sample population of clients. Transcultural knowledge possessed by respondents from all ethnic groups was reported in the moderate range. An expected finding from the study was that each ethnic group demonstrated a higher level of confidence in providing care to patients of the same ethnicity as the health care workers. Another interesting finding was that Asian Americans indicated a higher level of confidence in the knowledge and the ability to care for EAs than did care providers from Hispanic backgrounds. Findings from this study indicate the need for a higher level of competency for care providers from all ethnic backgrounds. The finding that EAs demonstrated a more negative attitude toward AA clients compared to Hispanics may provide a possible explanation to the claim that many AA are treated less than acceptably in some health settings and during interactions with health care providers.

An exploration of attitudes of CA participants regarding attitudes toward AA patients may provide insight into this dilemma: identify specific areas of concern: and possibly insight and self- awareness for care providers. The more information available on various attitudes and beliefs of AA women may also begin to point to further understanding of the differences in world views and places where open dialogue can begin. Consequently, if practitioners are to successfully address the health needs of AA women, information that will shed light on the unique cultural attitudes and beliefs of the group must be available. Relevant and timely information is desperately needed to assist health care professionals to identify ways to deal with the urgent health concerns confronting AA women. Culturally determined factors cannot be ignored, because they are extremely important in terms of their influence on attitudes and beliefs about different facets of the human experience, which is the praxis of positive and negatives health behaviors.

The phenomena of interest are cultural experiences of overweight and obese African American women, and the perception of health and health behaviors over four life stages. This study seeks to provide information for nurses and other health care professionals related to cultural attitudes and beliefs of African American women, developed over a lifetime, which may profoundly affect health behaviors and lifestyle choices. Attitudes, beliefs, and values are often unconsciously driven (Mendelson, 2002), as a result that some individuals may not be aware of the lifestyle choices made on a daily basis. Such decisions, though made insentient, may well have profound effects on

the health and welfare of that person. By engaging the person in an exploration of certain life experiences related to perceptions of health, health related behaviors, and body size, valuable information may become evident. Shambly-Ebron and Boyle (2004) suggest that recognizing the knowledge and experiences of African American women as "valid sources of information" can lead to more positive health outcomes (p.16). Further, Malpede et al. (2007) assert that an understanding of perceptions and ways of thinking within the African American cultural context is essential to eliminating barriers and promoting a change in unhealthy weight patterns.

This chapter addresses literature related to cultural influences on perceptions of health, health practices, and body size among AA women, 35 to 54 years of age that may influence health-related behaviors. The literature was reviewed to ascertain that studies related to this subject have been conducted previously. However, in keeping with principles of qualitative research, no in-depth review of the literature will be done until after data collection is completed.

A Review of related literature will begin as stated in the research question. Initially, the review will focus on the independent variables, cultural attitudes and beliefs. Secondly, the review will focus on the three dependent variables, perceptions of health; body size; and health behaviors. Subtopics may be included as necessary to ensure adequate coverage of the available evidence. Although significant earlier studies will be included, the majority of the literature will focus on studies completed over the last five

to six years. A few earlier studies are contained in this review, as their clinical or historical significance warrants inclusion.

Cultural Beliefs and Attitudes

Cultural Beliefs and Attitudes are unwritten values and mores that are passed down through generations and are seen as sacred within a particular group. According to Smeltzer and Bare (2004) the components of culture in the following manner: The concept of ethnic culture has four primary characteristics; learn from birth through language [spoken and unspoken] and, socialization; shared by members of the same cultural group and include an internal sense and external perception of distinctiveness; influenced by specific conditions related to environment and technical factors, and availability of resources, and ; It is dynamic and ever changing" (p. 14). Cultural attitudes and beliefs of AAs are heavily influenced by societal forces related to their unique history, which includes slavery and decades of discrimination, racism, and socioeconomic deprivation. Combs-Jones (2004) asserts, "for African Americans there is a social environment that heavily influences their ability to participate equally in all aspects of American life that includes a history of slavery and legal segregation imposed through Jim Crow laws of the last century" (p. 7). Within the AA family, women lives are dictated by the pressures of family members (Allen, 1995; Benin & Keith, 1995; Kane, 2000). They have been socialized as caregivers to others while their own needs being secondary. Culturally, many are encouraged to gain and maintain weight, through consumption of high fat, high caloric foods, which, heavily influences their eating habits.

In a descriptive qualitative study, Blixen, Singh, and Thacker (2006) explored cultural values and beliefs related to obesity and weight loss using purposive sampling among a focus group of AA and a focus group of CA women, ages 18 to 50 years. The study compared values and beliefs between AA and CA women. The two groups were composed of four to six women per group (N = 20 for both groups). All participants were obese, with a BMI of 30 or greater. Data were obtained via 90 minute audio-taped, semi-structured, face to face interviews. Six themes were drawn from the analysis of data: (a) attitudes and perception of weight; (b) areas of life affected by weight; (c) previous weight loss attempts; (d) barriers to successful weight loss; (e) medical knowledge related to obesity; (f) help from a primary care physician. All participants identified each of the six themes as having negative influences on lives. Primary problems related to weight differed according to ethnicity. African American women experienced greater difficulty with cultural influences; larger body sizes were less of a stigma and therefore suffered less self-esteem disturbance. African American women in this study also reported that pressure from family members to retain the weight, food cravings, and the culture of consuming caloric foods, heavily influenced eating habits. Alternatively, CA women experienced a greater sense of stigma, and attributed depression and a lack of commitment to weight problem. The women also differed in preference for the type of support from primary care providers. African American women chose a collective type atmosphere of weekly group meetings for teaching, evaluation and encouragement. Comparatively, CA women favored an individual weekly meeting with the primary care

provider in more of a paternal role similar to that of physicians of the past, where primary care practitioners exhibited punitive attitudes toward patients; scolding the person for non-adherence to a prescribed regimen (Blixen et al., 2006).

In an exploratory study, Brezo, Royal, Ampy, and Headings (2006) examined possible associations between health attitudes and racial identity among a group of AAs diagnosed with type two, diabetes. The purpose of the study was to examine associations between health attitudes toward diabetes and measures of ethnic identity. Data were obtained using a self-report questionnaire. The convenience sample consisted of 37 individuals of AA ancestry who were patients, family members, or friends of the patient attending a health clinic at Howard University Family Health Clinic. Twenty-two were actual patients and 15 were family members. Ages were reported as $\geq$ 45 years for patients and $\geq$ 18 years for non-patients. Participants reported themselves as Black (37%); African American (24%); Black American (8%); multiple ethnic origins (11%); and the remaining equated ethnicity with country or continent. The primary outcome of attitudinal measures were an awareness of predisposing risk factors for diabetes. sharing information about the diabetes diagnosis and health problems. and one's perception of susceptibility to diabetes (type 2). A direct correlation was found between ethnic identity and health attitudes; willingness to share one's diagnosis; knowledge of risk factors; and willingness to discuss diagnosis with family members. Correlations between a sense of ethnic identity and awareness of risk factors (statistically significant with Pearson's $r = .48$), willingness to share diabetes diagnosis ($r=.63$) and discuss personal health

information with family (r= 46; p=.001). The results of the study were consistent with cultural attitudes and beliefs among many AAs, such as being family oriented; and seeking support from family; frequently consulting family; and using alternative measures to treat health problems before seeking western medical help. Although these findings demonstrate support about certain cultural attitudes and behaviors among African Americans, further, more studies of this type are essential to buttress study findings, with larger population sample sizes before generalizations can be made about a specific population group.

Perception of Health

Health is a concept that is difficult to define because the meaning may vary for each individual. Health is an evolving concept with multidimensional components. O'Toole (1997) contends that health is a relative measure of functioning, a value judgement that is subjective (Leddy & Pepper, 1989). Leininger defines health as "a state of well-being that is culturally defined, valued, and practiced, which reflects the ability of individuals (or groups) to perform daily role activities in culturally expressed, beneficial, and patterned lifeways" (1991, p. 48). Although health status can be assessed through physiological measures, the client's personal evaluation of health status is necessary to obtain a more complete picture of health and well-being.

The meaning of health may vary for each individual. None-the-less, research findings indicate the interpretations, or the meaning of health, tend to have similarities along ethnic and racial, lines. *The American Heritage College Dictionary* (2000),

describes health "as the overall condition of a person," and then adds the following: optimal functioning and well-being; freedom from abnormality or disease; and being of sound mind and body. Owing to the state of health in the nation and the world, health professionals seek a more realistic view of health. Backett and Davidson (1992) relate that definitions of health and well-being or what is considered "being" healthy vary across cultures and over time. For certain ethnic groups, health is perceived as a sense of well-being, and can be disrupted in the absence of illness (Emami, Benner, Lipson & Ekman, 2000). Alternatively, well-being can persist in the presence of illness (Chamberlain & Zika, 1988; Emani et al., 2000; Groot, 2003; Orem, 2001).

Perception is defined as an awareness of the existence of something that can be discerned both physically and mentally (Mish, 1984). Perception is also a subjective awareness, interpretation, and evaluation of an object or experience through conscious discernment (Jarvis, 2000), the process of being aware that certain things exist through consciousness (Mish, 2006). Perception can be influenced by the worldview of the individual, which includes cultural beliefs and values. Subjectivity is a key factor in understanding the health care seeker and appreciating the unique needs of the person. Moreover, because one's perception is subjective, an awareness of a person's own perspective provides critical reference points in which individually focused care can be initiated. Additionally, for African Americans, perceived health status is a much stronger predictor of health care utilization than for Caucasian Americans (Brezo, et al 2006; Keenan, Marshall, & Eve, 2002).

Health perception and its influential factors are critical elements in the design, implementation, and success of lifestyle changes to improve health outcomes. For example, a person who perceives that health is better at a heavier weight than with one that is less and within the BMI range designated as normal by the health care community, may be quite resistant to engage in behaviors that may result in a lower body weight. Secondarily, providing health care for individuals deeply rooted in beliefs that have been passed down through generations, requires a degree of cultural competence to devise different approaches and follow-up strategies in order to provide culturally congruent care. Cultural-based care becomes essential in assisting the individuals, families and communities to attain, maintain, and preserve health and well being (Leininger, 1991). Meleis (1996) proposes that, "...by studying health from different cultural perspectives, a more contextual approach to health could be developed" (Meleis, 1996, p. 7).

Although self-perception of health has been a focus of the health care community for more than three decades, there is still much to explore and learn about the concept in relation to AA women. Over time, studies have shown that the perception of health is an important factor to consider when developing health education strategies (Franks, Gold, & Fiscella, 2003; Mendias, Clark, Guevara, 2001; Richardson, 2003). Janz and Becker (1984), relate that perceived health is as crucial as objective information in the action, or inaction of individuals on health-related concerns related to health (Rakowski & Cryan, 1990). Lee et al. (2007) found perceived health to be a reliable, independent predictor among adults 18 years and older of morbidity and mortality (Deihr, Williamson, Patrick,

Bild, & Burke, 2001; Idler & Benyamini, 1997; Wolf, Armour, & Campbell, 2008). None-the-less, perceived health, as an entity, must be understood from the worldview of the patient, in order to successfully address the health care needs of the person.

In spite of advances in technology, the vast amount of information available, regarding preventive strategies and treatment modalities, little progress has been made on the health states of AA women (Adderly-Kelly & Williams-Stephens, 2003). There is a dearth of information about how AAs define or describe health states. It is interesting to note that little is known about AA women and how individuals perceive health, and how such perceptions influence the actual health status and health behaviors. The following timely and important study highlights the need for relevant and accurate information related to AA women, health status, and the level of knowledge about the subject. The subsequent study likewise underscores the critical need for health teaching among African American women.

Sadler, et al. (2005) examined data from 1,055 AA women, ages 20 to 94 years (mean age 40.1 years) to determine what they perceived as their most serious health problem. Results of the study were surprising. Although cardiovascular disease is the greatest threat to the health of AA women, participants chose cancer as the number one health concern, while heart disease ranked fourth, following diabetes and stroke. Researchers concluded that cultural beliefs within the African American community, regarding specific aspects of a disease such as pain, disfigurement, and past experiences at a time when a diagnosis of cancer was almost always fatal, may have influenced the

findings (Sadler, et al. 2005). Researchers however, were unable to offer any plausible explanations why heart disease, a critical health threat to AA women was fourth among the list. Findings from this study are consistent with those from an earlier study where AA women were less likely to report an awareness of the fact that obesity and positive family history increased the risk for the development of heart disease compared to CA women (Mosca, et al., 2004). Such findings highlight the need for timely, relevant, and accurate health information among this particular group of women.

In an earlier correlation study, Mosca et al. (2004) examined knowledge and perception of heart disease, risks of developing heart disease and stroke, and the level of knowledge related to risk factors among a tri-ethnic group of women. The sample included 1,000 women 25 years of age and above (13% AA, 65.8% CA, and 12.6% Hispanic women). Major outcome variables were knowledge of the risks of heart disease and stroke; and perception of heart disease and preventative measures. The sample was divided by ethnicity and age groups (25-34, 35-44, 45-64, 65 and older). A randomized sampling process was used where 1,000 participants were selected from 2,018 households. Data were obtained using a 38-item questionnaire with open ended questions by telephone. Responses were scored on a Likert Scale (very well informed; well informed; moderately informed; not at all informed; and do not know/no answer). Assessment of univariate relationships was accomplished using t-tests with $p < .05$ set for alpha. Surprisingly, ratings of knowledge of heart disease and stroke by ethnicity revealed no appreciable difference between ethnicity ($p < .05$). Perception of knowledge

of heart disease and stroke by ethnicity and age group were also similar, ($p< .05$) with a few exceptions. The highest number of responses were from the moderately informed level (range was 44% – 52%). Among the age categories, the 25 to 34 group scored lowest (heart disease 28%, and stroke 41%), while the 45-64 and the 65 and above age group had higher numbers in the top levels (41% and 43% respectively). Group level scores were similar in the knowledge of stroke category as well. All three ethnic groups were strikingly similar in educational level, employment status, and median household, which may account for the parallel findings. A marked difference in marital status was found between the three groups. African American women reported a much lower marriage status compared to Caucasian American and Hispanic women (28%, 65%, and 58% respectively).

Moreover, the literature does reveal that misconceptions exist among the AA community, related to health risks and illnesses, certain treatments for disorders and illness, and the actual purpose of diagnostic exams. For example, in a dissertation study (Combs-Jones, 2004) of 26 midlife women found that among 26 AA women, several of the participants considered mammograms as a preventative measure, or a cure for cancer. In another ethnographic study about perceptions and beliefs among 30 AA women about hysterectomies, Augustus (2002) discovered that culturally related myths, fears, and sexual symbolism represented strong negative connotations, which resulted in a delay in seeking medical care or postponing the procedure until no other option was available. The life experiences of AA women are uniquely different from women of other ethnic

backgrounds. The literature reveals that certain factors including, but not limited to, cultural attitudes and beliefs, the conception of health, and available resources, profoundly impact the health of AA women (Barger, 2006; Williams, 2005)

Influential Factors of Health

Influential health factor also known as "Determinants of Health," is factors considered to impact the health status or level of functioning among individuals, families, groups and, communities. The fact that certain minority groups in the U.S. experience poorer levels of health compared to the majority populations has been debated and researched over several decades. Many public health scholars and other health professionals appear to agree that there is no single determinant to measure the status of one's health; but a compilation of rudimentary aspects interacting in different ways to determine health at a specific point of time in a person's life (Kumanyika et al., 2005). Factors considered as major influences on health are: biologic, cultural, socioeconomics, environment, ethnicity spirituality and social support. These factors have also been linked to weight status, body size perceptions, and health behaviors.

Lillie-Blanton and Laviest (1996) assert that the model generally accepted for overall health is an interrelationship between biologic and social factors. lifestyle behaviors, and health care utilization. Principal factors considered to have major influences on health comprise two primary categories which are: biological and physical. and, those of a social and cultural nature leaving health care utilization and lifestyle behaviors as secondary (Lillie-Blanton & Laviest, 1996; DHHS, 2008; Deckelbaum et

al., 1999; York, et al., 2004). The physical and social aspects of health status may be different in many ways on individual and group levels (Kumanyika et al. 2005).

Biologic Factors of Health

Studies on biologic determinants of health cover a wide range of variables and they are beyond the scope of this study. Biological factors, considered to be major influences on health include age, gender, race, genetic makeup, and physiologic status. According to the Healthy People 2010 initiative, biology accounts for an individual's genetic makeup or the presence of specific traits from parents, which may range from 20% to 40% (CDC, 2007; DHHS, 2006). Biological factors such as the potential to have certain diseases, and the tendency or the risk of developing particular diseases or disorders are to some extent are genetic in nature. Principal biological factors include characteristics of the person that is innate, such as body structure, facial features skin color and gender, (Bortz, 2005; DHHS, 2004). Physiologic processes in the form of stress, and responses to behaviors are also biological in nature (Bortz, 2005; Harrell, Hall, & Taliaferro, 2003).

Race. Biologically, race has been viewed as a negative factor for AAs over time, in terms of health status; morbidity; mortality; and obesity (CDC 2006; DHHS, 2008). Studies have shown that biological differences do exist among all racial minority groups, that place AAs and other minority groups at greater risk for development of certain disorders. They may also be genetically susceptible to certain abnormalities which may be shared between certain ethnicities. Yancy, Benjamin, Fubunmi, and Bonow (2005)

provide a classic example of racial differences among AAs where the physiologic processes in the renal sodium channel functions lead to a salt-sensitive hypertension, and, it is found that certain drugs are less effective in treating hypertension in this group. Evidently, some health providers consider that race is only a "marker" for the development of many of major disorders (Nesbit & Victor 2004).

While genetic and physiological studies continue, some researchers have begun to question the validity of discussing health issues in terms of race. However, AAs actually out number their EA counterparts in death rates from the highest 15 causes of death in the nation (DHHS, 2006, 2008) The U.S. Institute of Medicine has advised doctors to "abandon traditional racial categories because they are of limited utility for the purpose of health research" (Abrums, 2004, p. 89). This stance is based on the premise that the assumption of fundamental biological differences between racial groups is unfounded and in actuality, health issues are more effectively grouped according to community or regional issues.

Gender. Traditionally, biologic sexual differences in health status exists (MacIntyre & Hunt, 1997; Muennig, Lubetkin, Jai, & Franks, 2006; Singh-Manoux et al., 2008). According to Keleher (2004), gender in relation to health is an interrelationship between differences in biologic and psychological dimensions, and sociological experiences. Thus gender is also directly related to health conditions and premature mortality (Deeg & Kriegsman, 2003). Deckelbaum et al. (1999) assert that there are far more commonalities between genders than differences. Never the less, women overall

live longer; yet AA women experience a disproportionate degree of chronic disease and poorer quality of life. Additionally, AA women experience health differently from AA men (Muennig et al., 2006).

Age. Among African American women weight tends to increase up to the age 60, after which there is a decline (Tilghman, 2003). For many years the influence of age on health has been ignored by the healthcare community and researchers. However, with the fastest growing segment of the population being 65 years and over and the group who consumes the largest part of healthcare dollars; the government is now taking a closer look at healthcare and cost. Most people would jump at the chance of living longer, after spending 40 years working. To many, the thought of a long, relaxing retirement seems appealing. But to many over 60 years of age, if a longer life meant an increase in the length of ill health would people still feel the same? According Pullinger (1997) the over 80s population is predicted to double to five million by 2031. If the health of the aging population follows current trends that will mean people spend more of their lives fighting various illnesses. With the advent of technology and the focus on aggressive treatment of what previously were once terminal conditions, the emphasis in not living healthier but living longer. Fortunately, in the culture of African Americans there is a tradition that dictates that 'there is a time to live and a time to die' and many prepare for death as much as for other life events. Further, by age 60, the ravages of overweight and obesity may be irreversible; coupled with the poor level of healthcare, many individuals, AA women in particular, may resolve to the inevitable of poor health and early demise.

Body Size. Biologically persons with large body size are more prone to health problems. The relationship between health and increased body weight and body size has been well documented. Statistics have shown that body size associated with obesity affects the health and life-years across racial/ethnic lines (CDC, 2006; Harris, Launder, Madams, & Feldman, 1997; Hawkins, et al., 2007; NCHS, 2007). Daniels (2006) reports that weight gain of as little as 15 pounds (lbs) increases a person's risk for developing many chronic diseases such diabetes, hypertension and heart disease as much as 50%., whereas, a loss of 11lbs decreases one's risk by the same percentage point. Obesity is a complex bio-physiologic disorder with no one single underlying cause (Milks 1994). Most weight problems are said to be caused by an imbalance between energy intake and expenditure, where overeating and/or decreased physical activity are considered the primary causes (CDC, 2006). Allison (2005) purports that obesity is the number one cause of preventable deaths, close to that of smoking.

The biologic factor or heredity has also been implicated in many of the obesity-related diseases. In a large, prospective cohort study, Lloyd-Jones, et al. (2004) found that premature cardiovascular disease in at least one parent was predictive of future cardiovascular occurrences among male and female children, independent of other identified risk factors, suggesting a genetic link in the development of heart disease (Katmarzyk, Mahaney, Blangero, Quek, & Malina, 1999). However Bortz (2005) suggest that the risk for obesity within families in not wholly due to genetic disposition, but a more complex situation, where genetic vulnerabilities are enhanced by interactions with

environmental and behavioral factors (DHHS, 2004; Sparks & Frazier, 2002). In a systematic review of the literature, Walker-Sterling (2005) concluded that a substantial amount of evidence indicates a positive relationship between genes and the development of obesity. In reference to a number of studies of twins, families, and adoption, Loos and Bouchard (2003) concluded that the evidence indicated a significant link between genes and the development of obesity, with the genetic influence from 25% to 40% (Bouchard, 1997). Lechleitner (2004) estimated the influence of genetics to be from 30%. to as much as 70% on the development of obesity. Other reports place the numbers at 20% to 40, of biological influences on body size (DHHS, 2006).

Cultural Factors and Health

The influence of cultural factors on health has been well established. A significant body of literature exists on the influence of cultural factors on health beliefs and behaviors among AA women (Abrums, 2004; Ahye, Devine, & Odoms-Young, 2006; Banks-Wallace & Parks, 2004; Beech et al., 2004; Cohen & Koenig, 2003; Mastin & Campo, 2006; Nummela, Sulander, Rahkonen, Karisto, & Utela, 2008; Prividera & Kean, 2008; Rozin, 2003; Whitt, Kumanyika, & Bellamy, 2003). A number of scholars and health professionals suggest that the gaps exist in knowledge of cultural factors that affect on lifestyle practices among African American women. The National Heart Lung and Blood Institute (2008) developed a culturally appropriate educational booklet for AAs on healthy living book entitled *On the Move to Better Heart Health for African Americans*. In an easy-to-read format, the booklet provides concise information on heart

disease and its risk factors. The book states that "Knowledge is power". However it is just not enough to give an individual of AA descent a simple book to read when faced with powerful influences of culture that dictate every aspect of life for centuries. Everything in the lives of AA families are culturally linked. and include but not limited to family member roles, food types, food preparation. child bearing. child rearing and even to the body sizes and weight of women are an entrenched in culture. Further, the events that shaped the lives of African American such as slavery, discrimination and the deliberate customs the group was subjected to. prevented assimilation into the majority culture as other ethnic groups, such as the Europeans and Asian and some Hispanics are allowed to do.

Socioeconomic Factors and Health

Socioeconomic status (SES) is generally measured by household income and educational level (Liao, Tucker, & Giles. 2004). Which are directly relates lifestyles that can affect health. Lawson (1999) maintains that that the relationship between SES, illness and death rates has been well documented (Gorman. 2007; LaViest. 1996; Mackenbach, Simon, Caspar, Looman, & Joung, 2002). In the general sense. SES influences health in several ways. There is a lack of. or access to health care; individuals do not seek preventative services such as screening practices. and there are often delays in seeking actual needed critical services. or many never receive necessary care for lack of financial resources or awareness that the need exists. Socioeconomic levels also influence a person place of residence. where certain lifestyle and social factors including

the environment, act as determinants of health status and well being (de Hollander & Staatsen, 2003). An example of this is redlining used by financial institutions in the US to prevent African American families from moving into more affluent areas through higher mortgage rates and property prices (Brown & Bennington, 1993). In many AA neighborhoods the playground for children are sidewalks- whereas the more affluent neighborhoods afford amenities such as swimming pools, basket ball courts, tennis courts that keep children more safe (Do, et al, 2007, 2008).

Brown et al. (2004) indicate that there is a considerable amount of literature, which demonstrates an inverse relationship between SES and health status. Additionally, a direct link exists between social deprivation, and illness incidence in the general population. In a national multiethnic sample study of 19,812 respondents, Franks, et al. (2003) reported that AAs reported lower levels of health compared to CA and Hispanic adults 21 years of age and older. Additionally they found that, SES and lower health status were predictive of higher mortality levels. These findings were supported in a study conducted by (Dowd & Zajacova, 2007). The major difference between the two studies was that health status was more predictive of mortality among individuals in higher education and income levels are reported by Dowd & Zajacova (2007).

In a similar study, Gold et al. (2006) examined lifetime morbidity burden among a diverse sample of women. Findings revealed that AA women and American Indian women of low SES level had a greater likelihood of becoming ill. The significantly higher lifetime morbidity burdens among AA women are consistent with national trends

showing high illness risk and mortality rates. De Hollander and Staatsen (2003) assert that "social and lifestyle factors have gradually become the most significant causes of avoidable health loss" (p. 53). Stanhope and Lancaster (2004) indicates that the social view of health reflects key social factors that influence certain trends or pattern of health and illness on a broad scale, within a particular population. Health and disease are socially and historically patterned, where primary influences are economic, environmental, and cultural (Anderson, 1995; Schulz & Northridge, 2004). Link (1996) further suggests that social and cultural factors have an impact on health status among all cultures, past, present, and future.

According to Shambly-Ebron and Boyle (2004) AA women possess social and cultural perspectives that are uniquely related to their lived experiences. These experiences encompass the effect of ethnicity, social class, and gender in the development of values, attitudes and beliefs, and nature of their existence in society. Thus, before the health needs of AA women can be adequately addressed, it is imperative that health care professionals acquire an understanding of the life experiences that have shaped and continue to impact the lives of this particular group

Environment and Health

Vlahov et al. (2007) characterizes the environment as the predominant social and cultural determinant of health because it encompasses both the social venue and the physical surroundings. When viewed on the macro level, environmental influences reveal the complex multilevel ecosystem that range from family dynamics and SES level to

neighborhood ethnic concentration and crime rates. For AAs, the social and cultural atmosphere in many instances negatively influences health, both on the social milieu level and the physical residential surroundings. Chang (2006) relates that racial residential segregation has had negative impact on the health and wellbeing of minority groups.

Historically, economic and political mandates, legally ascribed codes and doctrines, and collective ideologies within the U.S. have created circumscribed areas of affluence and poverty. Thus the result of such actions is an unequal distribution of resources and a lack in access, that fundamentally affect the health of minority groups, including the majority of African Americans (Leigh, 1998). Disparities in access to economic resources, health care, and negative environmental forces greatly impact one's level of health, illness, and mortality (Vlahov et al, 2007). Combs-Jones (2004) asserts that "for Africa Americans, the social environment negatively influence their ability to equally part-take in all facets of American life" (p. 7).

Both the social environment and the physical environment are considered powerful influences on health status (Astin & Forys, 2004; De Hollander & Staatsen, 2003; Syme, 2004; Vlahov et al, 2007; Wight et al., 2007). The social environment is primarily relational, but also reflects stress producing situations and exposure to high risk behaviors in the community, workplace conditions, and society at large. The physical environment influences health in relation to one's neighborhood or geographical place of residence. Do et al. (2008) advised that neighborhood context and health status are at

least in part a significant function of disparities in health along racial lines. Wight et al. (2007) studied a nationally representative sample of 3,442 adults aged 70 and older and found that neighborhood poverty status was significantly related to poor self-rated health in later life. For many AA women, limited financial resources may determine their place of residence and all of associated health risks. Lynam (2005) relates that there is a common agreement that the environment and natural conditions do impact an individual's health status because of existing social inequalities.

Ethnicity and Health

The concept of ethnicity has frequently been associated and equated with race. While ethnicity is more comprehensive concept that includes mores, practices, and beliefs of a particular group, race is more biological in nature. In fact, a number of scholars propose that the use of race is currently inappropriate, considering that individuals have become a diverse society where many restrictions on dating and marriage outside of one's own ethnic group have become a frequent occurrence. For some individuals of minority status, the term race is viewed more negatively and has been associated with oppression, racism, and slavery; whereas ethnicity is more socially inclined and considered a more positive and appropriate term when referring to individuals from different ancestral backgrounds. Weeramathri (2006) suggests that the use of race as a distinction between groups as an objective method of classification was based on the premise of biological inferiority and strategic political exclusion and domination. In addition, the scientific basis for race has largely been discredited and

abandoned as a result of findings from genetic studies. Weeramathri further defines ethnicity as "… a complex social variable, with cultural and political dimensions but no biological dimension" (2006, p. 1).

For AAs, race and health status has been linked to poor mental and physical health because of the experience of racial discrimination, compounded by slavery (Clark, Anderson, Clark, & Williams, 1996; Kreiger, 1990; Polednak, 1993; Williams & Williams-Morris, 2000). Disorders such as hypertension and heart disease have been linked to the cumulative effects of the stress from exposure to this very idea (Borrell, Kiefe, Williams, Diez-Roux, & Gorden-Larsen, 2006). In a qualitative study, Benkert and Peters (2005) found that participants recalled experiencing discrimination in the health care setting and that it profoundly affected them and their decision to seek help in the future.

African-Americans are a very heterogeneous group. Never the less; generalizations about family structure, health beliefs, and attitudes toward health and illness are bound to suffer from stereotyping and racial bias. Having said this, there are other issues to consider; it is important that health care professionals realize that characteristics among AAs have frequently been attributed to ethnicity or racial factors that may actually be related to social class and certain disadvantages (Snowden, Libby, & Thomas., 1997).

Spirituality and Health

According to Newlin, Knafl, and Melkus (2002) spirituality is a vital element of

AA culture, which may or may not include organized religious practice. Historically, religion has been central in the daily existence of AA life from the time of slavery (Allen, 1995; Banks-Wallace, 2000). Empirical evidence has firmly established that a strong relationship between religion and spirituality and the concept of health and extended mortality (Hummer, Rogers, Nam, & Ellison, 1999; Larson, Larson, & Koenig, 2002; van Olphen, et al., 2003). Spirituality is frequently used interchangeably with religion and viewed as a component of culture in the African American community. Although spirituality had been implied in previous nursing theories, nursing personnel became aware of it an integral to practice with Watson's Theory of Caring (George, 1995; Watson, 1979). Boyle, Stygall, Mohammed, Keshstar, & Newman (2006) note that religion and spirituality have been part of coping resources for individuals experiencing life-threatening illnesses for quite some time. In recent years, spirituality has gained attention as an influential factor in health status and health perceptions. The literature reveals a plethora of information on spirituality, some of which indicated that that spirituality and religion play an important role in the lives of many African Americans (Banks-Wallace & Parks, 2004).

Spirituality is culturally shaped and contextually dependent in which complex attitudes and beliefs about health and illness can be beneficial or harmful (Delgado, 2005). In a review of literature, Boyle et al. (2006) reported that certain aspects of spiritual coping can actually be detrimental, whereas Mac Dougall (2001) suggests a more positive link between the constructs of health and spirituality. In a study of 234

patients on the effect of spiritual beliefs on illness outcomes. King, Speck, and Thomas (1999) found that "patients with stronger religious beliefs were 2.3 times more likely to remain the same healthwise or deteriorate (pp. 1298). Alternatively, Tanyi and Werner (2003) reported that spiritual well-being was positively associated with psychosocial adjustment among 65 women (primarily AA) patients diagnosed with end-stage renal disease. As part of the effort to decrease health disparities and increase the quality of life and well-being, the Healthy People 2010 program included a requirement of sensitivity to spirituality and religious preferences as an element of cultural competency for all Americans (DHHS, 2000; Newlin, et al., 2002).

In an ethnographic study on women from a storefront church, Abrums (2004) suggest that many AA women operate within a distinct system of beliefs related to their health and health practices. The women in the study perceived that knowledge which comes through spirituality, is based on experience, and thus more value may be placed on practical learning rather than on a formal education. Abrums suggested that many AA women may use formal education as a barrier to embracing new information related to disease prevention and health management behaviors (2004). Participants believed that the human body was a gift from God and the practice of placing health concerns in His hands and prayer is the best way of coping during illness. These spiritual-based responses to illness were viewed by researchers as "magical-religious rituals" that may provide coping mechanisms, generally viewed as "a palliative method for the individual [that] discourages one from seeking social change" and "…compensatory and accommodative

rather than corrective" (Abrums, 2004, p. 100). The women also expressed a fear of the medical system and doctors, and believed that they "...will die because people go in the hospital and never come out" (Abrums, 2004, p. 101). According to Abrums (2004) the study depicts a complicated picture of experiential and spiritual beliefs converging to create a critical often pessimistic stance toward health care, with both positive and negative outcomes in terms of African American female health issues. Abrums' (2004) "pessimistic stance" is not necessarily viewed as a negative among AA women. The issue is the belief that spirituality is more beneficial to their health than western medicine

Social Support and Health

Kim, Sherman, and Taylor (2008) assert that social support is an effective means by which people cope with stressful events, and consequently, the latter positively affects health and well-being. According to Cohen, Finch, Bower, and Sastry (2005) there is substantial evidence that social support fundamentally influences health status and the presence of certain support systems positively influences psychological and physiologically well being. (Hale, Hannum, & Espelage, 2005). Further, Syme (2004) purports that the lack of social support may have even greater negative effect on health than socioeconomic status. The most important social support among African Americans is the extended family. Within the extended family shared resources include shelter, food, finances and most importantly care protection of children.

Research study findings have consistently shown that there are higher mortality rates among individuals without support systems compared to those with social support

(Gallant, 2003; Ross & Mirowsky, 2002; Russek & Schwartz, 1996). These results have been further supported by several other recent studies. For example, Zang, Norris, Gregg, and Beckles (2007) studied health outcomes of 1,437 individuals with diabetes 70 years of age or older. Results showed that individuals with low levels of support had a 55% higher risk of mortality compared to those with high levels of mortality and a 41% higher risk than persons with medium level support systems. Several studies have also found a positive relationship between social support and both physical and mental health (Hale, et al., 2005; Kim, et al., 2008; Zang et al., 2007).

Social support is considered a universal need, yet there are profound cultural differences in the effectiveness of different types of support and how people use their support networks (Kim, et al., 2008). For AAs the dynamics of support systems have required unique approaches to maintain a degree of stability through the pressures of slavery and segregation. Sarkisian and Gerstel (2004) contend the family networks which existed in previous times have actually been destroyed by the recent economic and societal changes. Throughout these times AA women have been viewed as a strong, resilient foundation of the family. It is possible that the decline in health status among AA women may at least be attributed to the stresses of decades of maintaining such a role in the family and community and the deterioration of communal support within the AA culture.

The African American Family

The African American family is difficult if not impossible to define. Allen (1995)

relates that the AA family is depicted by a complex system of overlapping and shared community, functional relationships, values, affiliations, blood and non-blood ties that transcend any one area of life (Jarrett & Burton, 2000). Although the AA community is known for an extended family support system, historically, the family unit has been the most significant source of support. Kane (2000) cited five characteristics important to the functioning of the AA family unit. First, an extended family kinship has been consistently noted in the literature (Ard, et al., 2005). Kane (2000) noted that the extended family support system previously allowed the pooling of resources, both financially and personal in the manner of childcare and emotional assistance in difficult times. However, recent political, economic, and social changes in society have left the AA family unable to meet such demands (Benin & Keith, 1995). Secondly, parent, grandparents, other adult relatives, and family friends historically shared egalitarian and adaptable family roles. However over recent decades, family and community structure, as well as employment patterns, have changed resulting in potentially fewer extended family and friend support networks (Griffin, Amodeo, Clay, Fassler, & Ellis, 2006; Sarkisian & Gerstel, 2004). Strong religious orientation, the third characteristic, is well known and has been supported in the literature; this orientation may or may not be associated with organized religion, but it is also a source of formal and informal social support (Abrums, 2004; Ard, et al., 2005). Fourth, the focus on solid education and work ethic has been a consistent theme throughout African American history. Historically, AA parents have stressed that hard work and educational advancement are necessary to attain upward economic

mobility (Ard, et al., 2005, Kane, 1995). Finally, strong coping skills have been necessary for survival through difficult periods of hardships such as slavery, segregation, and repeated acts of racism (Allen, 1995; Kane, 2000; Sarkisian & Gerstel, 2004).

Thus for many AA women, the level of social support once available through family and community networks may no longer exist. Although, certain cultural attitudes and beliefs may still remain within a support network that may exert positive influences as well as negative ones, such as preferences for larger body sizes and certain dietary practices encouraging high caloric and high fat food consumption. Snowden et al. (1997) assert that the family may influence the health of a person in a number of ways. Lifestyle practices include both positive and negative behavior patterns, attitudes toward health and prevention, and relationally, a buffer against some types of disorders such as heart disease, stroke and the development of certain kinds of caners. Additionally, Gorman (2007) views social support as inextricably linked to SES where less social resources results in less available personal and emotional support.

Perception of Body Size

Body size refers to the physical magnitude or dimensions of a human being and is measured by the body mass index (Mish, 1984). In African American women, larger body sizes have been linked to cultural and historical influences, where "fleshy" women were viewed as being "healthy and fertile" as well as "well-endowed financially" (Johnson & Broadnax, 2003, p. 59). Being large also meant that the women came from an affluent family "or had the potential to be a good provider" (Johnson & Broadnax, 2003,

p. 59). Historically, heavier AA women who had hips and were seen stately, and were valued as marriageable because their body type was equated with potential to have children and, to be good mothers. During slavery times, larger voluptuous AA women were also more valued because of their birth giving potential and a good source of milk for their slave master's children (Dunaway, 2003; Johnson & Broadnax, 2003; Newton, 2005).

Review of the literature on body size perception and preferences revealed a plethora of information on studies that primarily indicated that AA women preferred, or were more accepting of larger body sizes. Many of these studies included AA women of specific age and across the age span: with studies done on older participants (Gore, 1999; Stevens, Kumanyika, & Keil, 1994; Rand & Wright, 2000; Riley, et al., 1998).

In comparison to their CA parallel group, AA women are more prone to obesity and less likely to lose weight and maintain weight loss. A possible contributing factor to their lack of success is that most interventions and strategies used in the past have been developed using the model designed for a majority population (Kumanyika, et al., 2007) a kind of "one size fits all", or "one model fits all" design (Kao, Hsu, & Clark, 2004). As health care community members are seemingly unable to make much progress in combating obesity in AA women, health disparities remain at extremely high rate among the group. Studies that provide information on the specific needs of AA women may increase the potential for health care professionals to affect more positive health-related outcomes.

Wilbur, Chandler, Dancy, Choi, & Plonczynski (2002) assert that health perception has profound effects on a person's lifestyle choices, and whether or not an individual adheres to a prescribed health regimen. However, this does not happen in AA women lives, frequently the health regimen is prescribed by the environment. The assertion made by Wilbur, et al. (2002) is well taken, however, prescribed health regimens for many AA women is dictated by what takes place in home. Few studies have focused on how African American women define or perceive health and how social and cultural factors impact weight status and body size perceptions.

In a recent qualitative study by Befort, Thomas, Daley, Rhode, & Ahluwala (2006) findings were mixed in relation to body size perception and satisfaction. The participants were 62 obese AA women aged 35 to 56 years from a community health clinic. Themes that emerged from the data were: (a) belief that all people can be attractive and healthy at larger sizes, (b) dissatisfaction with current body weight and self-consciousness with body size, (c) eating behaviors were the primary cause of weight gain, (d) the view that pregnancy, motherhood, and care giving as major precursors to weight gain, (e) view health as the most important reason to lose weight, (f) mixed experiences and expectations for social support and weight loss, and (g) prefer treatments that incorporate long term lifestyle changes rather that fad diets and medications. Many of the themes from this study were supported by findings in another study by Blixen et al. (2006) on values and beliefs related to body size that compared perceptions between middle class AA and CA women.

The Blixen, et al. (2006) study supported findings that AAs participants experienced stronger body image in comparison with their CA counterparts. Dissatisfaction with body size was inconsistent with most of the literature review. However, the perception appears to be gaining momentum in the AA community. It must be said though, that these women were on the high end of the weight scale with a BMI of 40.3 ± 9.2 kg/m^2 average. Concerns over health, functional abilities, and the impact of weight on social life as well as poor self image were mirrored by participants in the study by Blixen, et al. (2006). Participants in the latter study were slightly younger and comprised a smaller sample, compared to ones included earlier in this review. The belief that AA women can be attractive at larger sizes is consistent with findings from other studies (Lynch, Chang, Ford, & Ibrahm, 2007).

In another comparative qualitative study, Malpede et al. (2007) explored how race influenced weight-related beliefs of (30 AA and 30 CA) female university students aged 19 years and older. Participants were asked specifically "How does being black/white affect your weight?" For AA women primary themes focused on (a) traditional and cultural food preparation, eating behaviors, and body size ideals; (b) poor food selection and limited access to healthier foods; (c) lack of information and education on healthy eating and body weight maintenance and increased risk for chronic disease with associated medical costs; (d) highly demanding and stressful lifestyles; (e) the influence of genetics. For CA women, more considerations were given to (a) expectations of the perfect body and ideal of thinness; (b) thoughts that success depended on beauty defined

by thinness (yet having a negative body image); (c). sociocultural pressures to be thin and preferences for thin women by male counterparts; (d) different appearance standards for men and other racial groups; (e) having access to health care and health education increased possibilities to be thin; and (f) genetics. Findings in this study demonstrated that deep social and cultural differences do exist between some AA and CA women that require careful consideration when designing weight loss interventions for the two groups as well as the need for further study of this issue.

Thomas, Mosley, Stallings, Nichols-English, and Wagner (2008) examined perceptions of obesity among a group of obese women (17 AA, 13 CA) 21 to 67 years of age. Participants experienced common situations related to being obese, such as cultural influences, poor food choices and low self-esteem. Common barriers were family issues, lack of time, money and environment. African American women voiced several barriers not considered an issue among CA women such as access to exercise facilities and healthy food choices, hair style, and suitable exercise clothing issues. Two themes unique to the AA women provided support for findings reported in other studies over time—that their ideal body size should be larger, and they were satisfied with their existing larger body size. The one unique feature for obese CA women was a desire for support from other individuals experiencing obesity. Differences noted among participants in the above study indicated that social and cultural factors are important, but that similarities are present in the two groups as well.

Most of the previous quantitative studies examined body image, body size

perceptions and attitudes among AA women group, or between AA and CA women. However, an early mixed method study done by Altabe (1998) examining weight-related body image among women (185) and men (150) from several different ethnic groups (AA, Asian American, Caucasian, Hispanic), found that all minority participants reported more positive attitudes toward their bodies when compared to those in the CA group. Participants from both genders and all ethnic groups were all similar in ideal body size, though no actual body size or weight range was provided in the report. African American women reported the most positive overall self body image and size attitude, while CA women had the highest body discrepancy scores. In contrast, Snooks and Hall (2002) explored ethnicity and body size/image attitudes among a 51 middle class AA, CA, and Mexican American women. Although significant differences were found in actual BMI between AA and CA women, no significant difference was found among the three groups in ideal or real body size, body image, and self-esteem scores. Findings should also be viewed with the consideration that AA women in this study were significantly heavier compared to the two other groups, suggesting that a difference still exists in actual body size satisfaction. In addition, similarities in body image among the three groups of women were supported in an earlier study by Fitzgibbons, Blackman, and Avellone (2000) who compared body image among women in a tri-ethnic sample of 231 AA 63 CA, and 95 Hispanics. Comparisons of BMI and body image discrepancy showed no significant difference between the three groups of women.

Cachelin, Rebeck, Chung & Pelayo (2002) also reported findings that did not

support the traditionally held position of AA women desiring, or being more accepting of larger body sizes. The study examined body size and body image preferences among groups of men and women from four different ethnicities (AA, Asian, CA, and Hispanic). The sample population of 1,229 (n= 801) women and (n= 428) men, 17% AA, 23% Asian, 15% CA, and 45% Hispanic, ranged in age from 18 to 83 years (mean age of 24.3 [SD = 8.9]). Nine silhouette figure drawings of men and women were used to assess body ideal discrepancy, which ranged from attractive female and male figures, and acceptable female body size and perception of weight from four different categories (underweight, normal weight, overweight, and obese). While the study sample had significant age, gender and educational differences, the women in the study were younger, had lower BMIs, and were less educated than the other groups in the study. Ethnic differences were also present; Hispanics were less educated, AA had significantly higher BMIs compared to Asians who had lower BMIs. No significant difference was found between the three ethnic groups in acceptable body size. Nonetheless, the most significant finding was that no difference was found among ethnicities for body size preference once age, gender, and education had been controlled. A surprising finding was that while AA women did not prefer larger body sizes for themselves, they did select the heaviest female drawing as the most appealing female to men. European American women chose the thinnest of all the silhouettes. This finding suggests the possibility of ambivalence on this issue among AA women, and that traditionally held beliefs about larger body sizes are in some part present in this particular group.

There is also a perception that AA women are overweight and obese partly because for generations, AA men have preferred heavier women, or are more accepting of larger body sizes (Greenberg & LaPorte, 1996; Hargrove & Keller, 1993; Jackson & McGill, 1996; Kumanyika, 1993; Porter, 2001). Such values of appreciating fuller figures have been shaped by traditional views from within the AA family and community where fuller body sizes were considered physiologically healthy (Bissell, 2002; Webb, Looby, & Fults-McMurtery, 2004). Furham, Petrides, and Constantinides (2005) suggest that men place more emphasis on physical attributes in relation to women than the women did for men, and that physical attraction between men and women has long been influential in how women viewed themselves. Newton (2005) insists that strong cultural values and past life experience over generations still affect the preferences of many AA men today.

Information related to body size preferences among men is small. A few earlier studies have reported findings that African American men demonstrated a preference for women with larger body sizes. For example, a classic, well-referenced, early study by Greenberg and LaPorte (1996) indicated such results. The study examined body type preference in women between a group of AA men (n = 63) and CA men (n =116). Participants ranked women's body size preferences in order of the most desired from a set of nine silhouettes of varying sizes, from underweight to obese. Results showed that CA men preferred significantly smaller female body figures compared to the AA men. Although sample sizes were small, the findings were similar to those from a study by Thompson, Sargent, and Kemper (1996) of 337 CA and 157 AA adolescents. Three

other, more recent studies had similar findings (Bissell, 2002; Webb, et al., 2004; Schippers, 2009).

Recently the idea that AA men prefer women with larger body sizes has been questioned, suggesting the assumption that AA women are because it is more desirable to AA men has little validity. Research findings on this issue have been mixed. Additionally, the argument is that as AA men become more acculturated their preference for women's body size values changes. For example, A dissertation study by Porter, (2001) examined female body size preferences among 196 matched pairs of undergraduate students (n = 388) from Howard University (maintained as an, Historically Black University [HBU]) and the University of Maryland (considered a, Historically White University [HWU]). Results revealed no difference in body size preference for women between the two participants from the HBU and the HWU universities. Surprising to the researchers, men from both HBU and HWU universities scored high on racial identity suggesting that they had retained a high degree of traditional cultural beliefs and attitudes, and the environment of the primarily European American college environment had little influence on the students. However, the similarities in racial identity scores suggest that large differences and similarities exist among AA men even with high levels of traditional cultural values, suggesting that traditionally held beliefs about larger body size preferences among AA men may not be as firmly established in the AA community as previously thought. These findings were supported by results from a similar study by Meshreki and Hansen (2004) and Freedman, Carter, Sbrocco, and Gray

(2004). In the study by Freedman et al. (2004), the sample included AA and CA men in which also compared waist and hip ratio preferences. Although AA men showed no difference in body size preference, they did choose women's figures that were more curvaceous, compared to their CA counterparts.

The review of literature on body size revealed that this is a complex issue among AA women and where conflicting attitudes and beliefs exist. Research studies show that many AA women of all ages and economic levels report preferences or satisfaction with larger body size, though to a lesser degree among those with higher incomes and education levels. The fact that fewer AA women of higher SES either desired or were comfortable at larger sizes could indicate a greater exposure to health information and social pressures to lose weight from the majority population and the media. While many AA women may not desire or be satisfied with a larger body size, the examination of the literature does show that many women experience pressure from within the families and community to remain overweight or obese.

Several studies reported that a high percentage of AAs, women in particular reported underestimation of actual body size compared to CA counterparts. The results may be correlated to another finding, that the standard for normal body size in the nation does not accurately reflect the differences in body structure among AA women compared to the majority population of their CA counterparts. Many of the studies revealed that the higher the level of overweight status or obesity, the greater the degree of underestimation of body size. The latter may indicate that AA women do have different views on weight

status; it may also indicate that the larger the individual become, the less one are able to accurately self-identify with extremes of weight. Thus the person may experience a distortion of what is viewed in the mirror, similar to the mal-adaptive syndromes in anorexic women.

Research findings were mixed on women's body size preferences among AA men. Thus the impetus to remain heavy may still be a factor since AA women primarily date and marry AA men. Several studies indicated that many AA men had preferences for women of normal and smaller sizes. This finding may be an evolving trend that could possible affect the attitudes regarding AA women's weight status. A major concern for this researcher is that overweight status and obesity among AA women is more than a simplistic phenomenon of cultural preferences for larger body sizes, and a complex issue that deserves careful and extensive examination of certain issues that are salient too much of the African American family and community life.

Certain researchers argue that while the larger body size ideals for AAs may in fact be protective measures against eating disorders of "thinness" primarily among CA girls and women, the risks of increased morbidity and mortality associated with larger body sizes has become a critical issue of health. Smith (2006) asserts that "It is critical that research is conducted to determine the degree of influence that identification with the AA culture has on body image, weight management behaviors, and ultimately one's physiological size, or body mass index" (p. 27).

Heredity and Body Size

Heredity is the transmission of characteristics from one generation to the next. It is the process that causes the biological similarity between parents and their offspring. Genetics is the process by which heredity is studied. Genetics has been implicated in large body size among African American women. In several studies, a familial correlation was found in BMI among adults. Twin studies show that these similarities are "attributable mainly to genetic influences rather than to effects of a shared environment" (Schousboe et al., 2004, p. 39). In a study of the impact of environment versus genes on truncal, skin fold thickness, BMI, waist and hip circumferences among adult twins, researchers found a high heritability of all traits, leading to the conclusion that genes, not the environment are largely responsible for many aspects of body size. Hawkins (2007) purports that while there are large increases in obesity among AA adults; the same is also occurring in children and young adults, leading researchers to consider genetic, sociological and physiological factors are responsible for obesity in the group. Genetics revealed that heredity has also been indicated in many obesity-related diseases such as heart disease and diabetes (Katmarzyk, et al., 1999). For example, in a large prospective, cohort study, Lloyd-Jones, et al. (2004) found that premature cardiovascular disease in at least one parent was predictive of future cardiovascular occurrences among their male and female children, independent of other identified risk factors. This suggests a genetic link in the development of heart disease. However, Katmarzyk et al., (1999), suggest that the risk of obesity within families is not wholly due to genetic disposition, but a more

complex situation, where genetic vulnerabilities are enhanced by interactions with environmental and behavioral factors such as poor dietary habits and sedentary lifestyle (Bortz, 2005; DHHS, 2004; Finch & Tanzi, 1997; Sparks & Frazier, 2002).

Another area of genetic research found that some populations who have experienced famine or food scarcity in history developed a "thrifty gene" that stores energy as fat during times of prosperity in order to be ready for another famine (Alleyne & Laport, 2004; Hawkins, 2007). As part of the genome project, studies have discovered a link of leptin (the protein that is highly correlated with total adiposity) levels on chromosome 2 in AAs (Hawkins, 2007). However, the prevalence of this predisposition in the AA population is not currently known (DHHS, 2004). Measurable physiological differences have been noted, which could partly explain the high rate of obesity among African American women. Particularly with the abundance availability of energy-dense foods and low levels of physical activity, the situation leads to a constant battle against excessive weight gain.

Several studies have compared the resting metabolic rates (RMR) between EAW and AAW in relation to larger body sizes and found that the latter group does experience lower levels RMR (Gannon, DiPietro, & Poehlman, 2000; Melby et al., 2000; Weinsier, et al., 2000). In a brief literature review, Luke, Kramer, and Dugas (2007) maintained that there is evidence that AAs may also have lower active energy expenditures in addition to their lower resting metabolic rates, caused by a smaller, highly active, internal organ mass. Never the less, authors concluded that the differences were insufficient to

account for much of the higher rates of obesity among African American women.

Genetic predisposition and differences in metabolic and physiologic processes are only two influential factors of overweight status and obesity. Thus the socialization process among families, groups, ancestral cultural values and beliefs have begun to receive credibility as an important factor in the development of obesity AA women. Baltrus, Lynch, Everson-Rose, Raghunathan, & Kaplan (2005) explored body weight among a large group of AAs and CAs (1,186 men and 1,375 women) ages 17 to 40 over the course of 34 years. The study found that AAs tended to be heavier and gained more weight during adulthood, which placed them at the greatest risk for morbidity and early mortality compared to the CA counterparts. Attitudes related to the ideal body size and cultural differences in body image may have lead CA women and girls to reduce their caloric intake more so than African American women.

Socioeconomic Status and Body Size

Socioeconomic status (SES) generally, measured by combining educational level, income, and occupation, and it represents a family's social and economic position relative to others (American Psychological Association, 2010). Individuals of low SES may be at increased risk for overweight status and obesity due to unhealthy behaviors. According to Everson, Maty, Lynch and Kaplan (2002) "factors ranging from limited availability of affordable nutritious foods in local supermarkets and stress that accompanies uncertainties faced by low SES individuals may contribute to poorer diets and more sedentary lifestyle"(p.891). Their environment fosters the tendency toward obesity and

overweight in AA. There is a lack of physical activity combined with high-calorie, low-cost foods a positive energy balance. Socioeconomic level is a major contributor to weight gain, which suggests that the core issue, may have begun during early life and is a potential contributor to childhood overweight status and obesity. The major implication for SES is that AAs have lower purchasing power and have to buy less healthy food.

Notably, the socioeconomic dimension of obesity has not been a consistent factor, when considering studies of the international level that have spread to all social levels in both underdeveloped and developed countries (McLaren, 2007). Thus, income level is not a consistent predictor of obesity. In certain countries, "a certain body shape/size may have prestige that is not necessarily in keeping with its economic dimensions" (McLaren, 2007, p. 36). However, in the US and among AA women in particular, SES, is an important factor in the development of obesity because income and education (which are primary components of SES) frequently dictate where and how people exist in society. Socioeconomic status more often than not determines the neighborhood where one lives and thereby the quality and type of food availability as well as access and affordability of recreation and physical activity facilities (Do, et al., 2007, 2008; Everson, et al., 2002).

Generally AA have lower educational levels affects purchasing power which limits their ability to provide appropriate foods for their families and afford housing in environmentally sound neighborhoods. Research has also shown a significant relationship between obesity and socioeconomic status among AA women. The tendency toward overweight and obesity in AAs is fostered by our environment. There is a lack of physical

activity combined with high fat, low cost foods result in a positive energy balance. Socioeconomic level is a major contributor to weight gain which suggests that the core issue may have began during early life and is a potential contributor to childhood overweight status and obesity. The major implication for SES is that AAs have lower purchasing power, and have to buy less healthy foods.

Rundle, et al. (2008) investigated the relationship between SES and body size among a large population group in New York City (4610 men and 8492 women). The sample included individuals of AA, Caucasian, Asian, Caribbean, and Hispanic descent. American, Researchers found a significant inverse relationship between SES (as measured by income and education) and body size among the women in the study. Zip code poverty level was also strongly associated with body size. Researchers suggest that a possible explanation for these findings is that individuals with higher incomes have more resources to purchase healthier foods and get more exercise. This study clearly shows the relationship between low SES and conditions that could lead to obesity among AA women. Since AA women tend to be less educated and earn less, they are more vulnerable to the development of obesity (Robert & Reither. 2004). This position is further supported by a meta-analysis conducted by Wang & Beydoun (2007) using a large cross-sectional sample of adults. Data from the Behavioral Risk Factor Surveillance System and National Health and Nutrition Examination Survey (BRFSS NHANES) was used to examine the relationship obesity, ethnicity, and SES Results showed that AA had the highest prevalence of obesity overall, and that 80% of AA women ages 40 years or

above were overweight and more that 50% of the women were obese. Additionally, resulted demonstrated that minority groups and individuals in low SES levels had higher levels of obesity in all age groups.

James, Fowler-Brown, Raghunathan, & Van Hoewyk (2006) conducted a longitudinal study of 1112 AA women, ages 25 to 50 years and examined the relationship of SES, childhood and adult obesity levels. Education, occupation, income levels, and home ownership were used to determine SES levels. Results demonstrated that the odds of being obese were 50% higher among women in low SES compared to those in high SES levels in childhood and 25% higher during adult years. Comparison of women in high-low and low-high levels revealed a 55% greater potential toward obesity. The odds doubled for women in low-low SES levels compared the high SES ones during childhood and adulthood years. Researchers concluded that the cumulative burden of deprivation during critical periods and the risk for long term obesity related to were consistent with previous research findings.

Environment and Body Size

For AA many women, much of the evidence indicates that these factors exert a negative influence where an inverse relationship exists between SES levels and environment and the development of overweight status and obesity (Casagrande, Whitt-Glover, Landcaster, Odoms-Young, & Gary, 2009; Chang, 2006; Do, et al., 2007, 2008; James, et al., 2006; Robert & Reither, 2004). Environmental influences on body size appear to interact with socioeconomic status, since income often dictates in many cases,

geographic location. In a study of neighborhood environment and body size, Boardman, Saint-Ornge, Rogers, & Denney (2005) examined differences in obesity on neighborhood levels using data from the 1990-1994 National Health Interview Survey. Findings indicated that each neighborhood's level of obesity rate demonstrated a strong positive association with a greater risk of higher BMIs on the individual level, leading to the conclusion that individuals are more likely to be obese if they reside in a neighborhood that has a high proportion of obese residents. These findings were supported by a meta-analysis by Do, et al. (2007) which examined research studies on the relationship between BMI, neighborhood, and ethnicity using the NHANES III data from 1988 to 1994. Results demonstrated a significant relationship between neighborhood disadvantage and high BMI levels among. A surprising finding was the lack of significance in the association of BMI and education indices among AA women.

Casagrande, et al. (2009) conducted a literature review on the relationship between the built environment, diet, physical activity and obesity among African Americana. Overall findings suggested that the presence of perceived barriers to physical activity and decreased social support were associated with obesity. Lighter traffic, the presence of sidewalks, and perceived safety were associated with increased physical activity. The presence of supermarkets in neighborhoods was positively associated with meeting fruit and vegetable dietary guidelines. Findings from the review support previously held arguments that environmental factors may be of great importance in the development of overweight status and obesity.

Health Behaviors among African American Women

Health behaviors among African American women have become an area of major concern over recent years as chronic health conditions, premature deaths, overweight and obesity continue to increase in this group. Health behaviors are defined as any action, conscious or otherwise, has an effect on the health of an individual, whether the activity is positive or negative (Orem, 2001). For the purpose of this review, health practices will be considered consistent with health behaviors. The health behavior most directly linked to health status is that of regular physical activity followed by dietary practices, as both directly impact body weight and influence disease burden, premature mortality, and quality of life (DHHS, 2006). National health organizations, health professionals and scholars from other related areas have generally agreed that health behaviors greatly impact the health of the nation (CDC, 2006, DHHS, 2006). The American Heart Association (2009) and the Department of Health and Human Services (2006) reported that actively participating in certain positive health behaviors decreases morbidity and mortality, including those related to obesity and overweight status. The data from these three institutions show that 59% of Americans are sedentary, with the highest percentages being AAs at approximately 16% nationally.

To understand health behaviors of African American women, one must carefully study their history; as mentioned before in this literature review. This group for many generations has a long well-documented history of discrimination, poverty, poor social skills and low levels of education, low income and inadequate healthcare. According to

Johnson, et al., (1995) health behaviors, often viewed as a matter of personal choice, are the primary determinants of disease development. However, the many benefits of sustained regular physical activity and diets low in fat and salt is a luxury that many AA women could not cannot afford, hence under difficult conditions they fed themselves and their families with what was available to them which demonstrates that these habits were passed down through generations due to uncontrollable circumstances within the AA family. This is supported by Whitt et al. (2003) who suggests that the low levels of physical activity among African American women tend to begin "early in life and continue throughout adulthood" (p.1887), suggesting that behavioral patterns begin in childhood and adolescence may become lifetime habits. Massie (2002) examined the relationship between physical activity during childhood and adolescence and current levels among a randomly selected multi-ethnic group of 419 adults from a large Midwestern alumni database. Results of the study indicated that a significant correlation exists between childhood and adolescence physical activity and adult physical activity levels, suggesting an early environmental, familial and cultural link to adult physical activity.

Although risk factors for the development of chronic health disorders and premature death exist for AA women, the focus has been directed toward modifiable risk factors, especially for many minority populations, in efforts to decrease the widening health disparities gap. The need for risk-factor reduction remains uppermost for African American women. However, primary, barriers to modification of health behaviors in

African American women remains low educational levels and low income. Braveman (2009) reported that AAs have extremely low educational attainment levels and income compared to Caucasian Americans. This has been a consistent trend over decades (US Census Bureau, 2008). The US Census Bureau (2008) further revealed that mean earnings for AA women are much lower than both male and female CAs and AA men with the same levels of education across degrees earned.

Physical activity and diet are the primary factors in the development of obesity and major influences on health status. Data from the BRFSS were examined related to self-reported health behaviors (Lewis & Green, 2000).The findings indicated that AAs have not been successful in changing overall health behaviors. Along with health status, health behaviors are reportedly influenced by a number of factors. Low levels of physical activity and dietary habits have consistently been associated with poorer health status and increased body weight, overweight status and obesity (CDC, 2006; DHHS, 2006, 2008; Mora, Lee, Buring, & Ridker, 2006). Since obesity overweight is considered to primarily stem from an imbalance between food intake and energy expenditure, activity among AA women has become a problem of great concern (Whitt et al., 2003). A longstanding problem has been the inability of the health care community to identify, develop, and implement policies and strategies to increase individual physical activity and affect a positive change in dietary habits among AA women.

The many benefits of sustained regular physical activity have been investigated and supported in a number of laboratory and epidemiologic studies, and documented by

national health organizations (Gretebeck, 2003; Grzywacz & Keyes, 2004). Regular physical activity has been shown to help prevent cardiovascular disease, hypertension, type 2 diabetes, obesity, and osteoporosis, and decrease mortality (DHHS, 2004). Regular physical exercise has also been positively associated with psychological health (Wise, Adams-Campbell, Palmer, & Rosenberg, 2006). Even at modest activity levels of activity, walking and bicycling as little as 30 minutes a day four or five times a week, for instance, have proven to be beneficial (DHHS, 2006). Hawkins (2007) relates that although physical activity has also been linked to improved metabolism and good cholesterol, 68% of AA women reported less than 20 minutes of leisure-time physical activity per week.

Recent studies have also reported results that cultural and health beliefs directly impact health behavior (Annunziato et al., 2007; Barnes et al., 2007; Davis, Clark, Carrese, Gary, & Cooper, 2005; Drayton-Brooks & White, 2004; Dutton, Martin, Welsh, & Brantley, 2007; Farmer, Reddick, Agosyino, & Jackson, 2007; Guilfoyle, Franko, & Gorin, 2007; Koch, 2002; Lynch et al., 2007). A number of studies have indicated that in general "African American women reported less health-promoting behaviors overall" including less "self-actualization, exercise and nutrition" activities as compared to other groups " (Drayton-Brooks & White, 2004, p. 85). Other studies have found that AA women are less likely to exercise, quit smoking, lose weight, and have a mammogram to test for breast cancer" (Drayton-Brooks & White, p. 85).

Several qualitative studies conducted over recent years indicate that many AAs

still hold to beliefs, attitudes, and practices passed down through generations. In a dissertation study, Combs-Jones (2004) explored the social and cultural meanings of life situations related to health, health behaviors and aging among 27 AA women ages 36 to 74 years. Key findings of the study were: (a) eating and diet were connected to culture and that food played a central role in day to day life through eating and sharing, (b), Images of self which included a tolerance for overweight, (c) different standards for weight that was related to self-image, and their own standards for body weight (d) the stress of racism and discrimination which occurred outside of their segregated communities and the resultant health-related effects accumulated over time (e) barriers in access to healthcare and the persistent disparate treatment of AAs, and (f) the role of spirituality in conception of health and illness and coping with stresses of daily life. These results illuminate the complex issues AA women face in daily life situations; and how those situations exact an effect on the health and eating behaviors of the women in this study.

In a qualitative ethnographic study, Liburd (2003) explored historical and cultural perspectives on food among 23 overweight and obese AA men and women with type 2 diabetes. Thematic categories that emerged related to: (a) food preparation and consumption, (b) symbolic meanings of food such as "wealth", (c) preparation of food as an artistic performance, and (d) communication of acceptance, friendship, and community through food. Findings also yielded themes on the historical perspectives of food and the eating ritual within the AA culture: (a) food in the AA female identity, (b)

food and the AA ethnic identity, and (c) food in the relationship of AA women. These findings demonstrate that AAs have a unique relationship with food which influences lifestyles choices, health behaviors, and more frequently than not, body size and health status.

Research on how life situations or factors influence physical activity behaviors among AA women is limited. This is an important area to consider because of the unique life circumstances in the lives of AA women. Four qualitative studies (Richter, Wilcox, & Greaney, 2002; Sanderson, Littleton, & Pulley, 2002; Wilbur, et al 2002; Young, He, Harris, & Mabry, 2002) were found that were conducted in several locations within the US among AA women from rural and urban areas and ranged in ages 20 to 50 years. Focus groups were conducted with two to nine women in each group. Sample sizes ranged from 39 to 50 participants in each study. Results from these studies indicated that the women identified both social and physical environmental issues, cultural and policy factors as influences on activity behaviors. Social issues related to limited resources, affordability, and family roles and responsibilities which required them to place themselves last, and by the end of the day, they had little energy or desire left to exercise. Family and communities responsibilities were identified as significant barriers to engaging in physical activity. Environmental issues related to a lack of safe areas to walk and limited access to exercise facilities in their residential areas. The major cultural factors for decreased physical activity were that exercising was seen as a part of the Caucasian culture and the acceptance of larger body sizes within the AA culture. The

most salient point in the finding from these studies is the similarities in the factors identified as important influences on the ability or potential for these women to engage in physical activity. These findings support the contention that AA women encounter unique and different circumstances which influence their health behaviors coupled with long standing cultural beliefs and attitudes.

Yarcheski, Mahon, Yarcheski, and Cannella (2004) conducted a meta-analysis on the predictors of positive health behaviors. Results of the study demonstrated a strong negative effect for loneliness and a moderate negative effect for stress. Perceived health status, social support, and future time orientation had moderate positive effects. For African American women, loneliness may be a concern since a high number of AA women are living in single households. Social support and future time orientation are extremely important as predictors since many AA women may have less social support than in past generations due to the disintegration of the AA family and weaker support systems.

According to Beech et al. (2004) lifestyle and health behaviors related to diet, exercise, and body image are influenced by the culture of the mainstream environment and that of specific ethnic groups which may differ greatly. Studies were also found that indicate other factors also influence the participation, or lack thereof, in health positive behaviors. The principal influences noted could be classified as those of a sociocultural nature. For AA women, social factors primarily relate to SES, environment, spirituality, and cultural attitudes and beliefs.

Kumanyika et al. (2005), posits "…food intake and physical activity are profoundly influenced by situational, socioeconomic, and cultural variables" (p. 2038). The researchers also convey that "There are gaps in our understanding of what it might take to foster major changes in the weight-related eating and activity profiles of AAs, especially regarding economic and social contexts" (2005, p., 2042). Hartley (1961) supposed that psychologically, behavior is determined by three primary forces, the drive to satisfy one's needs, the individual's view of the world, and what the person has learned. The information can only be obtained from the persons of concern, AA women. Major gaps remain in the understanding of how certain sociocultural factors influence diet and exercise (Shaw, O'Rourke, Del Mar, & Kenardy, 2009).

Summary

This chapter focuses on the literature review related to cultural influences on beliefs and attitudes related to perceptions of health, body size and health behaviors among AA women, undertaken to identify gaps in knowledge in this area. While valuable insight about certain factors influence the health status, the high incidence of overweight and obesity, and the ability, or lack thereof, of AA women to practice positive health behaviors, little information is available on the unique experiences of the women and how those experiences influence the way they view health, body size and health behaviors. Considering the high prevalence of overweight and obesity among AA women and the increasing incidence of chronic health conditions with its associated premature

death rates among AA women, there is a need to identify and develop measures which will assist in combating this problem.

The literature clearly documents that over time certain factors strongly influences the lives of AA women and their existence in the world in which they live. Certain factors unique to the AA experience, which dates back to slavery, continue to impact the lives of AA women. This literature review visibly demonstrates that cultural factors passed down through generation, in a number of ways influence the manner in which AA women view themselves, their health, and certain behaviors, including those related to health. Failure of the health care community to address the problems of declining health status and increasing levels of obesity is partly related to a lack of understanding of the unique experiences of the AA woman, and the inability to address the culture care needs of this group. Leininger and McFarland (2002) contend that health care policies and practices will be unsuccessful unless the cultural beliefs, values, and practices of the receiver of care are known and used. Thus life experiences and perceptions of those events are of extreme importance because they influence attitudes and beliefs, which underlie positive and negative health behaviors. The review demonstrates that information related to cultural beliefs and attitudes of AA women relates to perceptions of health, body size, and health behaviors are essential.

The literature review also demonstrates a critical need for information on how certain cultural beliefs and attitudes influence the perceptions of AA women with regard to health body size and health behaviors. A few studies were found which the perceptions

of AAs related to health. However, to the researcher's knowledge, no study has explored the influence of cultural beliefs and attitudes related perception of health, body size, and health behaviors among AA women. Results from this study may provide information that can be used, in the development of hypothesis, and testing and contribute to the understanding by health professionals with regard to the unique experiences of AA women, which may be helpful in the daily interactions with this group.

CHAPTER III

PROCEDURE FOR DATA COLLECTION

A qualitative phenomenological approach was used to explore and describe the lived experience of AA women in relation to how cultural attitudes and beliefs influence perceptions of health, health practices and body size. The qualitative phenomenological method is particularly well-suited for this study because the approach is directed toward exploring the human experience, which is "...a central concern of nursing science" (Lobiondo-Woods & Haber, 1994, p. 258). In phenomenology, the presumption is that each dimension of a person's history, including past experiences, exists in the present (Husserl, 1982; Lobiondo-Woods & Haber, 1994). Parse (1999) contends that knowledge about human experiences is drawn from personal descriptions of experiences provided by the individual. This study will cover four life stages of participants (childhood, adolescence, young adulthood, and middle adilthood) to uncover the essential structures related to cultural beliefs and attitudes and how those beliefs and attitudes impact certain perceptions of each individual.

The phenomenological method applied in this study was first developed by Husserl (1859-1938) and further refined by Giorgi (1985). Husserl attempted to design a method of viewing human beings and their life-world context in order to identify the essential uniqueness of the human world (Husserl, 1977, 1982; McPhail, 1995). Giorgi

(1997) asserts that Husserl's descriptive method of inquiry requires the researcher to pursue the most invariant descriptive end using the process of reduction. The descriptive method, offers a clear-cut progression of inquiry, which provides structure to the critical process of analysis (Whiting, 2001). Like Husserl, Giorgi's method seeks to discover essential themes of a phenomenon as experienced by the person. Themes need not necessarily be repetitive to remain crucial to the individual's experience (Giorgi, 1985; Rose, Beeby, & Parker, 1995).

Nursing has used the phenomenological method to guide research over the past two decades (Parse, 1999; Polifroni & Welch, 1999). Giorgi (2000) contends that the phenomenological approach provides scientific guidelines for nursing research. The key to appropriate application of the phenomenological method is to use the language specific to the discipline in question. The researcher must employ sensitivity to the phenomena under study and proceed with an acute level of vigilance toward the perspective of the particular area of study (Giorgi, 1997).

Nursing, as a practice discipline and a human science, exists to meet health care needs of individuals who experience or have the potential to experience health care problems (Meleis, 1991). In order to meet the health care needs of clients, nurses must have an awareness of the client's perspective. As a human science, nursing is concerned with gaining an understanding of a person's perception of experiences as they are lived by the individual. (Giorgi, 1997; Meleis, 1991). Munhall (2001) and Macnee (2004) contend that qualitative research is important to knowledge aquisition and theory

development in nursing. Parse purports that "the understandings gained from research expand the knowledge that nurses use in practice" (Parse, 1999, p. 1384). Further, Macnee (2004) relates that the hallmark of a professional nurse is keeping abreast of current research, and using those research findings in practice.

Exploring personal experiences of individuals is essential because valuable information may be gained that could impact how nursing care is designed (Price, 2003). Rose, et al. (1995) emphasize that both nursing and phenomenology utilize observation, interviewing, and interaction to explore and acquire an appreciation of a person's perception of certain experiences. Arnold and Boggs (1999) contend that having clients tell their stories allows the nurse to acquire an understanding of the cultural context of an individual's health care needs. Employing the phenomenological method to uncover the essence of culturally related experiences of individuals permits the expansion of nursing knowledge without the use of prescriptive quantitative methodology (Parse, Coyne, & Smith, 1985).

The purpose of this study is to describe the lived experiences and the meaning of cultural influences on the perception of health in African American women and the reflective disclosure of health practices on body size in relation to obesity and overweight in this population. The approach is a phenomenological one conducted through semi-structured, face-to-face interviews of the experiences of these women over four life stages in reference to perception of health, health practices, and body size. The process focuses on four life stages beginning with childhood through adolescence followed by the

young adulthood, middle adulthood, and the final section of the interview includes the present stage of life.

Setting

The study will take place in a large southwestern city in the United States. Locations and times of written interviews and audio recordings will be agreed upon by the participants, according to their availibility and level of comfort. To ensure privacy, the interviews will be conducted in a secure area to minimize disruption and minimize distortions of audio recordings.

Participants

The target population for the study consisted of overweight or obese African American women between the ages of 35 and 54 who were born and raised in the United States. The study sample was drawn from the target population. Participants were recruited through advertisement from a home health agency, a local church, and a physician's office. Flyers were posted at strategic places within these locations and snowball sampling was also employed to enhance recruitment of participants (Appendix E).

Purposive, snowball sampling was used in the study, to enable the investigator to select participants having characteristics of the phenomenon of interest. Randomization of subjects was not indicated since the sample was drawn from a population group that is living the experience of the phenomenon. According to Denzin (1978), any participant belonging to a specific group is viewed as representing the entire group. Criteria for

determining sample size of the study are: (a) the purpose of the research; (b) availability of resources; (c) reasonable coverage of the phenomenon of interest and, (d) data saturation.

A sample of 6 to10 participants is generally considered acceptable to obtain adequate coverage for a phenomenological study or until data saturation is reached (Munhall, 2001; Patton, 1990; Polit & Beck, 2004; Speziale & Carpenter, 2003). Eight participants were interviewed for this study. As the focus of this study was African American women who are overweight or obese, persons designated as being of normal weight for height or underweight were excluded as well as individuals of non-African lineage. The cultural influences of the women of non-African descent may be very different due to differences in cultural heritage and backgrounds and socialization processes within and among family groups. Women of African descent who were not born in the United States were also excluded from the study for the same reason.

Protection of Human Subjects

To ensure protection of human subjects who agreed to participate,study approval was obtained from the Texas Womans' Institutional Review Board prior to data collection; The guidelines of the Institutional Review Board at Texas Woman's University were followed .Participants were asked to give consent to participate in the study and for audio recording of the interview prior to initiation of the interview.

Participants in the study were informed of the general nature of the study and the approximate amount of time required for each interview. Potential benefits were also

explainedand risks as a result of participating in the study were stated on the consent form and reviewed with each participant To reduce the risk of loss of confidentiality, code numbers were used on the Demographic Data Form and questionnaire. Demographic data has been reported in the aggregate to maintain confidentiality.

The researcher maintained a separate list identifying the participant's names with the code numbers. The list and dates are in a locked file in the researcher's home and will remain for a specified number of years and then disposed of in an appropriate manner. Participants were advised that there is no payment for agreeing to be in the study however, each received a $25.00 Wal-mart gift card for participating in the study. Participants were informed that selected quotes or passages will be used for the purposes of professional presentations and/or publications. Nonetheless, no information that can identify them will appear in the text of any publication. Participants were also informed at the beginning of the interview that they had the right to withdraw from the study at any time without penalty or loss once the interview began.

Instruments

An instrument was designed for interview to reflect four life stages: (a) childhood; (b) adolescence; (c) young adulthood; (d) middle adulthood (Appendix C). A demographic Data Sheet will include weight and height (which was used to calculate body mass index), work status, income, and age (Appendix A). The instrument was evaluated for content, completeness, and consistency by six fellow graduate students and two experienced doctorally prepared nurse educators researchers.

An interview guide was also developed by the researcher to provide consistency of the interview process (Appendix D). The guide assisted the researcher to follow a specific protocol during the interview process. An instruction form was developed for the participants, to provide information about the study, the variables under study, and the interview proces (Appendix B). The instruction sheet provided definitions of terms which may have been unfamiliar to the study participants and ensured that each participant received the same information about the interview and the variables under study; and provided a more consistent exchange of information during the interview process.

Data Collection Procedures

The written instruction sheet was reviewed with each participant providing general information about the interview process; definitions of health, health practices and body size. A consent form was signed before initiation of the interview, and demographic data were collected (Appendix F). One 60-minute interview was conducted with each participant. The interview proceeded from the participant's earliest memory of childhood through adolescence, young adulthood, and middle adulthood. All interviews were audio recorded. Interviews were transcribed by a professional transcription service.

Pilot Study

A pilot study of the methodology and instrument was completed during the summer of 2004 using a convenience sample of four African American women. The purpose of the pilot study was to evaluate and refine the study protocol and interview process. Additionally, the pilot study provided the researcher with the opportunity to

improve the accuracy of data collection and minimize loss of time and resources. The pilot study offered the opportunity to conduct a more trustworthy and valuable study.

During review and analysis of the pilot study data, the following themes emerged: deprivation, resignation, and resilience.

Deprivation is defined for the purposes of the final version of the study as withholding or taking something away from an individual, removal of some dignity (Mish, 1984). Words that share the same or similar meaning are strip, despoil, divest. Examples of supportive participant statements are:

> "Well you know what? I wondered at that age how come we didn't know a family doctor...but I don't think we ever had one".
>
> "There are so many of us that do not have health insurance that stop us from seeking medical attention."
>
> "Financially that's another thing, you don't always have enough money...to buy Splenda or Nutra sweet or Sweet and Low.. The soymilk is high (expensive) or those of us in menopause."

Resolve is defined as to separate oneself from something (Mish, 1984). Words that share the same or similar meaning are, resign, adapt, and reconcile. Participants' supporting statements are:

> "I know I will never be a small person because of my medication [She is an asthmatic who during flare-ups takes prednisone. One side effect of the drug is increased appetite], so I have learned throughout my life to deal with that."

"I have accepted this plight. I just don't ever think of being a thin person."

"I was always comfortable with my size because that's all I knew."

Resilience is defined as an ability to recover from or adjust easily to misfortune or change (Mish, 1984). Words that share the same or similar meaning as resilience are rebounding, hardy, and adaptable. A participant response follows:

"She was an old lady that could go outside in the winter time and wash her hair and never had a cold. I think that she felt like she was indestructible. She was the toughest woman I knew."

Areas of weakness were identified by the results of the pilot study. Measures to strenthen the study are as follows :

Maintaining a journal will provide additional data which hopefully could support the participants responses and add to the richness of the process.

An instruction sheet has been developed for use before and during the interview process to decrease the potential for misinterpretation of the meaning of the variables and important concepts in the study, such as culture. Notetaking during interviews will be more detailed.

The participant's non-verbal behavior will be observed more closely and assessed for consistency between the participant's verbal responses and non-verbal behavior.

Limitations of the pilot study were the small sample size which included four participants (the recommended number of participants for the study was six to 10 participants). In addition, marital status, the weight or body size of the participants, and

income level decreased the potential of finding more diverse experiences.

Treatment of Data

Descriptive statistics were used to summarize the demographic data (statistical means and ranges). Income has been presented in median and ranges for comparison. Height and weight were used to compute the body mass index. The BMIs were evaluated by descriptive statistics. The procedure used for qualitative data analysis, as outlined by Giorgi (1985) employed for purposes of this study. They are as follows:

1. *Read the entire description of the experience to get a sense of the whole.*
2. *Reread the description.*
3. *Identify the transition constituents of the experience.*
4. *Clarify and elaborate on the meaning by relating constituents to each other and to the whole.*
5. *Reflect on the constituents in the concrete language of the participant.*
6. *Transform concrete language into the language or concepts of science.*
7. *Integrate and synthesize the insight into a structure describing the meaning of the experience.*

Data analysis proceeded as outlined above through a step-by-step process and methodical analysis of specific statements and identification of themes. Bracketing was used to help the researcher identify presuppositions and suspend her own experiences. Specific, objective data was identified and included from the participants' raw data to support findings. Confirmation of transcribed data and the implied meanings were

clarified with participants during the data analysis process to support the data.

The method used to guide data analysis requires that the initial phase commence with the bracketing and reduction of any previous experience and ideas concerning cultural beliefs and attitudes of AA women that the researcher has knowledge of or awareness. Once the presuppositions of the researcher were identified and bracketed, the second stage of data analysis began.

During phase two of the process, the seven-step procedure delineated by Giorgi (1985), the researcher followed a deliberate course which directed the researcher to initially become familiar with the data by reading and rereading the material to gain a sense of the total lived experience.

The next step in the process,dealt with identification of transition units or "constituents.". Key constituents were compared and clarified in light of the concrete language of the participants. In the final step of the process, the phrases were transformed into the concrete language and structure of the participants which communicated the whole of the experience. A logical progression of continued discovery where intimate involvement, described as immersion (Parse, 1991) with the data occured. During the next phase, the procedure required reflection on the data in the context of the participants specific wording of phrases or statements. Lastly the process proceeded to describing the essence of the phenomena by creating and incorporating structural units of meaning.

Trustworthiness and Threats to Validity

Since the researcher acted as the instrument of data collection, full disclosure of

relevant information and researcher qualifications were provided to each participant to ensure credibility of data. Transcribed data was confirmed with six particpants of the study. An external reviewer of the tapes and transcribed data was employed to support dependability of the research process. To address objectivity and neutrality of data, an inquiry audit of taped interviews and transcribed data was also conducted.

Summary

The empirical literature documents the paucity of studies that have examined the cultural beliefs and attitudes of African American women related to health, health practices and body size. A qualitative, phenomenological study method was used to describe the lived experience and the meaning of perceptions of health, health practices, and body size in relation to cultural beliefs and attitudes of African American women. A one-hour, face-to-face, semi-structured interview was conducted with eight African American women, ages 39 to 54 years. Data was analyzed using Giorgio's seven-step process to uncover themes and will be presented in the data analysis in Chapter four. The data will represent the essences of the "lived experience" as told by the participants.

CHAPTER IV

ANALYSIS OF DATA

This chapter details the finding of this phenomenological study, which explored the lived experiences of cultural beliefs and attitudes related to the perception of health, body size, and health behaviors in AA women. The sample consisted of eight overweight and obese African American women ages 39 to 54 years. In analysis according to Husserl, the first and best known is the *epoché* or "suspension" that he describes in *ideas* in which the phenomenologist "brackets" all questions of truth or reality and simply describes the contents of consciousness. Intentionality is accomplished by consciously directing the one's thoughts toward an object, in this case, the phenomena of interest, and focusing on the essential features, the meanings of the experience as told by participants (Priest, 2002). Thus, Husserl (1982) refers to a notion of "intuition" that differs from and is more specialized than the ordinary notion of "experience," but intuitions that are eidetic, marked by extraordinarily detailed and vivid recall of visual images that we recognize as meanings and necessary truths in them (reflective) and not merely the contingent things of the natural world (pre-reflective).

Using the phenomenological approach, this study questions "What is the essential structure of the lived experience of influences of cultural attitudes and beliefs related to perceptions of health, body size and health behaviors among overweight and obese

African American women ages 35 – 54"? Eight women participated in an open-ended, audiotape-recorded interview, describing their subjective experiences of being overweight/obese. The descriptions were analyzed by phenomenology. Significant statements were extracted, meanings formulated, and themes identified. Eleven theme clusters in four categories emerged from which an essential structure was derived. Themes extracted from in depth content analysis represents in totality of the shared experiences lived by these women over four life stages, beginning with their earliest memories in childhood (pre-reflective) throughout adolescence and young adulthood, up to their current phase in life - middle adulthood (reflective). During data analysis, several themes were uncovered, which illuminated each of the three areas explored. This chapter includes a description of the sample and findings from extensive in-depth analysis of the data, using the approach developed by Giorgi (1985). Themes were organized according to the areas explored and presented accordingly with the exception of one universal theme that involves all three components of the study.

Description of Sample

Descriptive information on the participants was obtained from data collected via a Demographic form designed by the investigator prior to the initiation of the interview. This information is presented in Table 1. Eight AA women from a major Southwestern city in the United States participated in the study. Ages of the women ranged from 39 to 54 years, with an average age of 47 years. Three of the women were overweight and five women were obese, with BMIs ranging from 26.0 to 52.0 (average BMI was 37.2). Five

of the women were single, two were divorced, and one was married. Educational levels varied from one participant with a high school diploma to two participants post master's degrees with an average of 16 years of education. Seven participants worked full time and one was unemployed, but currently in a job-training program. A wide distribution of income was noted, which ranged in intervals from $5,000 – 20,000 level to the 70,000 – 80,000 with five of the eight women earning greater than 50,000 per year.

Family life situations during childhood and adolescence were complex for a number of the women in the study. One participant spent a good part of her late childhood and early adolescence in foster care. Two other participants were raised in urban areas of other states and moved to the city of investigation as adults. Three participants grew up in the rural nearby areas, and two participants were raised in the city. Most of the women were from households with two parental figures and only one of the eight women was raised in single-parent home. A summary of demographic data participant is included in the table that follows.

Table 1: Participant Demographic Characteristics

Participant	Age	BMI	Marital Status	Income -Thousand	Education Years	Employment
P010	51	28.3	Divorced	$40,000 50,000	16	Full Time
P011	39	29.8	Single	$ 5,000 20,000	12	Unemployed
P012	39	50.2	Single	$30,000 – 40,000	13	Full Time
P013	46	37.8	Divorced	$60,000 70,000	17	Full Time
P014	52	52.0	Single	$70,000 80,000	16	Full Time
P015	53	26.0	Single	$40,000 – 50,000	15	Full Time
P016	43	45.5	Married	$70,000 – 80,000	18	Full Time
P017	54	27.8	Single	$70,000 – 80,000	21	Full Time
Mean	47.1	37.2	___	$48,000 – 59,000	16	___
Range	39 - 54	26- 52	___	___	12-21	

Findings

Data analysis of the collective experiences of the women in this descriptive phenomenological study yielded one mega theme and ten major themes. Food emerged as a universal theme that was a constant thread that dominated much of the life experiences of the women in this study. They viewed health as how you look and feel; Knowledge deficit, and awareness of health emerged as the essence of participant's experiences related to the perception of health; Self satisfaction with physical appearance and the preferences of AA men toward large size women (like women with meat on their bones), were the themes derived from perceptions of body size. Finally, five themes were extracted from the data related to health behaviors; cared for, guided, supported; disassociation; struggle to regain balance; reliance on traditional cultural practices and mistrust.

Table 2: Table of Themes

CATEGORIES AND THEMES	
CATEGORY	THEME
1. Universal Food	Food as an integral part of life.
2. Perception of Health	Health is how you look and feel. Knowledge deficit of health. Awareness of health needs.
3. Perception of Body Size	Self-perception of physical appearance Size Preference - African American men prefer larger, more curvaceous women
4. Perception of Health Behaviors	Care provided, guided, and supported by parental figure while at home. Disassociation – loss of control of learned health habits. Struggle to regain balance of health behaviors Reliance on traditional cultural health practices Mistrust of the healthcare system

Category 1: Food the Universal Theme

Food as an Integral Part of Life

Food is an integral part in all facets of life among the women in this study represented a variety of functions and symbolic meanings, which extended across the variable explored and throughout the life stages of the women in the study. It is truly the center of entertainment within the family. Experiences with food were some of the first memories recalled by participants during the interview. It was used as a preventative measure against illness. Participants recalled meals being prepared "from scratch" which was considered in its purest state when grown and prepared in the home environment, or

purchased from organic food markets. Eating well or healthy was viewed as health prevention. Certain foods were considered taboo and thus, harmful to health. For example, food cooked with tomato sauce was associated d with a woman's monthly biologic process. The types and amount of food consumed was recognized as a contributor to gaining excess weight.

Food was also used as a source of comfort to help in dealing with stressful situations and life events such as loss of loved ones. Participants recalled events where they and/or other family members engaged in emotional eating. For some of the women, limited resources during childhood meant food scarcity and limited choices, thus the expense of eating healthy food was perceived as a barrier to weight loss throughout the lifespan which impacted the lives of some of the women in this study. The traditional high fat meals consumed such as fried foods, were symbols of cultural practices passed down through generations. Food was relational as well as social and symbolic of celebrations and family rituals. Every event was built around certain meals. Because of these cultural and social practices, food was definitely a barrier to weight loss. In addition, limited financial resources meant healthy foods were more expensive, and therefore, eating less nutritious and higher calorie foods was the norm. Supportive statements of the subthemes include:

Food as health prevention. "I guess they just fed you like hell - so if you were kind of fat-- they were convinced that that it would stop you from getting sick" (Gabby).

I eat healthy. Ninety percent of my meals that I eat I prepare myself. I'm not a big meat eater. The meat that I do buy is from a farm. I don't eat chickens unless they are farm raised. A lot of vegetables; we eat more vegetables than we do meat. I don't eat anything white. I eat brown rice and use brown sugar, and we eat red potatoes. So I have changed a lot and acquired a lot of my mother's ways (Ann).

Food as a symbol of cultural beliefs and taboo. My dad was from Louisiana, so he didn't like anything that was red, [it reminded him of a certain monthly time in a woman's life] so my mother really had to cook two dishes. If it was goulash, we would have plain goulash and then we had red goulash. Red indicated tomato sauce, and he did not eat anything with tomato sauce in it (Ivy).

Food choices as contributing to overweight and obesity. "My mother's mother promoted heavy eating. Her table always looked like the table in the movie 'Soul Food'...before she started dieting we had fried chicken and macaroni and cheese and stuff like that versus—baked chicken with salad or baked chicken with rice and salad or something like that" (Gabby).

"My grandfather always got doughnuts from a doughnut place. It was Shipley's back then. But I've got to tell you that in order to eat those doughnuts, we would put butter on them, toast them, and we thought we were in hog heaven" (Ivy).

Food as a source of comfort. "Me, personally-like I said, I am an emotional eater, so if I'm stressed or something is bothering me, then I'll eat junk, probably something sweet, something I'm not supposed to. That would probably be my biggest barrier. If I am under stress, yeah, I'm going to try to eat through my problem. And I think that's been one of my biggest issues from childhood to now" (Dana).

"My momma ate when she was sad--food was a comfort thing. And also food was a big deal for us to gather around. She felt happy when she had a lot of food" (Gabby).

Food deprivation as a symbol of poverty. Well, as a child I ate whatever they cooked 'cause, you know, if you don't eat— if you don't eat it you just go home hungry— go to bed hungry. And we only ate stuff like, well, grits or cereal or toast and stuff like that. And then as I got older we started having, like, meat, rice, a lot of vegetables, and cornbread (Gabby).

During that time of my growing-up era it was to clean your plate, waste not want not. And that's because they grew up in a time where, you know, my grandfather said they carried biscuits in a syrup container or something trying to walk to school (Fay).

But they were also from the Great Depression where food was a hot commodity, and it was very easy for them to be thin because as a matter of fact, they didn't

have any food. But so it was easy for my mom to be thin when she was growing up. There was no other way for her to be (Ann).

Food cost as a barrier to weight loss. I feel like sometimes that losing weight is very expensive because when you cut out that junk, then you know you need to go—well, I want to go to whole foods. I see it like - you don't have to go to whole foods. I would prefer to go to whole foods but that's very expensive. But, you know, it is hard just trying to keep that diet balanced (Fay).

And even though it costs a little bit more money, at the end of the day it is well worth it. But I know some people and their kids are overweight because they can't afford it. Really—they can't. I mean, you can really go and get a whole bunch of junk food for real cheap, but arugula and leafy lettuce and all that stuff is expensive. It's really expensive. And the drinks, the right drinks for you and things like that, those things are expensive. But if you can't afford it, it's hard to tell somebody what to do in their household if they just can't afford it and they have kids...it's more expensive to eat healthier. And with me, because I have diabetes and things like that, they want you to eat healthier, so I found out when I started trying to do better that it costs more money to eat healthier. And I could see why people eat a lot of junk because it's cheaper (Dana).

Food as a celebration, family ritual. We never ate a meal without praying over it. We always prayed for there to always be plentiful food for everyone on the planet and for food to be good. On Thanksgiving our house was an open door. My

father and my mother would cook, and any and everybody who wanted to come by to get a plate of food...Fried chicken—that was a treat, on payday—We couldn't wait for my dad—he got paid every two weeks, and when he got paid, we'd all pile up in the car and we'd go to the store and get a chicken and watch my mom cut it up. You know, I still cannot cut up a chicken today. It's really sad. But we'd have fried chicken on the days that he got paid because it was a big whoop. It was a big deal (Ann).

Food as a symbol of caring and security away from home. I can be exact. I left home in 1974, but I went to a university that also grew everything on the grounds. It was Sam Houston State University. It had an agricultural department, and what they produced there they brought to the different dorms and the cafeteria people cooked. It was mostly Blacks in the cafeteria, and I'm going to tell you, we had some fine food. Homemade doughnuts every morning, grits, bacon, eggs, sausage, cut up fruit fresh. Lunch could be some sort of casserole that they baked, breads were always present and, salads. And then dinner was the same. We had a lot of beef—steak, good steak, chicken, pig, and cow (Ivy).

Food as a symbol of rebellion. Because my sisters considered themselves as having an eating disorder as well, and because my mother wanted them to be thin, they just kept eating. They could control what they were doing and they were would say, "I don't want to be thin. I don't want to be what you want me to be (Ann).

Category 2: Perception of Health

Analysis of data revealed three themes which emerged under the perception of health: health is how you look and feel, knowledge deficit, and awareness.

Health is How You Look and Feel

Although several perceptions of health were given by participants, the notion that health was experienced through how one felt and looked was a consistent recurring theme. Health was perceived as a feeling of emotional and physical wellbeing, where one is able to experience life in good mental and physical functioning. Health status was also considered a visible commodity, which can be determined by characteristics that are revealed through one's appearance. This theme also represents the attitude or belief that how one look is an important factor in determining one's health status in relation to overall health as it relates to body size, which may or may not indicate whether a person is healthy or not. Supportive statements are:

> "My ideas and thoughts as related to health. We should all be in good health. Health is not just what you eat, but it's how you feel and how you look and what your mental abilities are." (Eden)
>
> "Health is a state of being—how you feel, how you look, and what you do… Health to me means waking up every morning feeling good" (Fay).
>
> "It just means that you're in good shape, you feel good. Not just look good but you feel good and you are in good shape, good health. Medically, I mean" (Ivy).
>
> Healthy children just looked like all the kids in my neighborhood. We didn't

know we were unhealthy, so we all thought we were healthy… I looked like, I guess the average young person growing up. I wasn't chubby or anything, so they looked like me---happy, fun-loving, wanting to play, interacting with other children. You really didn't know what a definition of sick was---you would hear parents say, that Johnny is not coming to school today. You kinda say, I guess that means he's not feeling well, but why he's not feeling well, you don't know. And the concept that he's healthy, he's not healthy, at that age you don't know (Fay).

"I was really not concerned with it [health as a teenager]. Yeah. I just was concerned with looking good." (Ann)

Knowledge Deficit Related to Health

Participants experienced a lack of knowledge related to health due to a lack of exposure to the appropriate information. Ackley & Lagwig (1999) defines knowledge deficit as a deficiency or absence of cognitive information concerning a specific subject or topic. Access to health related information was limited in the AA community during the time participants were growing up. Most of the women did not have routine health check-ups, nor did parents or guardians. Participants as children and teenagers lacked the knowledge and information about health, which continued for some into young adulthood. This theme revealed that concepts and the awareness of health were different in early life stages compared to the later ones. Perceptions of health were limited to what was expressed by parents or guardians. Knowledge limitations of parents and guardians influenced participants' thoughts and ideas about health. Supportive statements include:

When you are growing up and nobody is teaching you how to eat healthy, it's like the movie Soul Food. On Sunday, everybody is cooking everything, that's kind of how it was. As we got older, when my grandmother was sick and things like that, that's when they wanted to start talking to you about weight. But then when you're a teenager or in your 20s, it's a little late to kind of try to change somebody's lifestyle when they've lived their whole life one way…as far as when I was growing up, it wasn't. And I actually had this conversation with my mom, and it was like it's a learning process. It wasn't taught to me when I was little. So now I'm learning it for myself as an adult, and the only thing I can do is take that and reflect it on my children because it wasn't taught to me (Dana).

[I] didn't really think a lot about it as a child. You heard the word 'healthy.' I think growing up, in the era that I grew up, you didn't really— I guess knowing what it took to remain healthy or what it took to stay healthy. It wasn't discussed a lot (Fay).

When I was a child, again, back in those times you if you're a little thick, a little stocky, they thought you were really— really a healthy child. That wasn't necessarily true nor was it untrue but that's what— what they believe— if your child was kind of fat and plump, oh yeah, that's a healthy child right there. Today, that's just ignorance (Gabby).

Awareness of Health

Awareness is defined as having a realization, a perception, or knowledge of something through personal experience or exposure to the information (Mish, 1984). There was a process that occurred during the transition into adulthood. This theme reflects the recognition of the need for information about health and the acquisition of knowledge, although with limitations, during primarily young adulthood and the current middle adult stage. For most of the women, health information was not readily available as children and adolescents because of the limited knowledge of parents and guardians and restrictions on access to healthcare. Few of the participants were ever seen by health care providers as children and only as if a pressing health concern arose as young adults. Frequently, the realization of the importance of being healthy was prompted by pregnancy or the occurrence of health problems among themselves, other family members, and friends. Supportive statements are:

> Becoming a young adult, as I started aging, then it became a little more important or you became a little more aware of what was in your family line. Like when you would go to the doctor and maybe filling out a medical history even for your parents or whatever. It finally started clicking, what they mean about the bloodlines or what genetically runs in your family, so it started making some sense... Probably as I started getting a little more mature and reading and, I guess,

> the emphasis on health and how to stay healthy or how to become healthier. I found that just reading and, in general, talking to people made me more aware (Fay).

> I learned that as you got older, that the kinds of food you ate had a lot to do with it. When I was younger, of course I did not care. I ate candy, any kind of fried foods there was, but as I got to be an older adult, I knew that I couldn't do that or I shouldn't do that (Hana).

Category 3: Body Size Perceptions

Analysis of data yielded two major themes in body size: self-satisfaction with physical appearance and African American men prefer larger, more curvaceous women. The two themes reflect the fact that most of the participants in this study had experiences and perceptions that are outside of the generally held opinions of mainstream society. They also suggest that experiences of the majority of the women in the study follow along traditional cultural beliefs and attitudes about women's body size held over generations within the African American culture.

Self Satisfaction with Physical Appearance

The overwhelming majority of participants in the study did not gauge their ideal body size by body weight or traditional size standards such as a specific size of a piece of clothing. Ideal or acceptable body size was judged according to how one looked in their clothing or how physically comfortable the person was. Although several of the women were larger than they desired, only two of the participants ascribed to nationally

recognized body weight standards. The women also cited influences from African American community in the form of role models and popular media. Supportive statements include:

> I don't really try to look at weight. What I look at with me is that I want to be comfortable in my own skin, in the clothes that I wear, not how much I weigh because I can weigh 180 and look like a stunner (laugh). And that's just the truth. To me, like this, these extras (fat rolls around the midriff) that bothers me. So if I don't have these extras but I have these hips; that, could work for me. If I can lose some of these hips, that will work for me. But it's how I fit in my clothes, how my trousers hang on me, how a shirt looks on me. That's what matters to me, not how much I weigh because if my clothes look good on me, I feel good, then it is what it is. I was happy at a size 22-24. I had a little stomach, but it wasn't real big. I had hips, but they were nice, they were curvy, and I was happy with that. I didn't have a desire to be any smaller. So to me weight, it's just how I feel in my clothes. When people say, "Oh, you've lost weight," I don't see it. I never see it. I'll be like, "I did?" That's just kind of how I am. I don't see it. I don't see it in my clothes; I don't look in the mirror and see it. But that's just me (Dana).

> As I get older, you see sometimes gaining weight is not as bad as you think it is, or you see it as a normal form of life because out of high school you put on ten pounds very quickly, college years you put on the pounds. So you tend to kind of

deal with some realities. You also see just because you're a larger size doesn't mean you're just so unhealthy. Or we go through the trends like when we went through things about fat is not as ugly as we thought it was, especially with the Moniques and advertising in the magazines that you don't have to look like that, like with Queen Latifas and them, so you start being kind of influenced by the media also (Hana).

I feel absolutely thin now. I'm overweight, I know. I have been overweight all of my adult life. I have at least carried about 15—I've gone up 20 pounds more than what I—and I don't sweat about it. I really don't. I buy clothes to fit my body, and I keep moving as long as when I go to the doctor, the doctor says I am fine (Ann).

Size Preferences-African American Men Prefer Larger, More Curvaceous Women

The perception that most AA men have preferences for women of larger body sizes than normal, and/or women with fuller body figure types appears to be culturally embedded into the AA way of life. Other descriptions included voluptuous, plump, curvaceous, and big. Shared experiences were primarily related the AA men of a potential or actual partners. However, some of the women recalled situations related to body size preferences or acceptance, which included men in other significant roles such as a parent, other family member, or a friend. This theme was supported by data from six out of the eight women interviewed. Supportive statements include:

I think black men like women that have something that they can hold on to. They don't want them to slip through their fingers. I just think that being voluptuous or whatever is acceptable, being plump is acceptable. If you're too petite, something's got to be wrong with you (Cami).

I think with a woman who has a little bit more weight on her, what the scales consider overweight for size, they don't see that as overweight. They see that if you're a little bit overweight, it's fine by them- then you're considered to be *fine* [emphasis added]...let's say like the boyfriend or boyfriends over time. Since I have always dated black men, black men in my experience have never really complained about having a little bit more weight on us compared to another nationality (Hana).

It depends on what culture you are. I think different cultures have different perceptions of what pretty is and what body type is acceptable or the norm for beauty. So I really think it's what culture you are, because some cultures that think women who are a little thicker are more beautiful, and some cultures think the thinner you are the more beautiful you are. Some like petite women. ..I think African American men really do like hippy [large hips] women. I really do. I know my dad says leggy, but I really do think they're either leg guys or most of them like hips. The majority of them don't like little bone thin women— but some do. You have your norms everywhere, but I don't think so (Eden).

Two of the eight women in the study expressed opposing views. These two

women were the smallest of the group and both expressed going through periods where they were obsessed about gaining weight and actually experienced problems with bulimia. One of the participants suffered with both anorexia nervosa and bulimia since childhood but she currently felt stable and is doing well. It is important to note that both women had one parent who was extremely negative about overweight women. The following statements demonstrate this fact very clearly:

> My parents—my mother instilled the fact that fat is horrible and in order to not be fat you had to eat less and exercise, and that was a part of my mental problem, so that's where it all started. She constantly said, "You have to eat less. You have to eat a lot of fiber. My mother was a very healthy person. But I was the youngest of five girls, and I was the only one that wasn't heavy. I was the only one with an eating disorder...For my mother, she liked Twiggy. Twiggy was a model when I was growing up, and Twiggy was thin—ultrathin—and my mom would say, "Now, that's how you're supposed to look (Ann).
>
> My daddy didn't like no fat woman; He was a very tall and slender man. He did not want to gain weight. He ate but he didn't get big and he was extremely active. My momma had problems with my dad because she got fat on him and he didn't like it... I observed how my dad looked at my mom and I understood that she needed to lose it (the weight). So, that really influenced me to never get too big when I get older... Men, do not want a fat woman. They're so body conscious and they've got a bad attitude and I think they have a bad attitude period. So I would

say today's men or today a man does not want a woman that is overweight - they express that in everything they do (Gabby).

Category 4: Health Behaviors

Five major themes that relate to health behaviors surfaced during the analysis process, which spanned from childhood to the current life stage of middle adulthood. The themes were: (a) care provided, guided, and supported by parental figure while at home, (b) disassociation – loss of control of learned health habits, (c) struggle to regain balance of health behaviors, (d) reliance on traditional home remedies, and (e) mistrust of the American healthcare system. All participants were born between the mid 1950's through the early 1970's where many African American families consisted of two-parent households and most often an extended family (Allen, 1995).

Care Provided and Supported by Parental Figure While at Home

Seven of the eight women in the study grew up in a home environment where there were two parental figures. There was also some support and guidance from one or more extended family members. Most participants recalled that positive child-rearing practices were employed, which included providing balanced meals and guided physical activity to the extent of the knowledge of the parents/guardians. Cultural attitudes and beliefs about family and child rearing practices were passed down as grandparents were often called on act in the role of parents whenever the occasion arose. These women grew up in an era where the family unit was the primary source of love, guidance, and support; supplemented by the extended family and community. Supporting statements include:

> My grandparents were the main caregivers for me… "they were very positive role models. They provided balanced diets, like I said, the extra-curricular activities, books, magazines to read. We always had well-balanced— the only thing, I mean, I liked— I would eat my vegetables because we had a garden so there was always plenty of grains, beans, peas, carrots, whatever grew in that geographical area. We had meat. We had chicken, the basics, chicken, beef, pork, and fish. It was fried, baked, boiled (Fay).

> You could participate in a choir or dance or whatever, but you always had to participate in some athletic activity. So I ran track. They didn't care if you danced or sang or whatever, cheerleader, whatever it was, but you always had to participate in an actual physical sport. So I was on the track team just because I *had* to be on the track team. But I really loved dancing, and I realize I was doing two active things, but they didn't consider dancing activity, so that was different (Eden).

An atypical practice among African Americans at the time these women grew up was the practice of vitamin use. Ann, who was raised in a Northeastern state, recalls that her mother instituted certain preventative behaviors because of information she obtained from a weekly radio broadcast.

> My mom listened to a radio station after she had her first child, and there was a doctor, Carlton Fredericks, that used to come on the airwaves, and he told her that you could change bad health in one generation: and by promoting good eating

habits and supplementing your meals with vitamins, that you can get the ultimate in health for your children and for yourself. And that's what my mother did. We had a regimen of vitamins, we had healthy food, we had to drink a certain amount of water, and this is always while we stayed in her home…My mother used to always cook and prepare a healthy meal …She always made sure that we had vitamins and that we were well taken care of. We always went to the doctor (Ann).

Disassociation – Loss of Control of Learned Health Habits.

Pickett (2006) and Mish (2006) define disassociation as the process of separating or detaching, to break apart. For most of the women, the young adult years were a time to leave home for either college or to establish a life apart from the family of origin. However, participants experienced a loss of control in relation to their lifestyle and health behaviors, once they were away from the safety and security of the home environment and the influence, guidance, and support of parent and the extended family environment. Supportive statements include:

> During your college years, you tend to eat what's cheap, what's available. We used to go down the street where for 25 cents you could get what we called a sweat burger, but it was hamburger, or a hotdog. In between studying, we ate out of stress. The stress of trying to pass tests, comfort food became a good friend: chips, popcorn, soda out of the machine, and of course the sedentary lifestyle (Fay).

My health practices changed at the age of 19. I tried to eat very healthy. I was a model —I was a size 6 then. I stayed at that size for a long time. I was laid off from my job and out of work and dating a guy with an eating problem and I just sat at home and ate. That's when I started to gain weight" (Gabby).

"I guess during my 20s I lived the fast food life, and I'm paying for it right now" (Eden).

"I think that's when my health started to deteriorate - around 27of age. I just kind of let go of everything. And I think for the last ten years—because I'm 39 now—I have been really just struggling" (Cami).

Struggle to Regain Balance and Control of Health Behaviors.

After a period of time, these women recognized the need to change health habits. from primarily young adulthood, where negative health behaviors had resulted in weight gain and the development of chronic disease. For two of the obese participants. this was the point of decision to work toward decreasing their body weight. The women are currently working towards regaining control of their health and health behaviors but encountering some difficulty in achieving their goals. This was the case for all women in the study. Supportive statements include:

It's just like drug abuse. alcoholism: you probably got 12 steps that you need to go through that you fall off. you restart them. So that I don't feel like I'm stealing food or anything. I' m doing things gradually. That seems the work better for me... "It has to be done, when you accept the fact. then you do something about it.

So I am gradually, like I said, I decreased my sodium intake. I am not eating French fries everyday; I am not eating the whole chicken every day. So I limit everything in moderation. I walk at work. I'm just slowly trying to get into a better exercise of diet. But I don't want to call it diet. I guess a better re-teaching of what I need to do to correct and lose some of this weight (Fay).

"For my health habits now are I exercise, I tend to kind of be a little more cognizant of my foods such as cutting out the fried foods and try to increase vegetables. Of course that's always a struggle. I still wrestle with things that I had difficulty with in my childhood, which are sweets. I have decreased the amount of fatty foods because I am starting to see an increase of the high blood pressure, the cholesterol, and the blood sugar levels, so therefore, it's kind of like I'm getting scared because I'm trying to avoid the medications to because I know so many people, as well as family members, who do take those medications (Hana).

[As a middle adult] It's important. It's very, very important. It's just that I've lost control, and I'm grasping to get that back now. I've lost—it's more psychological now. It's like I know that I'm supposed to do certain things, but I'm not doing them, and I feel not helpless, not powerless, but I just really lack the self-discipline to go forward with a health regimen. It's so psychological (Cami).

Reliance on Traditional Cultural Health Practices

The reliance on health practices passed down through generations was common among the families of the women in this study. The reason in part is due to lack of access to traditional western and health care providers. But it is also deeply entrenched were the attitudes and beliefs about self-reliance and help seeking of care from within the extended family, community, and friends. Health prevention was practiced through things such as Cod Liver Oil, laxatives such as Castor oil and Syrup of Black Draught, used for cleansing. Often visiting a doctor or hospital was the last resort when home remedies were ineffective. Experiences revealed that there is still a tendency to rely on long standing concepts of home remedies for health conditions before accessing the health care system. Supportive statements include:

> When we got sick, we always had to have that old-fashioned—old kind of whiskey. It had an "old" on the label. It was a brown bourbon or whiskey—I don't know which one—and you had to take a jigger of that with lemon and honey and boil it on the stove, and then you had to drink it…any breathing problems, sinus, or whatever, that's what you had to have. And then you had to take a bath, and then you put on Vicks—you know that green Vicks in the blue jar—on your hands and your feet and you had to put on socks. And I think after that you just didn't want to be sick anymore, so you got better... before you go to the doctor. I'm going to say this, when I had pneumonia in the 9th grade, the reason we knew I had pneumonia was because we tried all of those things and

they still did not work. And so I had to go to the doctor because my mom was like, "There's something really wrong with you." And so I had to get antibiotics. But I was—what?—13 before I even had antibiotics. So it's not something I just do. This Hispanic lady told us about olive leaf, that you should take to get rid of all that sinus and change of the weather things, so since my 20s maybe whenever change of season comes along, I start taking two olive leaf extracts "if you did get sick they gave you some medicine like Black Draught or something like that; Vicks Formula 44 and Pepto Bismol. We only went to a hospital if we had to. My grandparents did not have access to health care growing up. You went to the midwife to have babies, and if you were sick, you went to some herbalist. They didn't call them that then; they called them a little old lady in the wood. And so I guess we stayed healthy, knowing that we didn't have access to health care. Those were their thoughts, and so they raised all of their children to think like that. And so like I said, when I get sick even today, I put on that Vicks and I'll put on those socks (Eden).

The only cultural practices were Syrup of Black Draught, once a week to clean out the body, a bowel movement. Sometimes, if you were sick, like if you had a fever, but one would go to the doctor also (Fay).

Mistrust in the American Healthcare System

The theme of mistrust developed out of a complex set of issues where participant family members, or the African Americans ethnic group were treated unfavorably by the

healthcare community or were not given due consideration for health concerns. Participants experienced a lack of trust related to the historical maltreatment of African Americans over time or personal situation experiences with the healthcare system. Issues surfaced surrounding decisions about research directed toward problems confronting African Americans; a lack of trust in researchers of different ethnicities; and the failure of those in healthcare to provide necessary information and safe, effect care. Supportive statements are:

> When I was in high school, we studied the Tuskegee experiment, and we talked about a lot of the things that happened to African American people back before we were even looked at as people. I was pretty discouraged and scared and always thought that, I'm not going to give the doctor the upper hand. I would definitely go to an African American doctor before I went to a Caucasian doctor, just believing that the [African American] doctor would not hurt me and his whole race (Ann).
>
> I've been given medications that almost killed me so I started doing strictly preventive care. You really don't trust doctors that much 'because some of them are not that informative. And, you know, you have to read up on your history and stuff and follow the history. I think, this is my opinion, I feel that they don't really care about— in my mind, I'm going to be honest, African Americans. I feel that they just deal with you halfway - enough to get you out, get the check, and that's that. So that's why I do prevention. I've dealt with too many doctors of

different nationalities that, uh-mm, are pretty cold. You know, when I had a hysterectomy they didn't explain anything to me. They just threw me out there and I was, like, *okay*. And then they don't really— I don't feel that you're really being helped so there's a lack of trust with the healthcare system on my part (Gabby).

Summary

The chapter detailed the findings of a phenomenological study describing the lived experiences of influences of cultural beliefs and attitudes related to perceptions of health, body size, and health behaviors in African American women. The sample consisted of eight African American women ages 35 to 54 years of age. Before data collection all participants were given full disclosure of what the study entailed, which included a contact of the person responsible for the guidance of the investigator. Data were collected during a one hour, face-to-face interview with each participant. They were allowed to speak freely about their lived experiences without investigator prompting. Questions were asked only for clarification. A total of ten major themes and one universal theme were extracted from the data. The collective findings represent the subjective experiences of the eight women from childhood to middle adulthood concerning the research variables.

CHAPTER V

DISCUSSION OF FINDINGS

The qualitative research study was used to investigate a phenomenon of interest related to health issues in African American Women. The method of phenomenology was employed to explore influences of cultural attitudes and beliefs related to perceptions of health; body size; and health behaviors among eight over-weight and obese AA women 35 to 54 years of age. The rationale for using a qualitative approach is that the aim of the project is an attempt to make sense of the phenomena through meanings people bring to them. The method uses a naturalistic approach that seeks out understanding the phenomena in specific settings or contexts. Further, the method can be used to better understand any phenomenon about which little is yet known. There are many studies which investigated health issues such as obesity, overweight, health behaviors and the perceptions of health in African American women, but there are very few in the literature with a deep approach of the meaning of these problems and how these issues are intertwined with the very fabric of the lives of these AA women.

Summary

A total of 11 themes were extracted from information obtained from interviews with participants. Four categories of themes emerged (Table 2). The themes were related to the three variables studied and represented different periods of lived experiences for the women from childhood to the current stage (middle adulthood). The shared

experiences of participants revealed cultural attitudes and beliefs acquired over time through socialization deeply influenced how they viewed health, their conceptions of body size and body image values, and the way they practiced health. Results also revealed that social and environment conditions unique to AAs, interacted with cultural influences and resulted in a reality that is different from the dominant population.

Discussion of Findings

Findings from the study resulted in four separate and distinct categories of themes. Category one emerged as a universal theme; food as an integral part of life. The theme was found to have symbolic meanings for the women that began early in life and extended to their current station in life and over the three areas explored. The subthemes which surfaced under category one are: (a) food as health prevention, (b) food as a symbol of cultural beliefs and taboo, (c) food choices as contributing to overweight and obesity, (d) food as a source of comfort, (e) food deprivation as a symbol of poverty, (f) food cost as a barrier to weight loss, (g) food as a celebration and family ritual, (h) food as a symbol of caring away from home, and (i) food as a symbol of rebellion.

Category two, perception of health, produced three themes; health is how you look and feel, knowledge deficit, and awareness of health. The themes illustrated that perceptions of health were culturally related and experiences from childhood influenced current thoughts and ideas about health. In category three, perceptions of body size, two themes emerged which related to body size, self-satisfaction with physical appearance, and that AA men prefer women with larger, more curvaceous body sizes, reflects

traditional cultural beliefs within the AA community, which are passed down over generations. Five themes surfaced under the category four, perception of health behaviors. The first three themes in the fourth and final category, chronicled the process of growing up in an AA family where, for most of the participants, children were loved, valued and cared for, yet with limitations of resources; health knowledge and access to health care. Dissociation followed during young adulthood as the women encountered the stresses that accompanied leaving home and attempting to establish a life outside of the family. The third of five themes related to health behaviors, struggling to regain balance, describes the current stage of life, where long standing habits, life stressors, and situational factors make establishing and maintaining positive health behaviors difficult. The reliance on traditional cultural health practices and a mistrust of the American health care system revealed experiences and perceptions from early childhood and continued to the current life stage unique to AAs which influences current health behaviors. A discussion of each theme category follows.

Category 1: Food As Universal Theme

Food as an Integral Part of Life

Food is a complex phenomenon among AAs because so much of the life itself is wrapped up in food. As a universal theme, food as an integral part of life was a thread that ran across the three areas of perceptions of health, body size, and health behaviors and over the life span of the women. Leininger and Mcfarland (2002) assert that culturally, food has seven universal functions and uses. The seven functions and uses of

food as described by Leininger & McFarland (2002) include: (a) maintenance of body functions and production of energy, (b) establish and maintain social and cultural relationships with relatives, friends, strangers, and others, (c) assess social relationships or personal closeness or distance between people, (d) to cope with emotional stress, conflicts, and traumatic life events, (e) to reward, punish, and influence the behaviors of others, (f) to influence the political and economic status of an individual or group, and (g) access, treat, and prevent illnesses.

The findings derived from the meta-theme of food were consistent with culture care knowledge and practices. The subthemes that emerged represented six of the seven cultural practices and beliefs related to food as described by Leininger and Mcfarland (2002). In addition to the basic use of food for meeting biophysical needs, the women recalled multiple symbolic and functional meanings food held over life experiences which aligned with Leininger theory. The subthemes, food as health prevention and food as a symbol of cultural taboo (avoiding foods believed to be harmful) are representative of the function, to access, treat, and prevent illnesses. Food choices as contributing to overweight and obesity reflect a cultural tradition which is opposite to the above prescribed function, yet descriptive of a contributing factor to the weight status of the women in this study. Third, food as a source of comfort is consistent with the function that food is used to cope with stress, trauma, or conflict. Forth, food deprivation as a symbol of poverty and food cost as a barrier to weight loss are associated with a symbol of political and economic status. Fifth, food as a celebration and family ritual and a

symbol of caring and security away from home aligned with the function of establishing and maintaining relationships. Food as a source of rebellion is reflective of rewards and punishments. The subthemes were also supported by findings from two other qualitative studies (Combs-Jones, 2004; Liburd, 2003). Leininger and McFarland (2002) indicate that although variations in food uses and functions exist among and between cultural groups, food is a universal phenomenon with biological, social, economic, and political characteristics. Knowledge of certain cultural aspects of food places the care providers in. "...a unique position to help clients establish and maintain good health through food uses daily and throughout the life cycle" (Leininger and McFarland, 2002, p. 206)

Category 2: Perception of Health

Health is How You Look and Feel

According to Leininger, health is a state of well-being which is culturally defined through the lens of the person's worldview (Leininger, 1997). The theme "health is how you look and feel" represents the perception being healthy or unhealthy can be determined by the way one looks and feels. The meaning of health was described similarly in an earlier phenomenological study of 30 AA women 40 years and above. Russell, Swenson, Skelton, and Shedd-Steele (2003) who reported that "looking good" was a major category with two components: a feeling perspective and physical appearance as perceptions of health. These are important findings considering the fact that healthcare access was limited for many of the women particularly during the time they were growing up suggests that individuals needed ways of determining the health

status of self and loved ones. Hence, they learned methods to determine the need for health intervention. Leininger and McFarland (2002) relate that traditionally African Americans frequently sought health assistance from family, friends, and or folk practitioners before accessing the American health care system. A major drawback to the practice however, is that the condition may be very severe or advanced by the time one enters the health care system. The proposed theme provides one possible explanation for the delay in help seeking, especially the reluctance to participate screening among African Americans. Using the frame of reference of how one feels or looks could represent a false sense of wellbeing and act as a barrier to health screening and prevention.

Knowledge Deficit Related to Health

Information about health was generally limited to the extent of parental knowledge in childhood and during adolescence; the added exposure to whatever was taught in public schools. Access to knowledge about health was further restricted by absence of routine visits to healthcare providers and the reliance on home remedies. Many of the women had no thoughts of what health was and thus unable to relate to the human condition. Leininger and McFarland (2002) purport that culture care beliefs, values, and practices are embedded in the worldview, as well as influenced by the social, economic, environmental, and ethnohistorical context of one's culture. Participants grew up amid turbulent times for AAs where survival of the individual and family required an orientation toward the present. Currently, the concept of health is future oriented where

one must plan and practice certain behaviors that are preventive in nature. The paradigm is incongruent with the historical sociocultural view among the AA culture (Leininger & Mcfarland, 2002).

Awareness of Health

Awareness is a process as well as a relative term in reference to the concept of health and as it relates to the lived experiences of the women in this study. As individual progresses through life, there is an acquisition of knowledge through personal and professional experience. For one participant in the study, it began with the recognition that she had an eating disorder that could be fatal if the behavior continued. For others, awareness that parents, relatives, and friends developed chronic conditions, often obesity-related. For still another participant, becoming a nurse provided an awareness of the concept of health and what was necessary to attain and maintain health. Awareness of the need for health education and a change in health behaviors was related to situational health concerns, and therefore, more present-focused as opposed to a future orientation toward health prevention practices. The need for health awareness among AA women is supported by several which indicated that many AA women of middle age and older expressed inadequate knowledge and misconceptions related to major risk factors, screening exams and health treatments (Augustus, 2002; Combs-Jones, 2004; Mosca, et al., 2000; Sadler, et al. 2007).

Category 3: Body Size Perceptions

Self Satisfaction with Physical Appearance

The theme of self- satisfaction with physical appearance, experienced by the women in the study was similar to findings in a number of previous studies (Altabe, 1998; Flynn & Fitzgibbons, 1998; Pratt, 2003). The findings do not suggest that all of the women in the study were satisfied with their current body size. For the most part however, their physical appearance, and how they looked in their clothes were more important than body size. Several of the women indicated a desire to lose weight, but not the extent of what is considered normal body size according to national standards. The perception that one can be attractive at heavier body weights is not new among AA women (Lynch et al., 2007). Befort et al., (2006) found that while obese AA women were dissatisfied being obese, they, believed that people can be attractive and healthy at larger sizes. The women's self-identity was centered on the cultural orientation of being an AA woman, and perceptions of what one is supposed to look like. For these women, there was uniqueness to being an AA female, with physical and psychological attributes distinctly different from the prevailing ideas of what is considered attractive and desirable.

The term closely related to the theme of self-satisfaction with physical appearance is body image. Body image is a socially mediated construct of perception that is internal to the individual and is influenced by culture (Gleeson & Frith, 2006). Experiences as told by the participants support the contention by Johnson and Broadnax (2003), that

body size and physical appearance among AA women is not a simplistic phenomenon. The very essence of what it is to be an AA woman is tied up in the sociocultural and historical context of the uniquely AA and individual experience. None-the-less, the finding that two of the eight participants in the study desired to be within the normal body size range demonstrates that differences do exist among AA women even in small numbers. Several studies also supported opposite findings. In a review of literature, Lovejoy (2001) found that although AA women do experience disturbances in body image to a lesser degree than CA women, they do develop eating disorders. This finding is consistent with the reported experiences of two of the eight women in this study.

Size Preferences-African American Men Prefer Larger, More Curvaceous Women

The belief that AA men prefer women with larger body sizes in the study was in part consistent with previous findings. Six of the eight women had life experiences that firmly established their perception that AA men preferred women that were voluptuous, curvaceous, and larger the in body size. Studies of female body size preferences among the men were variable as well. Several studies reported results that AA men desired or were more accepting of women with larger body sizes (Bissell, 2002; Greenberg & Laporte, 1996; Schippers, 2008; Thompson et al., 1996; Webb et al., 2004), while others had findings to the contrary (Freedman et al., 2004; Meshriki & Hansen, 2004; Porter, 2001). Whatever the findings on what AA men's choices for women's body size actually are, the experiences and perceptions of most of the women in the study indicate the belief that preferences exist for women of larger body sizes.

Category 4: Health Behaviors

Care Provided and Supported by Parental Figure While at Home

Care provided and supported by parental figure while at home as a theme reflects experiences recalled by the women during the childhood and adolescent stages of life. Consistent with literature, AA families during this period were generally supportive and protective environments where extended family members often had some degree of influence on the care and health behaviors of children (Leininger & McFarland, 2002). Limited knowledge about health influenced behaviors related to diet and physical activity. Participants were "active" but did not engage in any sustained regular activity with the exception of physical education in school and eating behaviors which were primarily traditional in nature. Thus behavioral patterns, such as low physical activity levels among AA girls, established early in life frequently become lifetime habits (Whitt et al., 2003). Most participants were provided what they described as "home cooked" and "balanced meals" where eating vegetables was encouraged and in some cases mandatory. Consumption of fruits were included but with less emphasis. Two participants experienced the "clean your plate" phenomenon which could influence later eating behaviors. An atypical experience was the participant who grew up in New York and was required to take vitamins daily and consume certain quantities of waters and foods her mother perceived as healthy. The participant also struggled with anorexia nervosa and bulimia.

Disassociation — Loss of Control of Learned Health Habits.

Disassociation refers to a separation, a disruption, or disengagement (Mish, 2006). For the women in the study, separation from the family unit and life stresses encountered resulted in a disruption previously practiced health behaviors. Disassociation occurred during primarily the young adult years when the women left home and were forced to deal with the stresses of establishing a life outside of the nuclear family. One woman described the situation as a "loss of control" where she lacked sufficient personal resources to gain balance and control over certain life situations. For some women college life became the major stressor. For another, the loss of a job; and still another, marriage and pregnancy was the catalyst to poor eating habits and little or no physical activity. Two of the women were overweight or obese from childhood. The remaining participants noted weight gain primarily during this period of time.

Struggle to Regain Balance and Control of Health Behaviors

The following theme represents the period of life where participants recognize the importance of health and the need to practice positive health behaviors. They have an awareness of the need to change certain behaviors. However old habits still linger. The theme is supported by reports from national organizations, which indicate that AA women consume diets higher in fats and engage in lower levels of physical activity compared to their CA counterparts (CDC, 2006; DHHS, 2006). One of the women is a newly diagnosed diabetic; two are hypertensive. There is the sentiment that a higher level of health awareness sooner may have prompted the women to make different behavioral

choices much earlier in the life, which may have influenced their current health status. None-the-less, findings from several studies on indicated that negative health habits acquired in childhood may be retained into adult the years (Alleyne & LaPoint, 2004; Beech et al., 2004; Gorden-Larsen, et al. 2002).

Current life situations have changed in some respects when compared to the young adulthood stage. For some women, life has become more stable; for others situational experiences have added more stressors. A change living situation, loss of a job, and recent loss of a parent were examples of things that influenced health behaviors. One participant revealed that her job as a nurse working with clients who had terminal illness was a great source of constant stress for her. Some of the women recalled resorting to emotional eating, a behavior developed early in life and later for others to help cope with stress.

Reliance on Traditional Cultural Health Practices.

The reliance on home remedies and folk medicine is a practice passed down the generations form slavery times. This practice is embedded in survival and care behaviors as well as cultural traditions, values and attitudes. The practices are based on multiple factors; (a) the lack of access to health care, (b) a history of abuse and neglect by western health care practices, and (c) a belief system grounded in trust in one's own kind, provided little options in the mind of many African Americans. The latter, a culture of taking care of one another is grounded in the sense of community and extended family connections which include blood and non-blood ties (Leininger & McFarland, 2002)).

Mistrust in the American Healthcare System

Issues of trust and access to health care are not a new phenomenon among the AA community (Leininger & McFarland, 2002). The theme of mistrust related to experiences and perceptions of a system that in the past was harmful to AAs, callus, and frequently inaccessible due to limited financial resources and restricted access to health care providers. Thus, AAs resorted to generational practices of home remedies and folk medicine to meet healthcare needs (Leininger & McFarland, 2002). Participants recalled experiences in different life stages where interaction with the healthcare system left them fearful and frustrated. A lack of trust in the health care system has major negative consequences. Low participation in screening behaviors; delayed help seeking; and reluctance to follow prescribed health regimens, which include a failure to take medications for chronic health conditions are reported examples (Syme, 2004). Research on the issue of mistrust among AAs in reference to health care support the experiences of the women in the current study (Jacobs, Italia, Ferris, Whitaker, & Warnecke, 2006; Lillie-Blanton, et al., 2000; Martin, et al., 2010). Shavers, Lynch, & Burmeister (2002) found that AAs are much less likely to participate in medical research, especially when the doctor is of a different ethnicity. Wynia, and Gamble (2006) add, that many AAs do not feel accepted or respected by health care providers. Delvin et al. (2006) reported that some of the participants in the study actually "...wondered if their health care providers were withholding treatment from them or even a cure" (p. 51).

Leininger's CCT was used to guide this study. The assumptions underlying

Leininger's theory were supported by the findings of the study. Themes extracted from the data of the shared experiences of the participants provide evidence of the existence of: (a) cultural beliefs, values and practices related to health that were embedded in the world view of the families and the women as well which influenced all aspects of their lives, (b) culture care values were influenced by family, social, political, economic, educational, technical and environmental factors (c) generic care knowledge that was widely used among the families of the women in the study, and the reliance on that knowledge even in current times, but to a lesser degree compared to when they were growing up, (d) the incongruence of health care concerns and practices for AAs led to issues of mistrust, that still exist today and among many of the women in this study.

The current study represented the subjective life experiences of eight overweight/obese AA women. Through lengthy immersion with the data, the researcher was able to extract themes which represented the reality as perceived by the participants over the lifespan in relation to three specific areas. The significance of cultural influences on perceptions of health, body size, and health behaviors was illuminated in the themes that emerged from the data. Pacquiao, Archeval, & Shelley (1999) notes that in order for health care to have a positive and lasting influence on the lives of the consumer, the context of care must be defined by the person's own beliefs, values and practices, which must first be identified.

Research has shown that cultural beliefs and attitudes do exert influences on perception of health and ultimately health behaviors. However, little information is

available on how life experiences help shape the cultural attitude and beliefs among AA women. Few studies have actually explored the influence of such beliefs and attitudes on perception of health, body size, and health behaviors using qualitative methodology. To the researcher's knowledge no study has explored the influence of cultural beliefs and attitudes of the three variables explored collectively.

Although this research presented the shared experiences of eight African American women, it must be said that African Americans are not monolithic. Leininger and McFarland (2002) assert that variations exist in all cultural groups as do similarities. This is an important concept for consideration to avoid stereotyping, which has been linked to racism and discrimination against African Americans and other minority groups.

Conclusion and Implications

This study explored the perception and experiences of overweight and obese AA women. Cultural beliefs and attitudes about body size may be the underlying variable on how health is perceived and health behaviors are practiced. The results offer insights into how the complex nature of culture, socioeconomic, environment and biologic factors acted as constraints to positive health behaviors in this group. For example, Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thomphson (2002), suggest that socioeconomic influences and cultural attitudes toward time orientation is an important concept to consider in relation to health perception and health behaviors among African American women. Many individuals tend to focus on current concerns and may have difficulty

directing energies toward health behaviors which may not demonstrate health benefits until years later.

The implications for dealing with quality assessment and quality of health care in the AA population include proper education, and training of primary care professionals, general practitioners and nurses in enabling patients to trust the system. Thus a culture of trust will engender a more positive response to care efforts from health care professionals. The perception that AA women do not see fat as ugly and that obesity is viewed as normal and not and unhealthy state are two misconceptions that seem to prevail in current literature (Gore, 1999; Kumanyika, 1991; Nelson, 2000). However, many AA women know that they are overweight/obese. Albeit many AA women do not ascribe to the national standards or the popular conception of 'thin' in the dominant society, they do however, desire a body size that is 'realistic' in terms of cultural standards of the AA community and personal values, which at times may be conflicting (Cachelin, et al, 2002; Combs-Jones, 2004; Snooks & Hall, 2002). African American women encounter difficult life circumstances on a daily basis in terms of racial and sexual discrimination; lower socioeconomic status; and heavy family obligations, which include a high percentage of single mothers. Overweight status or obesity is just one more reality that many learn to cope with and find sense of self-acceptance. One participant stated, "I know, I am an overweight woman, but I am a happy overweight woman, who knows the risks and side effects of being overweight. And I feel that everything should be done in moderation." The fact that most AA women have not been

successful at weight loss and/or maintenance does not mean that they are not actively trying to lose weight. For many AA women there is a lack of resources, which would enhance positive health behaviors. However, for a number of women in the AA population it is not a lack of resources or awareness, but a conflict between wanting to be healthy and desiring a culturally appropriate body size. Such is the case for several of the participants in the current study. Consequently, the challenge for health care professionals is to first gain an understanding of the complex forces which govern perceptions and behaviors, in order to increase the potential for successful intervention. Research has shown that cultural, social, and environment factors exert a powerful influence in the lives of AA women (Kumanyika, et al., 2007). Perceptions of participants in this study revealed that these factors were significant in their life experiences. None-the-less, the health care community is at a loss of where to go from here in improving the state of health in this group. This researcher believes knowledge of cultural attitudes and beliefs is an essential part of addressing health concerns and health behaviors among AA women. This information is lacking. Thus there is a need for more research in this area to tease out and uncover the intricate facets of the AA woman's experience from childhood through current life stages in order to understand the influences of beliefs and behaviors developed over a lifetime. According to McAlister (1981), "effective health promotion programs require a deeper understanding of the factors and processes which guide the development of health behaviors" (p. 25).

This study illuminates several important concerns where development of

culturally sensitive education strategies may be beneficial to AA women. Information directed toward changing the way health is perceived by many women in this group may increase receptiveness of health promotion and maintenance programs. Since many AA women struggle with desiring to be healthy and cultural attitudes of larger body size, a focus on the link between modest weight changes and decreases in disease risks rather that drastic weight losses may be more acceptable. Additionally, interventions directed toward changing the manner in which AA women relate to food may be more daunting, yet essential to the success of improving the health status of the women in this group. Finally, because of lack of trust in health care providers within the AA community, a greater commitment and involvement of AA health professionals is essential to the success of such programs.

Recommendations for Further Study

According to Bortz (2005), certain biological aspects of health may be genetically determined. However, health per se is not an inherited trait. Health is on a continuum that is passed down through many generations and considered to be associated with behaviors that are steeped in cultural traditions in ways that are written and unwritten among many in ethnic groups. Thus a certain portion of health may be passed down to future generations through health behaviors; beliefs and attitudes; socioeconomic; and environmental conditions. Health is also practiced via western medicine and healthcare providers that are more in keeping with the majority of ethnic groups. Although there are many qualitative and quantitative studies carried out on AA women, research studies

have barely scratched the surface of issues which affect the women in this group and what and how much needs to be done to assist the women to open up and honestly trust those that are charged with the health care of the nation. As an AA woman and a health care provider, I encountered many issues that came to the forefront in completing this study that go far beyond the visible aspects. Further research is essential, which goes further than the fact that AA women are overweight and obese and that they are more prone to chronic diseases that any other ethnic group; information which has already been established. The need for further research is in the area of where little is known about the experiences of AA women, and how they play out in their life situations, health behaviors, and health care choices. Findings from a few qualitative studies identified findings that were consistent with several of the themes that emerged from the data in this study. Since results from this qualitative study have limitations on generalizations, more studies related to the topics of research with this population are warranted and necessary.

Further exploration of the three areas covered in this study is recommended. It is further recommended that the life history method is employed because it provides a greater wealth of information over a lifetime of experiences, as opposed to a single place and time in one's life. Since generalization is not the goal of qualitative research, these findings have limited applications. Additionally, smaller sample sizes in qualitative research will require a greater number of studies for data generation. It is therefore essential, that more studies are undertaken.

Although generalization of findings from this study is very limited, that is not the

goal of qualitative research (Libiondo-Woods & Haber, 2002). The current study has provided rich data which may be used in developing hypotheses for further study in the area of health perceptions, body size and health behaviors among AA women. Data from the study may also be used in instrument development for further testing and refinement. Qualitative data can also be used to guide nursing practice because personal stories provide the voice to "...enlighten and enrich understanding of everyday health experience" (Libiondo-Woods & Haber, 2002, p. 141).

Summary

This study offered a glimpse into the life-world of AA women over four stages of life. Participants revealed the subjective experiences of existing in their life-world over time and space and how those conditions shaped perceptions of health, body size, and health behaviors. Health care providers must recognize that issues of health for AA women are complex and incorporate a number of different influences in which culture is a major component.

The lived experiences of eight AA women related to perceptions of health, body size and health behaviors were explored using the qualitative phenomenological approach. Themes extracted from the data revealed that cultural attitudes and beliefs did exert influences of the perceptions of the participants of this study. These findings are consistent with the framework of the CCT that proposes cultural and social structural dimensions influence and are influenced by the care expressions; patterns; and practices of the individual or group. The latter ultimately impact health and wellbeing in a number

of ways (Leininger, 1996). Further, the shared experiences of the women in this study revealed that perceptions of health and body size to some degree helped shaped thoughts and ideas about health behaviors. It is hoped that findings from this study will stimulate discussion on the topic; provide some insight into the life-world of AA women; and stimulate further research in the area.

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APPENDIX A

Demographic Data Form

Demographic Data Form
Participant Code Number__________

Age: ___________

Marital Status:

Married [ ]

Single [ ]

Separated [ ]

Divorced [ ]

Widowed [ ]

Education:

Years of school completed: _____________

Household Income:

$5,000 - $20,000	[ ]	$60,001 - $70,000	[ ]
$20,001 - $30, 000	[ ]	$70,001 - $80,000	[ ]
$30,001 - $40,000	[ ]	$80,001 - $90,000	[ ]
$40,001 - $50,000	[ ]	$90,001 - $100,000	[ ]
$50,001 - $60,000	[ ]	above $100,000	[ ]

Number in the household that you grew up in: _____________

Employment status of your parents or your guardians: (Please mark all that apply.)

Write the number of people working in your parent's home

Father [ ] Full time [ ] Part time [ ] NA **Mother** [ ] Full time [ ] Part time

[ ] N/A

Childhood - Worked: [ ] yes [ ] No **If working:** [ ] Full time [ ] Part time

Teenager - Worked: [ ] yes [ ] No **If working:** [ ] Full time [ ] Part time

Young Adult - Worked: [ ] yes [ ] No **If working:** [ ] Full time [ ] Part time

Your employment status as a young adult: [ ] Full time [ ] Part time [ ] N/A

Your current employment status: [ ] Full time [ ] Part time

Measurement Data

Height (stated): ______ ____ Weight (stated):

Calculated Body Mass Index (BMI)

APPENDIX B

Participant Instruction Sheet

Participant Instruction Sheet

A. Overview & Instructions

Thank you for allowing me to share in your life experiences. The title of my study is "The Influence of Cultural Attitudes and Beliefs on Health, Health Behaviors, and Body Size Among Middle-aged African American Women ". The objective of the study is to look at culture as a possible influence on how we view health and what we do about health. The areas I would like to explore with you are from your earliest memories as a child to the present time in two, one-hour interviews. During the two interviews, I will be asking you some questions about your thoughts and feelings as well as your experiences throughout your life. Many of these questions will focus on what you think or believe about health. I will also ask you what you or your parents have done to make you healthy or keep you healthy. What did you learn from your parents and what ideas you have of your own about staying healthy? The third thing I will ask you about is your thoughts, your beliefs, and your experiences in relation to body size.

So that we will have the same understanding about the things I am asking you about, I have provided a description or definition of each of the specific things that will be asked about during this interview.

Definition of Terms

For the purpose of this study, the following terms are defined:

1. Health is the level of physical, mental, and social functioning or wellbeing that may change in one way or another during a person's lifetime. Each person defines their health according to their life experiences and personal views.

2. Health Behaviors: any behavior an individual engages in to maintain or improve their state or level of physical, social, or mental functioning.

3. Body Size is the total mass or bulk of a person's body. We often equate our size with the size of garment we wear. The measure for body size in this study is the body mass index, referred to as the body mass index.

4. Body Mass index is a number representing the mass of a person's body size. This number is calculated from the height and weight of the individual. The number is compared to a national standard which indicates the degree of risk for developing certain health problems such as heart disease, high blood pressure, and diabetes.

5. Obesity and overweight status are categories of body size or body mass index that may indicate a higher risk for developing health problems compared to a person in the

regular sized category. The overweight category is a body mass index of 25.0 to 29.9. A person is considered obese when the body mass index reaches 30.0 or above.

6. Culture relates to values, beliefs, and life practices of a particular group that is passed down through generations which guides the thinking and certain actions of its members.

7. Beliefs refer to your strongest opinion about things such as an idea, a person, or a situation.

8. Attitudes are different from beliefs in that they refer to the specific way that a person reacts to a situation or idea.

APPENDIX C

Interview Guide

Interview Guide

Part A. The first part of this interview relates primarily to your thoughts and ideas about health.

Please tell me about your ideas and thoughts related to health.

How would you describe health? Give me an example.

What does health mean to you? Give me an example

When you were a child, what did you think about health?

What were some of your earliest memories about health?

What was your life like at that time during your childhood?

What did healthy children look like?

What did you think about health when you became a teenager?

What did you think about health when you became a young adult?

Tell me about your attitudes and beliefs about health since you became a middle-aged adult.

What attitudes and beliefs about health did your parents express when you were young?

Part B: The second part of this interview relates to your experiences, thoughts, and beliefs about a woman's body size.

Tell me about your thoughts and beliefs about body size when you were young (a child; a teenager).

What attitudes and beliefs did your mother express about body size?

What was your mother's body size?

What were the attitudes and beliefs your father expressed about a woman's body size?

Tell me about your thoughts or beliefs about body size during the time you were a young adult? Did your attitudes change in any way? If they did, how did they change?

Tell me about your thoughts and ideas about body size at this age in your life.

Tell me about the attitudes and beliefs expressed by a significant male person in your life. This can be a boyfriend, a husband, a friend, or a family member.

Were the attitudes and beliefs, expressed by a significant male person about body size different from yours?

How did the views of your significant person affect you're your thoughts about body size?

This question is about men's attitudes in relation to a woman's body size. What are your thoughts on the subject?

What were the attitudes and beliefs about a woman's body size expressed by close family members or friends?

How does the opinion of others affect your feelings about body size?

Part C: This section is about health behaviors or practices that you or your family engaged in.

What attitudes and beliefs did your mother express about eating?

What kinds of foods were important for you to eat? Give me an example.

How was food prepared during cooking?

Was your father involved in any way with what you ate, or how you ate when you were growing up?

Please describe any behaviors or actions, you or your parents engaged in when you were a child or a teenager to keep you healthy.

Tell me some things that were done in your family to keep you from getting sick?

Were you expected to do anything to keep you healthy or from getting sick?

Where did their ideas come from?

Were there other family members involved in caring for you as a child? If so, how did they influence your health?

Did your health practices change from when you were a child during your teenage years?

Did your health practices change from when you became a young adult?

If your health practices did not change, please describe how your beliefs influenced your behavior.

Tell me about the health behaviors you currently engage in.

What kinds of things did your parents do to keep themselves healthy?

Did they engage in any special activities, or practices? If so, what were they?

How did they know about the things that were important to them?

Tell me about your experiences with the health care system.

Did any experience with the health care system change the way you practice health?

Were there any changes in the way your parents practiced health?

Where you aware of any experiences your parents had with health care?

How did those experiences affect their thinking about health?

What attitudes and beliefs did your parents express about doctors and hospitals?

Did their impressions or feelings influence their health care choices?

APPENDIX D

Interview Protocol Guide

Interview Protocol Guide

Process Guide Sheet for Interview and Data Collection

Introduction to participant

Consent forms: review with participant and obtain consent

Three Copies of consent forms and give copy to participant

Collect demographic data

Inform/remind participant that tape recorder will be used.

Set tape recorder to start recording

Begin Interview

Initial anxiety reducing conversation

Review notes for clarification of any concepts or statements

Before ending interview:

Ask participant, if there is anything more she would like to share.

Offer opportunity for participant to ask questions related to the study.

Check to see if all required data has been collected.

End interview with thanking participant for sharing life experiences.

APPENDIX E

Research Study Flyer

Research Study on Cultural Beliefs and Body Size

Researcher looking for African American women willing to talk about health, body size and behaviors

Study Requirements

African American/Black women ages 35 to 54
Willing to spend one hour talking with a researcher
You decide a time and place for the interview that are good for you
No history of kidney disease
Women who are overweight
You will receive a Wal-Mart Gift card for each interview

For more information about this study, contact Everlyne Jackson, MSN, RN at 832-768-0843

"All information is confidential"

APPENDIX F

Consent Form

Consent Form

TEXAS WOMAN'S UNIVERSITY

6700 Fannin Street

Houston, Texas 77030

CONSENT TO PARTICIPATE IN RESEARCH

Title: The Influence of Life Experiences on Health, Body Size, and Health Behaviors of Middle-aged African-American Women.

Investigator: Everlyne Jackson everlyne.jackson@gmail.com 832/768-0483

Advisor: Sandra Cesario, PhD scesario@twu.edu 713/794-2110

Explanation and Purpose of the Research

You are being asked to participate in a research study for Ms. Jackson's dissertation at Texas Woman's University. The purpose of this research is to explore the life experiences of middle-aged African American women to examine how culture has influenced their perceptions of health, feelings about body size, and health behaviors. You have been asked to participate in this study because you are female and have identified yourself as being overweight or obese and between the ages of 35 and 54 years.

Description of Procedures

As a participant in this study you will be asked to spend one hour of your time in a face-to-face interview with the researcher. The researcher will ask you questions about your experiences related to health, body size and health behaviors over your lifetime. You and the researcher will decide together on a private location where and when the interview will happen. All documents and audio recordings will be labeled with codes and no identifying information will be used during the interview. The interview will be audio recorded and then written down so that the researcher can be accurate when studying what you have said. Participants who are smaller than overweight body size will be dismissed from the study.

Potential Risks

The researcher will ask you questions about attitudes, beliefs and behaviors of family members and significant others related to health, body size and health behaviors. A possible risk in this study is discomfort with these questions you are asked. If you

become tired or upset you may take breaks as needed. You may also stop answering questions at any time and end the interview.

Another risk in this study is loss of confidentiality. Confidentiality will be protected to the extent that is allowed by law. The interview will be held at a private location that you and the researcher have agreed upon. The tapes and the written interview will be stored in a locked cabinet in the researcher's office. Only the researcher, her advisor, and the person who writes down the interview will hear the tapes or read the written interview. The tapes and the written interview will be shredded within 5 years after the study is finished. The results of the study will be reported in scientific magazines or journals but your name or any other identifying information will not be included.

____

Initials

The researchers will try to prevent any problem that could happen because of this research. You should let the researchers know at once if there is a problem and they will help you. However, TWU does not provide medical services or financial assistance for injuries that might happen because you are taking part in this research.

Participation and Benefits

Your involvement in this study is completely voluntary. You may withdraw from the study at any time. Following the completion of the interview you will receive a $25 Wal-Mart gift card for your participation. The major benefit of this study to participants will be the opportunity to share their story in a safe environment in an anonymous manner; and the knowledge that their story may be of help to some other individuals or group. Participants who begin an interview and are unable to complete it, or choose to withdraw from the study, will still be compensated for the entire interview. The results of the study will be mailed to you by certified mail unless you request not to have it sent to you.*

Consent to Record

You consent to have your voice be recorded by **Everlyne Jackson**, acting under the authority of the Texas Woman's University, understanding that the material recorded for this study may be made available for educational, and/or research purposes and consents to such use.

Questions Regarding the Study

You will be given a copy of this signed and dated consent form to keep. If you have any questions about the research study you should ask the researcher; her phone number is at the top of this form. If you have questions about your rights as a participant in this research or the way this study has been conducted, you may contact the Texas Woman's

University Office of Research and Sponsored Programs at 940-898-3378 or via e-mail at IRB@twu.edu.

____

Signature of Participant Date

*If you would like to know the results of this study tell us where you want them to be sent:

Address:

____

____

____

APPENDIX G

Texas Woman's University Human Participant Research Confidentiality Agreement

Texas Woman's University Human Participant Research Confidentiality Agreement

Study Title: The Influence of Cultural Attitudes and Beliefs on Health, Body Size, and Health Behaviors, Among Middle-aged African American Women.

Principal Investigator (PI): Everlyne Cosey Jackson

I the undersigned, ________________________________, hereby agree to the following conditions of confidentiality concerning all information that may be supplied to me by members of the study research team.

- I agree to keep strictly confidential all information that may be communicated to me verbally, in written form, or in any other form.
- I agree to take all precautions necessary to prevent knowledge of this information from reaching any unauthorized parties. I clearly understand that authorized persons are only those persons who are approved members of the research team.
- I will not use any information provided to me for any purpose other than that required by the PI/research team.
- I will not keep any copies, summaries, or transcripts of the confidential documents provided in any form and will return all such documents to the PI/research team upon completion of my duties.

____

Name

____

Signature Date

____

Principal Investigator Signature Date

APPENDIX H

Leininger's Sunrise Enabler for the Theory of Culture Care Diversity and Universality

Leininger's Sunrise Enabler for the
Theory of Culture Care Diversity and Universality