DESCRIBING THE CULTURAL PERCEPTIONS OF WEIGHT AND PERCEIVED BODY SIZE WITH OBESE AFRICAN AMERICAN WOMEN:
A DESCRIPTIVE FOCUSED ETHNOGRAPHY

by

Patricia Ann Speaks

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A Dissertation Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF PHILOSOPHY

In the Graduate College

THE UNIVERSITY OF ARIZONA

2012
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ACKNOWLEDGMENTS

I first thank God for giving me the strength to push forward during this endeavor.

I offer my sincere thanks to my mother for her support throughout my life, my daughter Giana, who has been an uplifting spirit in my life, and to Kevin who has given me unwavering support.

To my Dissertation chair, Dr. Janice Crist, I offer my gratitude for the mentoring, support, and guidance she has shown me throughout my years as a student at The University of Arizona.

To my Dissertation Committee Members, Dr. Marylyn McEwen, Dr. Elaine Jones, and Dr. Kathleen May who challenged me to think and grow beyond me.
DEDICATION

This dissertation is dedicated to my dad, James A. Speaks who died February 28, 2011.
He always gave me support through his love, words of wisdom, and smile. Although you are not
here with me in body, you are here in spirit. Thank you for all you have done through the years.
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ABSTRACT

African American women (AAW) have the highest incidence and prevalence of obesity among all cultural groups in the United States. Understanding cultural factors which influence perception of body size and ultimately impact decisions by obese AAW to lose or manage their weight is essential in ultimately designing culturally appropriate interventions. Gaining insight into the core cultural perceptions and factors that influence acceptable body size is imperative to furthering scientific knowledge with obese AAW. Larger body sizes for women are often culturally accepted and perceived as attractive and desirable within the African American community. Self-definition and self-worth, concepts found in Black Feminist Theory, play a pivotal role in the perceptions that obese AAW have about weight loss and weight management. The interconnectedness of the two concepts provided a strong basis for this qualitative research design to examine how these concepts may influence perceptions of acceptable body size among AAW. The purpose of this study was to describe the cultural perceptions of weight and ideal body size with obese AAW from an emic or insider’s perspective. A focused ethnographic perspective was used to describe obese AAW’s cultural norms about perceived body size and describe obese AAW’s self-definition and self-worth that relate to perceived body size. A sample of eight obese AAW was recruited for the study. Data collection included: (a) individual interviews; (b) participant observation; and (c) field notes. The overarching theme derived from the data was “I’m Ok with Me.” There were four subthemes that supported the overarching theme. They included: (a) acceptance of heavier body size by others; (b) acceptance of heavier body size by self; (c) cultural foods that impact heavier body size; and (d) sedentary lifestyles that impact heavier body size. The overarching theme lays a foundation for nursing towards
cultural competency with obese AAW. Future studies are needed to further evaluate perception of body size and how obese AAW culturally define themselves and define their self-worth in relation to perception of body size.
CHAPTER I: INTRODUCTION

Obesity and its associated chronic medical conditions such as coronary heart disease, hypertension, stroke, Type-2 diabetes mellitus, and certain types of cancer have had a major impact on the lives of many Americans within the United States ( Centers for Disease Control and Prevention [CDC], 2009). In 2008, more than 74.1 million people in the United States were considered obese (American Heart Association [AHA], 2009). Prevalence (the proportion of people found to have a condition) (Nelson & Wilson, 2007) of obesity in 2009-2010 among US adult men was 35.5% and among US adult women was 35.8% (Ogden, Carroll, Kit, & Flegal, 2012).

Obesity, defined by body mass index (BMI), is a measure of body fat based on weight and height (Johnson, Williams, & Spruill, 2006). Healthy weight is defined as a BMI of 18.5 to 24.9 kg/m². Overweight is defined as a BMI of 25 kg/m² to 29.9 kg/m² and clinical obesity is defined as a BMI of 30 kg/m² or greater according to the CDC (2010). In 2010, Healthy People 2010 obesity objective of 15% reduction in obesity was not achieved by any state in the United States (CDC, 2012). A goal of Healthy People 2020 is to increase the number of adults who are at a healthy weight and reduce the number of adults who are obese (U.S. Department of Health and Human Services, 2009).

Obesity has resulted in a major financial burden on the United States’ health care system due to disabilities associated with chronic medical conditions and premature death among Americans (CDC, 2009; Visscher & Seidell, 2001). In 2008, health-care costs due to obesity-related hospitalizations and disability accounted for $147 billion (Finkelstein, Trogden, Cohen, & Dietz, 2009). Individual obese adults had an estimated health-care cost in 2008 of $1,429 per
year higher than those individuals of healthy weight. Obesity-related health-care costs by 2018 are estimated to be more than $344 billion of health-care spending. This estimation is due to obesity-related hospitalizations and disabilities (Humphries, 2009).

There is a higher percentage of obesity in the southern region of the United States than any other region according to Trust for America’s Health (TFAH) and The Robert Wood Johnson Foundation (RWJF) (2010). Mississippi led the nation’s obesity rates in 2009 with 34.4% of the state’s population obese. Louisiana (33%), West Virginia (32.5%), Tennessee (32.3%), Kentucky (31.5%), South Carolina (31.5%), Oklahoma (31.4%), Alabama (31.0%), Texas (31.0%), Michigan (30.9%), Arkansas (30.5%), and Missouri (30.5%) complete the top 12 highest reported obesity rates in the United States (CDC, 2012). Documented accounts for the differences in prevalence of obesity among regions include racial/ethnic behavior such as exercise and dietary choices, socioeconomic status (SES), and cultural norms such as cultural belief systems and attitudes about ideal body size (Bowman, 2009). There is consensus that the substantial differences in prevalence across regions are intricate and difficult to comprehend (CDC, 2009). Among the four regions of the United States, obesity prevalence is highest among African American individuals living in the South (36.9%) and Midwest (36.3%) than in the West (33.1%). Finally, the Northeast (31.7%) has the lowest obesity prevalence among African Americans (CDC, 2009).

The CDC (2007) has also committed to making obesity a health priority. The CDC Division of Nutrition, Physical Activity, and Obesity (DNPAO) currently funds 25 states to address obesity and the associated obesity-related chronic diseases. The focus is to improve the health of individuals through coordinated efforts statewide with multiple partners. Through
evidenced-based strategies of nutrition and physical activity addressed with obese individuals, DNPAO addresses the issues of obesity and its associated health conditions. The statewide goals of DNPAO include: (a) developing and maintaining programs that will support statewide improvement in physical activity and nutrition; (b) monitoring the prevalence of obesity within the state; (c) evaluating programs currently in place; and (d) submitting a report to the CDC annually on progress made (CDC, 2010a).

Obesity disproportionately affects African American individuals (44.1%) compared to Hispanics (39.3%) and non-Hispanic white individuals (32.6%) (Flegal, Carroll, Ogdon, & Curtin, 2010). Racial and ethnic behavior within the African American community which includes lack of exercise, poor dietary choices, and shared cultural norms and beliefs about ideal body size are linked to a higher prevalence and incidence (number of new cases) (Nelson & Williams, 2007) of obesity (Wilbur, Chandler, Dancy, & Lee, 2003; Davis, Clark, Carrese, Gary, & Cooper, 2005; Dammann & Smith, 2011). African American individuals were 50% less likely to engage in active physical activity than non-Hispanic white individuals resulting in death from heart disease and stroke almost twice that of non-Hispanic white individuals (CDC, 2007). Age-adjusted death rates for African American individuals exceeded non-Hispanic white individuals by 48% for stroke, 31% for heart disease, 21% for cancer, and 113% for Type-2 diabetes mellitus (CDC, 2009). Poor dietary choices such as the consumption of high fat and carbohydrates by African American individuals were also associated with increased weight and risk for chronic diseases (Bowman, 2009; CDC, 2009).

African American Women in 2007-2008 were 49.6% more likely to be obese than non-Hispanic white women (33.0%) and Hispanic women (45.1%). The increased trend was noted
from statistics in 1988-1994 when 38.3% of AAW were more likely to be obese compared to non-Hispanic white women (22.9%) and Hispanic women (35.3%) (Ogden & Carroll, 2010).

Research has shown that lower SES is correlated with obesity. Lower SES is not only highly correlated to obesity but is highly correlated to poor lifestyle choices among African American individuals and specifically AAW (Flaskerud et al., 2001). Individuals with lower incomes and less education were more likely to be physically inactive and choose high fat diets (McLauren, 2007).

African American individuals’ incomes are historically disproportionately lower than non-Hispanic white individuals’ incomes. The average income for African American individuals in 2010 was $32,068 per year while the average for non-Hispanic white individuals in 2010 was $54,620. The average income for Asian Americans in 2010 was $64,308 and Hispanic Americans was $37,759 (DeNavas-Walk, Proctor, & Smith, 2011). Statistics show that in 2010, 84.2% of African American individuals earned high school diplomas while 87.6% of non-Hispanic white individuals and 88.9% of Asian and Pacific Islander individuals earned high school diplomas (United States Census Bureau, 2012). Only 16.3% of African American individuals earned a Bachelor’s degree while 29.7% of non-Hispanic white individuals and 48.3% Asian individuals earned a Bachelor’s degree. Since the 2000 census, the National Committee on Pay Equity (2010) reported that the median earning for AAW in the United States only rose slightly to $31,824. Hispanic women’s median earnings were $27,181 while Asian-American women earned a median income of $42,331.

While lack of exercise, poor dietary choices, and lower SES play a vital role in obesity among AAW, beliefs about ideal body size also play a vital role in putting AAW at risk for
obesity (Flynn & Fitzgibbon, 1998). For example, Bennett and Wolin (2006) found that obese AAW were more likely than non-Hispanic white women to be satisfied with their current weight. Furthermore, these researchers concluded that more research needed to be done on sociocultural influences of weight among obese AAW. While one study found that obese AAW described their current weight as “desirable and attractive” (Boardman, Onge, Roger, & Denny, 2005) few documented studies have looked at the cultural perspectives of ideal body weight that impact obese AAW’s desire to lose weight. Cultural perspectives and factors due to life experiences and interpretation of values can strongly impact the behavior needed to lose weight or have successful weight loss (Davis et al., 2005). Successful weight loss in adults is defined as the loss of 5-10% of total body weight. Successful weight management in adults is defined as a weight change of at least 3% of total body weight (Stevens, Truesdale, McClain, & Cai, 2006).

Although the research literature supports obesity impacting individuals younger than 18 years of age, describing cultural perceptions of weight and perceived body in adult AAW is crucial in ultimately reducing the serious health risks such as coronary heart disease, hypertension, stroke, Type-2 diabetes mellitus, and certain types of cancer (Boardman, Onge, Rogers, & Denney, 2005). Also, studies of cultural perceptions due to life experience such as family structure, work values, and community norms, as described by Davis et al. (2005) and Hawkins (2007) have not been developed among individuals younger than 18 years of age; therefore, my study will not focus on individuals younger than aged 18.

Another important factor that is a cultural influence of perceptions of ideal body weight, desirability, and attractiveness is family and the “extended family” or “fictive kin.” The extended family or fictive kin can include close friends, community members, and religious leaders
(Hawkins, 2007). Describing perceived body size from a cultural perspective is essential in improving understanding and enhancing culturally competent education. Extended family or fictive kin play a pivotal role in helping to define acceptable body weight (Barbarin, 1983; Davis et al., 2005). Social and emotional support is given by extended family to obese AAW that aid in how they identify and perceive themselves (Barbarin, 1983).

Culture can be defined as shared primary attitudes and behaviors (Buxton, 2008). Cultures are uniquely based on gender, age, and ethnicity (Base-Smith & Campinha-Bacote, 2003). Culture is described as how a group of people see themselves (Banks & McGee, 1989). The perceptions and interpretations are often shared patterns of behavior that are learned through socialization and are unique to that group of people. Culture helps shape “values, traditions, and norms” (Wilson, 2011, p. 221). These values, traditions, and norms are passed along from generation to generation.

To understand the unique culture of African Americans and their cultural patterns, researchers must begin to gain understanding of the history of African Americans and the African American community that help to shape their thoughts, beliefs, and behavior patterns. The roots of African American culture stem primarily from the western coast of Africa. Slavery restricted many of the cultural patterns and practices for African Americans. Thus, many patterns and practices were lost, but some beliefs, patterns, and practices survived from West Africa such as oral traditions (storytelling), African music, and dance. These patterns and practices were passed on from generation to generation and exist today within African American culture. Other beliefs, patterns, and practices derived from slavery and as a result of survival during slavery,
have also been integrated within the traditional American culture such as religion, food, and interdependence (Saloy, 1998).

Religion or beliefs in a Divine power (Oxford Dictionaries, 2012) food, and interdependence have continued to be a mainstay of tradition among African Americans. These cultural traditions have been used as a source of strength for African American people from slavery to present day (Fullilove, 2001). The impact of religion, food, and interdependence as cultural tradition among the African American community has been seen within the belief system and worldview that ultimately impact their SES, family, and health. Within the African American community, religion is considered an important practice in resolving personal conflicts, healing illnesses, and resolving problems. Religion within the African American community is used to heal the sick and bring strength to the individual, family structure, and community.

Traditionally, food has been an important source of social gatherings for African Americans. Southern traditional food choices such as fried foods are often high in fat, cholesterol, and sodium. These food choices have been handed down from generation to generation and stem from the days of slavery when food choices were limited (Wilson, 2011). Interdependence through close family ties and mutual aid systems established through extended family or fictive kin provide strength within the African American family structure and community. Financial, social, and emotional reliance are examples of interdependence found within the African American culture (Chatters, Taylor, & Rukmalie, 1994).

The cultural experiences of African Americans and specifically AAW are reflective of their unique worldview (Collins, 2000). Individuals within a group are able to gain a personal
idea of self called self-definition and gain a sense of confidence called self-worth within their
culture. Through interactions, socializations, and interpretations of symbols that are learned
(Banks & McGee, 1989), AAW develop preferences of body size based on specific cultural
experiences which is reflective of their unique worldview. The concepts of self-definition and
self-worth found in Black Feminist Theory can shed understanding of perspectives towards
perceived body size and gain insight of cultural factors that influence weight loss and weight
management among obese AAW. Black Feminist Theory, the theoretical foundation for this
study, will be described in more detail, subsequently. The theory gave me the two concepts (self-
definition; self-worth) that were included in the purpose of the study and the research questions
guiding this study.

**Purpose of the Study**

The purposes of this study were to: (a) describe obese African American women’s
cultural norms about perceived body size; (b) describe obese African American women’s self-
definition and self-worth that relate to perceived body size.

The design for this study was a descriptive focused ethnographic study. The research
questions guiding this study were: (a) What are obese African American women’s cultural norms
relevant to perception of body size? and (b) What are obese African American women’s self-
definition and self-worth in relation to perceived body size?

**Background**

A person’s perception of “obesity” is determined by the person’s perspective of perceived
body size. Perceived body size is individualized and its perspective varies from person to person.
Perceived body size is often determined by sociocultural views (Hawkins, 2007). Thus, it is important to gain an operational definition of “obesity” that can be utilized in this research study.

“Obesity” has many connotations. The different connotations are based on economic and medical as well as socio-cultural and ethnic influences (Mack et al., 2004). It is often confusing for researchers to understand the cultural connotations and terminologies used in lieu of the scientific word “obesity.” The scientific term “obesity” is defined by the CDC (2007) as a BMI of 30 kg/m² or greater; but other definitions of obesity such as “excessive” amounts of body fat, “corpulent,” and “abnormal” amounts of “fatty tissue” are also used by the medical community (Dictionary.com, 2010; Free MD, 2009; Merriam-Webster, 2007). Non-medical individuals often erroneously use the words “obesity” and “overweight” synonymously (Hawkins, 2007). Within the African American community, there is a wider range of “acceptable” body sizes, therefore “obesity” and “overweight” are more difficult to define culturally (Hawkins, 2007; Towsend-Gilkes, 2001). Culturally within the African American community, terms such as “big-boned,” “PHAT” (pretty, hot, and tempting), and “fine” are articulated to describe obese AAW or attractive AAW of any size. These terms are culture-specific and are spoken by both genders within the community. The terms describe what is flattering, normal, and cultural (Edwards & Poff, 2008). For the purposes of this research study, the term “obese” or “obesity” will be used in its scientific connotation, which is a person who has a BMI of 30 kg/m² or greater. It is recognized that other terms were used by the participants of the study as reported in Chapter V.

**Theoretical Perspective and Worldview**

Jacques Derrida, a French-born philosopher, challenged Western civilization’s emphasis on dichotomous categories that accentuate the positive as being dominant (Caputo, 1997). The
word “dichotomy” is defined as a “division into two mutually exclusive, opposed or contradictory groups” (Dictionary.com, 2010). Examples of dichotomy include “good and bad,” “male and female,” and “white and black.” Another example, “PHAT” (pretty, hot, and tempting) in the African American culture describes an attractive, desirable woman while in Western society, PHAT describes a non-attractive, overweight or obese woman who needs to lose weight. Dichotomy, in Western text, Jacques Derrida concluded, explored hierarchies with one being more valuable than the other. He believed that all words have meaning and the meaning is hidden behind the word itself. He felt all words have significant meaning that could be analyzed and utilized in a positive way (Caputo, 1997).

Postmodernism opens the stage to examine philosophical truths as not having uniformity. Instead, it allows for diversification and analysis of traditional Western beliefs and values. This allows for multiple viewpoints and approaches to nursing ontology.

I subscribe to the postmodernism ideas of pluralism and diversity. I agree with Derrida who subscribed to deconstructing words, values, and ideas in order to gain true meaning, interpretations, and underlying messages (Caputo, 1997). Researchers can gain true meaning through exploring differences among individuals, communities, and cultures. Thus, there is no hierarchy of words or meaning. Instead, the meanings of words, beliefs, and values of individuals, communities, and cultures are diverse. Traditional Western values and beliefs should be questioned by researchers and individuals. There is not a unified meaning for any word, belief, or value system. Opposing ideas give light to new possibilities and meaning.

For example deconstruction can be used to challenge traditional Western philosophy and its stereotypical perceptions. Deconstruction allows for broader perspectives of oneself and other
cultures. Ultimately, deconstruction can have meaning for nurse researchers (Crotty, 2007). In addition, conceptual models in research using a deconstructive, post-modernism perspective will be more attuned to the unique cultural perspectives, ideas, and beliefs of the population being researched. This allows for building of knowledge from many perspectives.

Black Feminist Theory challenges the traditional Western philosophical thought process. Black Feminist Theory is derived from Critical Social Theory (CST), which theorizes that social reality is historically derived and is reproduced by individuals due to social, cultural, and political constraints (Collins, 2000). CST also theorizes that behavior, environment, and person are bi-directional, influencing determinants (Kincheloe & McLaren, 1994). Black Feminist Theory provides an interpretive framework that explores social, political, and economic issues that specifically influence AAW (Gentry, Elifson, & Sterk, 2005). This theoretical framework will be used as a foundation to guide this study with AAW and their struggle with obesity. Black Feminist Theory utilizes the unique cultural experiences of AAW to gain understanding of how race, class, and gender have contributed to decision-making within their individual, family, and fictive kin cultural environment.

Black Feminist Theory addresses the oppressive nature of Western civilization that has historically impacted cultural norms and specifically has impacted AAWs’ self-definition and self-worth (Collins, 2000). Black Feminist Theory integrates how race, class, and gender oppression impacts the basic concepts of self-definition and self-worth found in this theory. Self-definition as defined by Black Feminist Theory is those “lived experiences” that fashion a personal idea of self. Self-worth as defined by Black Feminist Theory is the envelopment of a positive self-esteem or confidence in oneself (Collins, 2000). Class as defined by Black Feminist
Theory is the life experiences that influence behavior and how an individual comprehends and solves problems (Shambley-Ebron & Boyle, 2004).

Also, Black Feminist Theory addresses how racism, classism, and gender have an important impact on behavior and thought of AAW in their day-to-day lives. An African American woman’s decision on when to lose weight and her perceptions of ideal body size are examples of AAW’s unique cultural experiences (Hooks, 2000) impacted by race, class, and gender.

The concepts of race – being African American, class – being a subordinate culture, and gender – being female encapsulate how body size and weight are perceived. According to Black Feminist Theory, the experiences and ideas shared because of race, class, and gender provide a unique angle of vision of self. These experiences and ideas influence self-definition and self-worth among AAW (Collins, 2000). Also, the concepts of race, class, and gender impact a major concept found in black feminism which is empowerment (Buxton, 2008; Collins, 2000). Empowerment of any culture is based on the basic tenets of knowledge, social, and economic independence, and community and political strength (Hooks, 2000). AAW have historically felt disempowered due to their race, class, and gender. They have historically struggled leading to overall lower SES and living in communities that may lack the support needed for better dietary choices, exercise facilities, and improved health care (Yancey, Leslie & Abel, 2006).

Black Feminist Theory suggests that AAW’s perception of self correlates with their ability to control their environment. Moreover, the theory also suggests that race, class, and gender place AAW at a socio-economic disadvantage. Thus, the disadvantages of being African American and a woman influence behavior due to exposure to oppression (Collins, 2000; Hooks,
Oppression can be classified as experiencing to racism, lower-income, inferior education, and/or inferior job status in comparison to non-Hispanic white individuals and other ethnic groups in the United States who have historically had better opportunities for education, better jobs, and higher incomes (Hooks, 2000).

The concepts race, class, and gender found in Black Feminist Theory are interwoven. It is theorized that an individual’s knowledge attainment in helping to define herself and her self-worth will ultimately empower the African American woman (Few, 2007; Hooks, 2000). Empowerment will bring about individual, group, and community change (Collins, 2000), thus decreasing health disparities and improving health outcomes.

Also, Black Feminist Theory highlights gender-specific, class-specific, and race-specific issues that cannot be addressed adequately from traditional conceptual frameworks. This theory puts AAW at the center of analysis and allows AAW to self-define themselves based on their cultural beliefs and experiences (Few, 2007; Collins, 2000; Shambley-Ebron & Boyle, 2004). The theory allows the researcher to gain understanding of the common challenges that obese AAW perceived in regards to perception of body size. Thus, Black Feminist Theory is a theory specific for AAW and their unique experiences.

Black Feminist Theory enables the researcher to deconstruct Western views of perceived body size. This will aid in gaining a culture-specific understanding of obesity among AAW and building knowledge. The theory also enables the researcher to describe the cultural norms that influence perception of body size which may ultimately: (a) improve understanding of core cultural values that may influence weight loss and weight management; and (b) inform culturally
tailored educational interventions to improve success with weight loss and weight management of obese AAW.

**Significance of the Study**

The U.S. Department of Health and Human Services National Institutes of Health’s (NIH) obesity research agenda provides rationale and direction specifically related to the need for extensive cultural research within the African American community and specifically for AAW (Think Tank on Enhancing Obesity Research, 2004). This report includes recommendations for gaining understanding on how culture impacts weight loss. Another recommendation includes using culturally appropriate theoretical models for research with AAW (Banks-Wallace, 2000; Shambly-Ebron & Boyle, 2004).

A review of the literature provides evidence that obesity is a complex issue. Although socioeconomic factors play a pivotal role in obesity among AAW, there are significant gaps in the research literature about perceived acceptable body size and cultural influences that impact the desire for obese AAW to lose weight. In-depth individual interviews and observations from an emic or insider’s point of view are necessary in order to gain a perspective of the perceived cultural influences. For example, I found evidence that culture plays a role in how AAW perceive their bodies through a small ethnographic pilot study conducted from January to August 2010. Two participants were recruited and participated in the interviewing process. The overall emerging themes identified were: (a) obese AAW rely on family and friends for validation of an acceptable body size and when there is a need to lose weight or maintain weight loss; and (b) obese AAW do not like to be compared to other ethnic groups or even women within their own ethnic group or ethnic subgroups because individual AAW consider themselves unique.
No research has described cultural perspectives of self-definition and self-worth that influence obese AAW to lose weight. The concepts of self-definition and self-worth cross all socioeconomic and educational levels for AAW. These concepts are not limited to poor and/or less educated people. This research study will provide culture-specific norms of perceived body size among obese AAW of different socioeconomic and educational levels.

Current research studies on AAW are narrowly focused (Kumanyika, Morssink, & Agurs, 1992). Cultural norms about perceived body size and self-definition and self-worth that relate to perceived body size among obese AAW have not been described in the research literature. Thus, this proposed research study will improve scientific knowledge through improving knowledge of cultural norms, self-definition, and self-worth and their impact on obesity among AAW. This new scientific knowledge will lay the groundwork for improved understanding of cultural norms of obese AAW and for developing culturally adapted interventional programs for weight management for obese AAW.

**Summary**

The purpose of this study was to describe obese AAW’s cultural norms about perceived body size and describe obese AAW’s self-definition and self-worth that relate to perceived body size. This chapter has provided an overview of the concept of obesity. This study will aid in the understanding from an emic point of view obese AAW’s perception of body size. A descriptive focused ethnographic method was used to describe the influence of culture on the phenomenon of perceived body size and self-definition and self-worth related to body size. Findings will be used to generate nursing knowledge and theory that will shape interventions designed to reduce obesity among AAW in the United States.
Black Feminist Theory served as the theoretical framework for conducting this research. This chapter included the essential concepts found within Black Feminist Theory. The theory shows how the use of a post-modern, critical social theory can aid in having a different perspective on cultural norms of perceived body size of obese AAW.
CHAPTER II: REVIEW OF THE LITERATURE

Introduction

This chapter is divided into five sections. The first section examines scientific research that explores how social and economic factors influence obesity among AAW. This section also discusses mortality rates due to health disparities. The second section explores genetic factors that play a role in obesity among African Americans and specifically AAW. The third section examines African American culture. The fourth section examines gaps in the literature to include culturally viewed perceptions of weight and perceived body size among obese AAW. The fourth section will also address gaps in the literature related to obese AAW’s cultural norms relevant to perception of body size and obese AAW’s self-definition and self-worth in relation to perceived body size. The fifth section examines additional research results.

The literature search included CINAHL (EBSCO), Medline, and Web of Science from 1980 to 2012. The search was limited to adults aged 18 and older living in the United States. The following key search words or various combinations of key words or phrases were used: obesity, obesity and genetics, African American women, African American women and health, African American women and self-definition, African American women and body image, African Americans and obesity, African Americans and diet, African Americans and exercise, African Americans and SES, African Americans and family, African American women and obesity, African American women and self-worth, African American culture, African American culture and weight, Black Feminist Theory, and African Americans’ perception of health. An extensive review of the literature showed no research has described obese African American women’s
cultural norms of perceived body size or self-definition and self-worth that relate to ideal body size among obese AAW.

**Social and Economic Factors**

Social and economic factors such as lower education, lower income, ethnicity, and access to health-care are acknowledged in the literature as influential determinants for a higher risk of obesity (Salonen et al., 2009). These factors are also highly correlated with health risks such as coronary heart disease, hypertension, stroke, Type-2 diabetes mellitus, and certain types of cancer (Hawkins, 2007, CDC, 2009). Many studies have found an association among socioeconomics, obesity and obesity-related health issues among African Americans, specifically AAW when examining race and gender.

Schieman, Pudrovski, and Eccles (2007) in a multinominal logistic regression analysis study of 1,164 adults aged 65 and older, examined gender, race, and SES on perception of body weight among older adults. The study included 293 non-Hispanic white women, 291 AAW, 295 non-Hispanic white men, and 285 African American men. The study found that AAW were more likely to be overweight or obese than non-Hispanic white men, non-Hispanic white women or African American men. The study also found that AAW had the lowest SES compared to other ethnic groups.

Another study explored racial and socioeconomic factors influencing obese women’s weight management practices. This study using grounded theory recruited 27 participants for focus groups in the state of Maryland. The study included seven low SES AAW, six high SES AAW, eight low SES non-Hispanic white women, and six high SES non-Hispanic white women. Emerging themes from this study included: (a) women of lower SES expressed cost concerns
with weight management efforts; and (b) AAW in all SES groups identified that cultural
influences such as food choices, environment, and family “complicate successful” weight
management (Davis et al., 2005, p. 1541).

Bowman (2009) used data from The National Health and Nutrition Examination Survey
conducted from 1999 to 2002 to compare the socioeconomic, lifestyle, and health status of
Caucasian and African Americans along with examining their food and nutritional intake
compared to their body weight status. Caucasian and African American adults ($N=1,398; \ N=354$)
aged 65 and older participated in the study. The study found that more African Americans lived
in low-income households than non-Hispanic whites (40.4% versus 21.3%). The study also
found that of the 177 AAW in the study, 75.1% were overweight or obese, while of the 689 non-
Hispanic white women, 59.7% were overweight or obese.

Allen, Mayo, and Michel (1993) found in a naturalistic study comparing 36 non-Hispanic
white women and 31 AAW body sizes that AAW of lower SES had a wider range of perceived
normal attractive body size than non-Hispanic white women. The study found that a wider range
of perceived normal attractive body size is developed from comparisons with other women in
their social settings and their perceived normal attractive body size influences whether or not the
women engaged in physical activity.

Weight related attitudes and practices of AAW were explored using a self-administered
questionnaire given to 500 AAW aged 25 to 64 (Kumanyika, Wilson, & Guilford-Davenport,
1993). The study found there was a higher awareness of obesity-related health risk among this
sample but perceived psychosocial consequences of being obese was limited. The study also
showed that social pressure along with body image impacted weight loss efforts.
Many past studies have identified SES as a strong link to body size and obesity among African Americans and AAW, specifically. Although my research study does not focus on the impact of SES on AAW, it does recognize as stated in Chapter I that salaries and education for AAW are less than any other ethnic group in the United States. It is important to identify studies that capture the socioeconomic and education component that may impact AAW physically, such as body size, but also may impact AAW emotionally, such as their self-definition and self-worth. According to some research studies, SES directly impacts environmental issues which then impact the ability for individuals to be physically active and make healthful dietary choices. Yancey, Leslie, and Abel (2006) for example, found that lower SES and living in communities that lack support needed for better dietary choices played a crucial role in the incidence and prevalence of obesity. These issues (lower SES and lack of support) can result in sedentary lifestyles and higher dietary consumption of fatty foods, leading to obesity and other weight related issues such as cardiovascular disease, hypertension, and Type-2 diabetes mellitus. Hawkins (2007) and Wilbur, Chandler, Dancy, and Lee (2003) also concluded that social class correlates with physical activity and healthful dietary choices. Duncan et al. (2003) found that AAW living in poor communities were more likely to have higher BMIs and be less successful with weight loss and weight loss interventions than non-Hispanic white women living in more wealthy communities. These researchers concluded that the higher the social class, the more likely an individual will be physically active and choose more healthful foods.

Current statistics indicate that education level is correlated with weight. Corral et al. (2012) found in a nationwide random telephone CDC survey on 11,142 self-identified African-American adults (3,791 men; 7,351 women) that lower education individuals were more likely to
be overweight or obese than college graduates. The CDC (2010) reported that 36.4% of women with less than a high school education were obese compared to 29.5% of women with a high school diploma. Women with a college degree had the lowest prevalence of obesity at 18.6%.

The United States Department of Education (2010) identified that the national high school drop-out rate in 1980 for non-Hispanic white individuals was 11.4; for African Americans, it was 19.1. In 2008, the drop-out rate was 4.8 and 9.9, respectively. Although the drop-out rate has improved over the years, there is still a disparity between the ethnic groups. Since AAW lead the nation in obesity and the high school drop-out rate is higher among African Americans, these statistics may show evidence that socioeconomics and education can play a role in higher obesity incidence and prevalence among African Americans.

Research also supports the notion that segregated neighborhoods are limited in the financial and community resources available to people living in those neighborhoods. Nationwide, 60-70% of African Americans live in predominately African-American neighborhoods while 60-70% of non-Hispanic whites reside in predominately non-Hispanic white neighborhoods that are unequal in their “built environments” such as recreational facilities, restaurants, and higher nutritional food choices in supermarkets (Powell, Slater, Chaloupka, & Harper 2006). Corral et al. (2012) identified that segregated neighborhoods are more likely to have fast food outlets, less likely to have fresh produce in the local supermarkets, and less likely to have recreational facilities than predominately non-Hispanic white neighborhoods. The study also found that African Americans living in segregated neighborhoods were less likely to eat daily fruit and vegetables or engage in daily physical exercise.
Poor areas with lack of community resources such as transportation, local medical clinics and hospitals, local preventive services, and school resource programs result in feelings of powerlessness within the African American community (Allen et al., 1993; Davis et al., 2005; Schieman et al., 2007). It has also been suggested that powerlessness among AAW due to socioeconomic disparities as a result of “racism and sexism” causes anger and stress, resulting in possible health consequences such as obesity, diabetes, and hypertension (Thomas & Gonzalez-Prendes, 2009, p. 94).

Higher mortality rates as a result of health disparities due to high prevalence and incidence of obesity among African Americans are documented in the literature. Stevens et al. (2012) in a prospective investigation studied 15,792 African American and non-Hispanic white adults aged 25 and older. This study found that BMI and mortality rates were slightly higher in African Americans and specifically AAW than in non-Hispanic white individuals and non-Hispanic white women.

A quantitative study examined the relationship of BMI and waist circumference with the risk of death among 51,695 AAW aged 21-69 (Boggs, et al., 2001). Results showed as BMI increased so did the risk of death. Waist circumference was associated with risk of death with obese AAW women in the study.

**Genetic Factors that Play a Role in Obesity**

The role of genetics and identifying genetic markers in obesity and the management of weight loss in obese individuals can be individualized as more research is done in how genetics contribute toward obesity. Genetics may play a role in the issues related to obesity and weight loss (Sorensen, 2001). Research is beginning to emerge recognizing that multifactorial
interactions are important in the development of effective management programs for obese individuals.

Despite the need for general dietary recommendations such as low fat, low calorie, high fiber diet, current research findings show the effects of nutrigenomics, which is the study of the interaction between nutritional intake and genetic variation, or gene-diet interactions (Johnson et al., 2006). Nutrigenetically tailored diets may result in better compliance, longer term BMI reduction and improved blood glucose levels, according to one study (Ioannis et al., 2007). Nutrigenetically tailored diets may also allow for the identification of individual variations or responses to common obesity interventions such as low-fat and low-cholesterol diets that can be designed for individual genotypes, although implementing single dietary changes may not sufficiently treat or prevent obesity. From a multifactorial perspective, genetic and familial propensities to obesity coupled with diets higher in fat will most likely result in higher BMIs (Johnson et al., 2006). This supports the assumption that the right diet must be defined in the context of an individual’s genotype (Eckel, 2005).

Studies have begun to show an association between obesity and genetics (Bouchard, 2010; Choquet & Meyre, 2011). Recognition of this association began as early as 1962 with the identification of the thrifty gene (Bouchard, 2007). The thrifty gene is theorized to ensure survival of famine populations by storing energy as fat during flourishing times (Hawkins, 2007). Since 2003, over 400 genes have been identified as directly or indirectly affecting human obesity (Synder et al., 2004). Studies have identified the linkage of leptin levels which is correlated with total adiposity, to a region on chromosome 2 containing a gene pro-opiomelanocortin that is specific in African American individuals and Hispanic American
individuals (Commizzie & Allison, 1998; Rotimi et al., 1999). Few genes to date have been identified to contribute to “monogenic forms” of obesity, but researchers currently theorize that there are multiple genes or “polygenics” as contributors to obesity in individuals (Sorensen, 2001; Hinney, Vogel, & Hebebrand, 2010).

The notion of the impact of genetics on obesity is somewhat recent in the literature. Identified evidence of chromosomal linkage to obesity in African Americans in the research literature provides evidence for future research (Cheng et al., 2009) in this area. It is yet to be determined how genetics play a role in obesity-related research along with identified research in environmental and sociological factors. The genetic influence will require further genetic research to gain understanding.

**African American Culture**

As discussed in Chapter I, the literature defines culture as the “shared knowledge and schemes created by a set of people for perceiving, interpreting, expressing, and responding to the social realities around them” (Lederach, 1995, p. 34). Some anthropologists have identified larger body size attitudes in some African cultures. It is thought these African cultures may have passed along these beliefs from generations to present day, which plays a role in the cultural beliefs of some African American individuals and families in the United States (Brink, 1989).

A qualitative study using six focus groups of middle aged obese AAW explored perceptions of body size to design a weight loss intervention program. The study found that there was an acceptance of larger body sizes among the women in the study (Befort, Thomas, Daley, Rhode, & Ahluwalia, 2008).
According to the literature, family and social pressure associated with cultural tendencies often bring about acceptance of body image and body size. Obese AAW belong to two cultures. They belong to the culture of obesity as well as their familial culture. Each of these cultures is interactive and influential among obese AAW. The family and social pressure of being obese should be considered in planning culturally responsive nursing interventions and discussing body image and body size (Base-Smith & Campinha-Bacote, 2003).

Low-income AAW (N=46) in a qualitative study using structured interviews shared their thoughts about weight loss and perceived weight loss obstacles. Mastin, Campo, and Askelson (2012) found that the women understood the benefits of weight loss but preferred familiar cultural and comfort foods than foods that may increase weight loss efforts.

Body image and weight were explored among AAW with 24 AAW aged 21-47 (Baturka, Hornsby, & Schorling, 2000). The study found that family and social pressure tend to bring about self-acceptance of body image. The authors also found that there is cultural pressure for the AAW to be self-accepting of their body image and there are social and physical barriers to weight loss. This is similar to findings that internal factors such as attitudes and family structure as well as external factors such as cultural beliefs may have implications for weight loss and weight management (Davis et al., 2005). In this qualitative study, some of the AAW also recalled being pressured by family members to accept being overweight.

There were several studies that highlighted the importance of culture in understanding African Americans including their perceptions on food choices, family beliefs, and social pressures. A study of 65 AAW between the ages of 40 and 65 participated in a focus group. The
study identified cultural and social norms were significant around food choices including types of food the amount of food (Rowe, 2010).

Perceptions of obesity among non-Hispanic white women and AAW of different body sizes were studied to determine differences in body images, knowledge of health risk, and weight loss attitudes (Thomas et al., 2008). The study used focus groups to collect data ($N=17$ African American; $N=13$ non-Hispanic white women). The study found that both groups ate in response to negative emotions. AAW liked their body image more than non-Hispanic white women. A barrier to weight loss included culture such as family influence. Time, money, and lack of support from physicians were also considered barriers to weight loss.

Beliefs about body size, weight, and weight loss among obese AAW were explored in order to form a weight loss intervention program (Befort et al., 2008). The study used focus groups ($N=62$ obese AAW). The study found that the women in the study believed that they could be attractive and healthy at a larger size, were more likely to identify eating behavior such as food choice as the primary cause for weight gain, and that health and functional status were motivators for weight loss.

In a quantitative study at a historically Black university of 191 male and female college students, researchers found that African American female students were more likely to be obese than African American male students (Gipson et al., 2005). The findings also suggested that African American female students were accepting of their larger body size.

In a qualitative study of 55 AAW, perceptions of weight had both cultural and individual meanings (Gore, 1999). AAW’s criteria for weight loss were sometimes identified by
comparisons with Western dominant culture. The same study also found that perceptions of ideal weight had cultural meaning as well as individual meaning.

These cultural beliefs of acceptance of body size are shared from generation to generation. A larger body size is not only acceptable but valued within the African American culture and is shared with children. The research literature supports this cultural belief. One study found that African American parents consider their children “healthy” or “cute” if they are considered “plump” (Walcott-McQuigg, 2005, p. 157). Although there are some studies that address the cultural beliefs of acceptable larger body sizes, research has not addressed my research questions for adult AAW: (a) what are obese AAW’s cultural norms relevant to perception of body size? and (b) what are obese AAW’s self-definition and self-worth in relation to perceived body size?

**Gaps in the Literature**

Although there is extensive research regarding obesity and associated medical conditions demonstrated in this literature search, there are gaps in the research literature describing the cultural perceptions of weight and perceived body size with obese AAW. There are no descriptive focused ethnographic studies that describe obese AAW’s cultural norms about perceived body size or describe obese AAW’s self-definition and self-worth that relate to perceived body size. Observations and in-depth individual interviews from an emic or insider’s perspective are lacking in the literature. Furthermore, conceptual models specific for AAW such as Black Feminist Theory have not been used as a conceptual framework to gain understanding of the African American Woman’s perspective.
Although some studies have reported that AAW are less likely to engage in a regular exercise regimen and less likely to have access to affordable, healthful foods (Yancey, Leslie, & Abel, 2006), describing cultural norms about perceived body size have not been examined in nursing research (Hooks, 2000). Gaining insight on how race (being African American), class (subordinate culture), and gender (being female) influence the cultural perceptions of weight and perceived body size is important. This insight is significant research that will ultimately impact the need for future studies.

The significance of a large proportion of AAW being the head of households shows the financial responsibilities AAW have within the household resulting in families being fully dependent on the woman for financial sustainability. AAW head 43% of all African American households (Hamilton-Mason, Hall, & Everett, 2009). This financial responsibility may impact how AAW define themselves (self-definition) and what their perception of themselves may be (self-worth). Neither of these concepts – self-definition or self-worth - has been described in the research literature as it relates to obesity among AAW.

Current literature has identified that SES including low income and lower levels of education is highly correlated with an increase in incidence and prevalence of obesity. AAW are more likely to have lower incomes and lower levels of education in the United States as previously stated. It is important to remember that self-definition and self-worth cross all socioeconomic and educational levels. It is important therefore to describe the cultural perceptions of weight and perceived body size with obese AAW from different income levels and educational levels. Ethnographic research in this area provides a starting point to describe cultural avenues on perspectives and factors that influence obese AAW to lose weight. Gaining
insight will help to develop scientific nursing knowledge to: (a) improve understanding of core values that may influence weight loss and weight management; and (b) enhance culturally competent educational interventions to improve success with weight loss and weight management of obese AAW.

The literature also identifies interventional programs established are often problematic because of factor affecting recruitment and retention such as trust and cultural competency (Taylor, 2008). The lack of scientific data to support how AAW may differ from other ethnic groups in their perception of body size may be a result of limited scientific data. These problems include successful weight loss and the ability to sustain the weight loss over time. Intervisonal approaches relate to only short-term goals and do not consider long-term approaches to sustain weight loss (Kumanyika et al., 2007).

**Additional Research Results**

The previous discussion describes research indicating influences that may uniquely impact decision-making for African Americans and specifically AAW related to obesity. This section describes research literature that shows similarity among ethnicities in decision-making about weight loss and perception of health.

Some studies found that the perceptions of acceptable body size are similar for obese AAW and non-Hispanic white women. For example, the relationship among weight, body dissatisfaction, and self-esteem was examined among African American and non-Hispanic white non-pregnant female dieters (N=21,920) aged 21 to 65 who were “generally overweight” (Caldwell, Brownell, & Wilfley, 1997, p. 128). The study found that although AAW had higher BMI and fewer were married, both racial groups had equivalent body dissatisfaction.
Another study with a sample of 167 AAW compared the relationship of weight, body image, self-efficacy, and stress to health-promoting behaviors among college educated AAW. The quantitative study showed that a positive body image and positive self-efficacy were related to the intent to engage in health-promoting behavior. The study also found that levels of stress negatively influenced a person’s decision to adopt health-promoting behaviors (Edmonds, 2006).

A longitudinal quantitative study on perceptions of self and ideal body size were measured over a 13-year period (Lynch et al., 2008). The study used a sample size of 3,665 of African American men and women and non-Hispanic white men and women. The findings showed that when obese AAW perceived themselves as obese and felt their body size was large, they gained less weight over time.

Another study of 80 AAW and 80 non-Hispanic white women examined a broader conceptualization of attractiveness of different ethnic backgrounds. The study found few differences between AAW and non-Hispanic white women in their concepts of attractiveness. Both ethnic groups reported similar views of attractiveness (Davis, Sbrocco, Odoms-Young, & Smith, 2010).

A quantitative study of 33 AAW and 155 non-Hispanic white women compared perceived and physiological measures of health. The study found that although AAW were more obese, less fit, and ate less healthful foods than non-Hispanic white women, they perceived their weight, physical shape and appearance, physical fitness, and eating habits to be no worse than non-Hispanic white women (Duncan, Anton, Newton, & Perri, 2003). This study showed that both AAW and non-Hispanic white women perceived themselves similar in their perception of appearance and health habits.
Summary

In summary, obesity related studies are narrowly focused and have not historically taken into account obese AAW’s cultural norms about perceived body size or obese AAW’s self-definition and self-worth that relate to perceived body size. Cultural differences must be understood in order to achieve favorable outcomes that can improve health among AAW.

The current research literature has focused on socioeconomic and environmental factors such as education and income that impact obesity among African Americans and AAW, specifically. Current research provides only the social and economic perspectives that influence decision-making among obese AAW to lose weight or management weight loss. It does not provide a comprehensive perspective or understanding of the cultural perspectives and cultural factors that also play a vital role in this epidemic among AAW.

Some research literature acknowledges there are cultural and ethnic differences in body size perception that need to be described (Kronenfeld, Reba-Harrelson, Von Holle, Reyes, & Bulik, 2010). These cultural differences expand to all socio-economic levels within the African American population. The current literature also reveals that body size perception may or may not influence the desire to lose weight. In-depth individual interview can provide insight into how body size perception is influenced within the African American culture.

Finally, Black Feminist Theory has been used with AAW to explore other health issues such as HIV and AIDS, but has not been utilized with obesity. Black Feminist Theory which placed AAW at the center of analysis can provide a framework for researchers to describe cultural perspectives of self-definition and self-worth in obese AAW and describe cultural factors that influence cultural norms about perceived body size.
CHAPTER III: METHODOLOGY

Introduction

Qualitative research is used when the researcher is attempting to discover, describe, or explore underlying meanings or patterns of relationships in the “social world” (Dew, 2007, p. 425). As qualitative researchers immerse themselves into the social world or the “natural” setting for data collection, they are able to describe what is happening and how people act and react in their own setting. This unique way of data collection aids researchers in a broader understanding of human behavior (Hammersley & Atkinson, 2007; Spradley, 1979).

 Paramount to a qualitative approach is inductive reasoning. Inductive reasoning utilizes interviews, participant observation, visual methods, interpretive analysis, and field notes to gain an understanding of the social world. Prior theories or assumptions are set aside (Dew, 2007). An ethnographic approach is rooted in anthropology. The goal of ethnography is to describe the culture from an emic or insider’s view. This view reflects the values and beliefs of the individual and culture being studied in its own terms (Spradley, 1979). Ethnography aims to not only describe what members of a culture think or do but through in-depth engaging with members of a culture and its community, gain understanding of cultural concepts and behavior patterns. These cultural concepts and behavior patterns provide a worldview for researchers and a focal point for future health care for an ethnic group (Borum, 2007, Craig & Cook, 2007; Goulding, 2005). This is an appropriate research method when little is known about the research topic (Spradley, 1979) such as describing obese AAW’s cultural norms about perceived body size and describing obese AAW’s self-definition and self-worth that relate to perceived body size. Ethnographic research can generate new hypotheses or be the building blocks for future qualitative or quantitative
research (Kuhn, 1970; Spradley, 1979). Writing ethnography is a process that “brings the culture to life (Spradley, p. 204) and is written in everyday language (Sandelowski, 2000).

This descriptive focused ethnography guided by Black Feminist Theory aimed to describe personal and environmental influences impacted by race, class, and gender (Collins, 2000) in order to gain meaning of cultural norms about perceived body size. The study also aimed to put AAW at the center of analysis utilizing the concepts found in Black Feminist Theory (self-definition, self-worth) in order to gain meaning of behavior fashioned by AAW’s lived experiences within the family, community, extended family, and fictive kin.

There is no identified published research describing obese AAW’s cultural norms about perceived body size or describing obese AAW’s self-definition and self-worth that relate to perceived body size. It is hoped that this descriptive focus ethnographic study will build a foundation in order to gain understanding of obese AAW’s cultural perceptions and factors of obesity among AAW in order to generate nursing knowledge and theory that will shape interventions designed to reduce health disparities among obese AAW.

In this chapter, I describe the method used in this research study. This chapter is divided into the following sections: research design, setting, description of the participants, recruitment, recruitment challenges, protection of human subjects, procedure, data analysis, and summary.

**Research Design**

The descriptive focused ethnography has several unique data collection methods that distinguish it from other ethnographic research: (a) short-term field visits; (b) intensive use of data collection and data analysis; and (c) participant observation of small elements of a specific culture. The literature has supported that the social sciences including nursing benefit from short-
term participant observation rather than the anthropological long-term participant observation. Unlike anthropologists, social scientists that choose a focused ethnography generally focus on an element of a familiar culture, deeming it more advantageous to have short-term participant observation (Knoblauch, 2005).

The principles of James P. Spradley (1979), Martyn Hammersley (2009), and Paul Atkinson (2009), renowned ethnographers, were used substantially for my research design. I used their approach for developing a research sequence including: (a) asking descriptive interviewing questions; (b) observing participants; (c) transcribing data; and (d) data analysis.

The main goal of an ethnographic approach is to describe the influence of a culture on the phenomenon of interest (Sandelowski, 2000). My main goal was to describe obese AAW’s cultural norms about perceived body size and describe obese AAW’s self-definition and self-worth that relate to perceived body size. An ethnographic approach to my research enabled me to go beyond what was said to begin to understand the “shared system of meanings” called culture (Goulding, 2005, p. 294) by discovering the cultural knowledge that influenced perceptions of body size among obese AAW. Thoughts, feelings, memories and ways of doing things from a cultural perspective were revealed (Craig & Cook, 2007). My research approach allowed a better understanding of the perception of body size through describing the specific cultural influences better than other qualitative research designs (Roper & Shapira, 2000).

Setting

South Carolina has a total population of 4,625,364, with 27.9% of the population being African American (U.S. Census Bureau, 2012). In 2006, the median income for African Americans in South Carolina was $22,473 (CDC, 2007). The median national income for all
ethnicities from 2006-2010 was $51,914. Persons below the poverty level during the same timeframe were 16.4%. South Carolina has 42 counties. Richland County was the county where all data were collected. Richland County was chosen for this study because it houses the capital city of Columbia. It is also where the principal investigator (PI) lives. Columbia is the largest city in South Carolina, 41.7% of the population are African American (U.S. Census Bureau, 2012). Richland County has a population of 384,504 with 14.3% living below the poverty level. The county has 181,974 non-Hispanic whites, 176,538 African Americans, 8,637 Hispanics, 8,548 Asian-Americans, 1,230 American Indians and 7,358 classified as “other.” Overall, as of 2010, 83% of persons aged 25 and above graduated from high school in the state of South Carolina with a high school diploma (U.S. Census Bureau, 2012).

**Description of the Participants**

A purposeful sampling method was used. Purposeful sampling uses predetermined criteria and is often used in qualitative research to provide adequate information to ensure rich or detailed data (Sandelowski, 1995; Morse, 2005). This approach ensured the participants had a unique knowledge of the study chosen. The study was not intended to be generalizable but to describe the perceptions of obese AAW and discover interpretive theory (Germain, 2001).

Inclusion criteria were: (a) female aged 18 or older; (b) African-American descent; (c) self-reported weight and height in order to calculate a BMI of 30 kg/m2 or greater; (d) willing to participate in two, 60-90 minute audiotaped interviews; (e) willing to discuss cultural perceptions of weight and perceived body size; and (f) speak English.

A sample of eight obese AAW aged 18 or older were recruited for the study. Participants were recruited until saturation or no new themes emerged and the research questions were
answered. Sample size in qualitative research not only includes the number of participants in the study, but also “the number of interviews and observations conducted” (Sandelowski, 1995, p. 180). Thus, the small sample size facilitated an in-depth study (Hammersley & Atkinson, 2009).

**Recruitment**

Recruitment settings were two local African American churches and a local predominately African American neighborhood. A local community pastor and a local Registered Nurse were natural gatekeepers who provided entrée to obese AAW within these settings. Their affiliations within these communities provided assistance in the recruitment of obese AAW. Potential participants for the research study were recruited by the (PI) with the assistance of the natural gatekeepers through recruitment flyers (Appendix A) and word of mouth. Recruitment flyers were posted by the PI in the two churches and local predominately African American neighborhood.

The Registered Nurse talked to women within the church and in her neighborhood about the study. I visited the neighborhood twice in order to establish rapport and introduce myself to the women and families living in the area. I posted my flyers in the neighborhood at the local store after my visit.

I was introduced in church by the pastor during Sunday service as a doctoral nursing student looking for “overweight ladies” interested in talking to me about how they viewed themselves. The pastor told me that he would announce in church about the study being done by me and to contact me if they were interested in being a part of the study. My flyers were posted by me in the vestibule of the church.
Approximately 35 women called me over the phone to gain more information about the research study. At that time, the women were given an opportunity to decide if they wanted to make an appointment to talk with me in person in a mutually agreed upon place such as the church or their private home to determine if they met the inclusion criteria for the study. Of the approximate 35 women who called, 9 women decided to follow through with making a face-to-face interview appointment. I then made interview appointments with nine women and reserved a private location of the participants’ preference. All nine of the women chose their private home which was a familiar place for the interview appointment. Eight of the women kept their appointments. One woman was not home when I arrived and did not return my phone call or the phone call of the gatekeeper. The other eight women met the inclusion criteria, and participated fully to the end of the study.

**Recruitment Challenges**

Recruitment challenges are an issue addressed in the literature when conducting research with African Americans. Historically, recruitment and participation of African Americans in scientific research have been difficult preventing extensive research in the area of health disparities (Kumanyika et al., 2007). Reasons for low recruitment and participation include fear of social injustice, lower education levels, lower economic levels, cultural differences, and privacy issues (Qualls, 2002). These identified recruitment and participation in research challenges are well documented in the research literature and pose a significant challenge for scientific researchers.

I found that using natural gatekeepers (local community pastor; Registered Nurse) was paramount in successful recruitment. It provided the door to allow me to gain entrée into the
community and thus enabled me to recruit obese AAW in my study. The natural gatekeepers were able to introduce me to women in the community and help me to immerse myself into the community for observation. The natural gatekeepers established the initial appointment times for me to meet with the women individually. The natural gatekeepers made themselves available either by physically being nearby or via phone during the initial semi-structured interview. The natural gatekeepers being available helped the participants feel comfortable with the initial interview. After establishing rapport with each participant, I was able to set up second interviews independently with each participant in the study.

**Protection of Human Subjects**

Obese AAW were recruited exclusively in this research study. I recognized and ensured the need to protect the rights, welfare, and wellbeing of the participants involved in this research study. Approval was obtained from The University of Arizona’s Institutional Review Board (IRB) prior to any data collection (Appendix B). I adhered to human subjects’ protection criteria to ensure risks to participants were minimized and reasonable in relation to anticipated benefits. In order to safeguard this vulnerable population, the following were adhered to: (a) a detailed explanation of the research study was provided by reading the consent form to the participants by the PI (Appendix C); (b) participant consent form was then obtained by the PI; (c) confidentiality of the personally identifiable information was maintained throughout the research and thereafter. For example, all tape recorders, transcripts, and field notes were maintained in a locked cabinet in the PI’s office. All interviews were accessible only by the PI on a password-protected file in the PI’s personal computer; (d) anonymity was maintained for all participants by using codes in lieu of names, birthdates, or other identifying information; and (e) participants were verbally
reminded throughout the study that they were free to withdraw from the research study at any time.

**Data Collection**

**Interviews**

After an informed consent was obtained from each of the participants, a demographic questionnaire (Appendix D) was completed. The self-completed demographic questionnaire provided information about each participant and verified that they did meet inclusion criteria, even though they had already met initial screening criteria. All of the participants met the secondary screening and were retained in the study. A small monetary gift of $15.00 was allotted to each participant. After the first interview, $5.00 was allotted and the remaining $10.00 was allotted after the second interview. This monetary allotment was not intended and did not seem to be coercive.

Each individual interview with the participant lasted 60-90 minutes. Each participant in the study completed two interviews. All interviews were audiotaped and transcribed verbatim. To assure anonymity, numbers were used in lieu of participants’ names in all written notes. I attempted to build a rapport with each participant during the interviewing process. I remained cognizant that the goal of each interview was to gain an emic perspective (Spradley, 1979), as each participant described how cultural norms influenced their perception of body size and their description of self-definition and self-worth related to their perceived body size.

In following Spradley’s (1979) recommendations of first ethnographic interviews, I attempted to develop a rapport with the participants and elicit information through descriptive questions, listening, and showing interest in a nonjudgmental manner. I asked the same initial
open-ended interview questions with each participant. All women were asked the following questions: (a) How do you see yourself when you look in the mirror? (b) Describe how your family sees your body size? (c) Describe how you think your body has changed over time? (d) Describe what do you like about yourself? and (e) What do you value about you? (Appendix E). As the participants began to feel comfortable with the interviewing process other prompts such as restating key phrases and silence were used based on responses of the initial interview questions and to clarify information obtained in the initial interview to improve rigor (Geertz, 1973). I was able to listen and observe in order to learn more of the culture (Spradley, 1979). Other examples of prompts used in order to learn more of the culture were: (a) “Really,” and (b) “Tell me more about that.”

**Participant Observation**

Participant observations were also conducted. Participant observation is defined as overtly or covertly viewing a person’s or persons’ behavior and the consequences of that behavior (Spradley, 1979). Participant observation according to Spradley (1979) includes recording specific details.

I conducted participant observation at two banquet events held at a local church within the African American community. Three of the participants actively participated in the two separate church banquet events. This gave me an opportunity to immerse myself as a participant in the African American culture and observe the banquet events. I had the opportunity to observe the women socializing with family and other guests throughout the night. I was able to observe the women’s eating patterns, cultural socialization with family and friends, and cultural foods served at the events.
I recorded field notes immediately following interviews and participant observations to capture body language during interviews, eating and socialization patterns, and cultural foods served at the banquet events. The field notes were a rich source of data for this study. Field notes or written records from observations of behaviors and interviews were maintained in detail in order to maintain a “thick description” of the culture. Use of observing, recording, and analyzing the culture were used to gain insight and meaning (Geertz, 1973).

**Data Management**

A software program, ATLAS.ti 6 was used in part for data management. Domains also called analytic categories (Spradley, 1979) from transcripts were entered into this software program for qualitative data analysis. The software program was used in part to view “semantic relationships” (Spradley, 1979, p. 108) and the interconnectedness of the codes. I was able to group the semantic relationships either by ATLAS.ti 6 or manually for broader concepts (themes). ATLAS.ti 6 was useful in seeing relationships and links to identify broader concepts or themes.

**Data Analysis**

Data analysis in ethnography, according to Spradley (1979), involves the “search for the parts of a culture and their relationships as conceptualized by informants (p. 93) also called participants. What is produced includes verbal descriptions, explanations, and theories. Analysis in ethnography is ongoing and inductive, utilizing data sources until a clear cultural picture is seen (Spradley, 1979). Since data analysis is not considered a separate stage of the research, it starts in many ways in the formation of the research questions and continues through the process of writing the dissertation. Most qualitative researchers will agree that formally the process of
analysis begins with analytic notes. This repetitive process results in theory generation, descriptions, and explanations of data (Spradley, 1979).

As with all ethnographic research, data analysis began with the initial interview and continued with my observations and field notes throughout the duration of the study. I listened to the audiotaped interviews and transcribed them verbatim. During this research study I compared the transcripts to the audiotaped data to confirm accuracy. Field notes were utilized to aid in accuracy of interpreting data.

In following Spradley’s (1979) recommendations of ethnographic research, key domains or analytic categories were generated from data bits or quotes identified as being important by reading and re-reading the transcripts line-by-line. Key domains identified led to constructing “semantic relationship” (p. 107) systems of classifications or codes which were named by the PI. These systems of classifications (codes) were compared and contrasted for analysis leading to theoretical notes which formed a chain of ideas that were abstract up into common themes. The common themes were constructed and placed into meaningful analytical units. This process continued until saturation or no new themes emerged. Field notes helped to compare and contrast responses from participants. Field notes were also used to describe my impressions and document themes as they emerged, as recommended by Spradley (1979).

Black Feminist Theory was a foundation for data analysis. Black Feminist Theory suggests challenges and experiences that are unique for AAW (Collins, 2000). Common descriptions and perceptions of obese AAW were analyzed to identify common themes and experiences shared among this group. As I analyzed the themes that emerged from the data, I was able to take into account how common challenges and experiences of race, class, and gender
impact obese AAW’s viewpoint on body size from a unique cultural perspective. Black Feminist Theory guided me to distinguish common themes and experiences that were unique to AAW utilizing the concepts found in Black Feminist Theory - self-definition and self-worth.

Analyzing from a Black Feminist Theory perspective, I was able to acknowledge other worldviews. Black Feminist Theory also enabled me to describe cultural perceptions and factors that may ultimately generate new theories and guide culturally-sensitive practice. Culturally-sensitive practice involves tailored programs and interventions that address the specific values and belief systems of that culture. Thus, gaining insight from an obese AAW’s viewpoint about ideal body size will assist practitioners and researchers in lifestyle modifications to improve health.

**Trustworthiness**

Trustworthiness of qualitative research findings is an evaluation of whether the findings are representative of the reality of the experience (Lincoln & Guba, 1985). Trustworthiness can be ensured by meeting criteria for evaluation of rigor (Lincoln & Guba, 1989). Four criteria were used to ensure trustworthiness in this study as recommended by Lincoln and Guba (1985): (a) credibility; (b) transferability; (c) dependability; and (d) confirmability.

Credibility or “truth of the findings” is established in qualitative research through peer debriefing or corroborating research with non-biased colleagues. Dr. Janice Crist, PhD, RN, FNGNA, FAAN – Associate Professor University of Arizona College of Nursing - and Dr. Carolyn Jenkins, DrPH, RDCDE, APRN-BC, FAAN – Professor Medical University of South Carolina College of Nursing – separately read the verbatim transcripts. Dr. Crist and Dr. Jenkins
identified common themes to compare with themes that I had previously identified. Dr. Crist and I spoke on several occasions in order to corroborate emerging themes identified.

I also shared my findings with an African American nursing colleague, who has a Doctorate in Education, to gain her perspective of my findings to ensure credibility. I felt that a cultural non-biased perspective from an African American colleague would support credibility. She gave feedback indicating that my findings were congruent with personal and professional experiences she has had in the community while living in the South and dealing with her own personal issues with obesity.

I maintained a reflexive journal in order to reflect and remain aware of my own personal biases, thoughts, and ideas. My journal incorporated feelings of being a health care provider and how that may or may not have impacted how I responded to the participants. Some of the concerns I considered with this research study included the following aspects of my research experience: (a) being African American; (b) being a woman; (c) being a nurse practitioner; and (d) being of a healthy weight. I felt these were differences between the participants and me that could have influenced how obese AAW might respond to my questions during the interviews and how I might interpret their response. I remained cognizant of being an African American woman, a nurse practitioner of healthy weight when I interviewed the women and when I observed them in the community. This enabled me not to be as easily influenced by my personal biases. Writing about being an African American woman who is a nurse practitioner of healthy weight in my journal was cathartic in revealing my biases so that they would not impinge on my research (Craig & Cook, 2007). A bias I identified was that healthy weight is important to me both
personally and professionally. It was important that this bias was not reflected when I interviewed the participants in this study.

Member checking is sharing findings with the participants involved in order for the participants to analyze findings and comment on them in order to decrease incorrect data interpretation. I shared my findings with two of the participants who were able to share their comments. Both felt I captured the feelings and ideas that they tried to share with me during the interviews. Credibility is also established through triangulation in which more than two methods of data collection, such as field notes, interviews, observation and/or reflective journal, are used to ensure adequacy (Lincoln & Guba, 1989). Interviews, observations, and field notes, were methods of data collection used in order to improve credibility.

Transferability or applicability is how the findings of an inquiry can be relevant in other contexts or with other participants. Transferability is ensured through thick description. Thick description entails describing in sufficient detail what the researcher can evaluate and maintain through a clear audit trail so other researchers can evaluate transferability (Lincoln & Guba, 1989). A clear audit trail is accomplished by maintaining raw data such as written field notes, data reduction and analysis including summaries of field notes, data reconstruction including themes, relationships, findings, and conclusions. A clear audit trail is also accomplished by maintaining process notes including strategies, materials relating to intentions and dispositions including personal notes and expectations, and instrument development information such as observation formats and pilot forms (Lincoln & Guba, 1985).

Field notes taken during participant observations helped me to compare and contrast responses from participants to ensure a thick description. Field notes also were used in addition
to the narrative interviews to describe my impressions and document themes as they emerged. I also found them helpful in aiding in the accuracy of interpreting data. My field notes were discussed with my Dissertation Chair, Dr. Janice Crist to aid in identifying gaps in the data.

Dependability or consistency of the findings was accomplished by sharing the major themes that emerged with two of the participants in the study. The participants were invited to communicate feedback to me to ensure trustworthiness as also recommended by Lincoln and Guba (1989). The feedback from the participants verified the proposed themes.

Confirmability is the process by which the researcher identifies where he or she is ideologically in the normative and identifies claims of others. At the same time, the researcher is honest about his or her own subjective reference claims, not allowing normative evaluative claims to interfere with what is observed or heard from participants in the study. Confirmability was achieved through my reflexive journal. Through writing in my reflexive journal I became aware of how I felt about obesity as a health professional, yet I remained non-biased with the participants during the interviews and observations. I am aware as a health care provider that when I talk to obese patients, I counsel them on healthy diets, exercise, and weight loss. As the PI, my role was to learn about the culture.

Summary

A descriptive focused ethnography was used to describe obese AAW’s cultural norms about perceived body size and describe obese AAW’s self-definition and self-worth that relate to perceived body size. This chapter detailed the research design, setting, recruitment, and data analysis. This chapter also described how trustworthiness was ensured for this qualitative research study.
CHAPTER IV: STUDY CONTEXT AND PARTICIPANTS

In this chapter the settings in which data were collected are outlined. Also described are the sample inclusion criteria and the individual study participants.

Setting

Six of the eight participants attended one of the two predominately African American churches in which participants were recruited. Two of the participants lived in the same predominately African American neighborhood. All of the participants lived in low to moderate-income predominately African American neighborhoods in the capital city of Columbia, South Carolina.

Three of the participants were observed in the community during two separate cultural banquet events. The first banquet occurred during the Christmas holiday season. The second banquet occurred around Valentine’s Day. The events involved family, friends, and church members interacting and eating in a Christian atmosphere. The banquets were coordinated by a local African American church. The cultural events occurred on a Saturday evening and food was catered by an activity center located on the church grounds. Individuals participating in the events were able to serve themselves food while interacting with family and friends. There were more than 100 individuals at each event. The events lasted approximately 3 hours.

Seven of the initial individual participant interviews conducted occurred in participants’ homes. One of the individual participant interviews was conducted at a local church. All second interviews were conducted in the participants’ homes.
Sample Inclusion Criteria

AAW that fit the inclusion criteria were recruited and interviewed for the study. AAW from a wide socioeconomic and educational background were recruited in order to have a broader informational representation of data and to aid in richness (Sadelowski, 1995). Although individuals in the sample were similar in race and gender, their demographic characteristics differed. As listed in Table 1, dichotomized or two opposed groups of data were included: (a) low and higher income women; (b) less than high school and college graduate; and (c) younger and middle-aged women.

Data on the characteristics of the participants were collected through a demographic questionnaire given prior to the first interview. As listed in Table 1, the survey questionnaire included the following: (a) current weight and height; (b) currently pregnant; (c) age; (d) United States citizen; (e) primary spoken language; (f) current income; (g) ethnicity/race; (h) current marital status; and (i) educational level. The questionnaire was completed and returned to the investigator for demographic collection purposes prior to the initial interview. Missing data included income as “not available” for two participants.
TABLE 1. Characteristics of Participants

<table>
<thead>
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<tr>
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<tr>
<td>MEAN</td>
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<tr>
<td>SD</td>
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**Study Participants**

In this section each participant is portrayed with a glimpse of who she was as she described herself through the demographic questionnaire. Not all information is shared, to maintain confidentiality. The participants are described numerically to also ensure confidentiality.

Participant One described herself as being in her 50’s, with some college education. She was divorced with a current weight between 150 and 170 pounds. Her BMI score was 33. Her self-reported yearly income was around $20,000.00. She was interviewed in her home where she lived by herself although her adult children and grandchildren came to visit often.
Participant Two described herself as being in her 20’s, also with some college education. She was single, with a current weight between 200 and 225 pounds. Her BMI score was 35.2. Her self-reported yearly income was less than $10,000 per year. She described having a significant other and young children.

Participant Three described herself in her 50’s, with some college education. She was single, with a current weight between 225 and 250 pounds. Her BMI score was 43.5. Her self-reported yearly income was above $50,000 per year. She lived by herself but her adult children and grandchildren came to visit often.

Participant Four described herself as being in her 30’s, with less than a high school education. She was single, with a current weight between 200 and 225 pounds. Her BMI score was 37.8. Her self-reported yearly income was “not available.” She was currently unemployed. She described herself as having a significant other and young children.

Participant Five described herself as being in her 20’s, with some college education. She was separated, with a current weight between 150 and 175 pounds. Her BMI score was 32.9. Her self-reported yearly income was less than $20,000 per year. She has children.

Participant Six described herself as being in her 50’s and a college graduate. She was single, with a current weight between 175 and 200 pounds. Her BMI score was 41.2. Her self-reported yearly income was above $30,000 per year. She has adult children and grandchildren that sometimes live with her.

Participant Seven described herself as being in her 30’s and a high school graduate. She was single, with a current weight between 225 and 250 pounds. Her BMI score was 40.7. Her self-reported yearly income was less than $30,000 per year. She has children.
Participant Eight described herself as being in her 20’s, with some college education. She was single. She described her income as “not available.” Her current weight was between 175 and 200 pounds. Her BMI score was 30.9. She has no children.

Summary

Chapter IV provides a brief description of the setting and sample criteria of the participants of the study. A sample of eight participants provided data in this study. The characteristics of the participants were diverse in order to gain better insight of the overall cultural perspectives and factors that play a role in obesity among AAW.
CHAPTER V: FINDINGS

Chapter V provides the findings or cultural descriptions of my research study after data collection that included in-depth individual interviews and observations of participants. Analysis of the data addressed focused on the research questions guiding this study: (a) what are obese African American women’s cultural norms relevant to perception of body size? and (b) what are obese African American women’s self-definition and self-worth in relation to perceived body size? The following findings answer the above research questions. The findings are intertwined between both research questions and will be addressed together.

As discussed previously, the data obtained from personal interviews, participant observation and field notes were analyzed over the course of several months. Demographic information was obtained from a demographic questionnaire from the initial participant interview. The questionnaire was completed by each participant and given back to the PI upon completion prior to the first interview.

All the participants (N=8) described their idea of an acceptable body size. Perceived body size by participants in this study was described in relation to family and social expectations, perceived ideal body size, dietary choices, and cultural values and norms. These descriptions were discussed as personal norms in contrast to broader societal norms.

From analysis of the data, the overarching theme, “I’m Okay with Me,” emerged. Four subthemes were identified to support the overarching theme. They are: (a) acceptance of heavier body size by others; (b) acceptance of heavier body size by self; (c) cultural foods that impact heavier body size; and (d) sedentary lifestyles that impact heavier body size. The overarching theme and subthemes which support the overarching theme will be fully described in this
chapter. Data bits which are excerpts or quotations from interviews which support the subthemes will be used to indicate the richness of the data and support the overarching theme. The overarching theme, subthemes and data bits examples for each subtheme are shown in Figure 1.

**“I’m Okay with Me”**

- Acceptance of heavier body size by others:
  - “Mom accepts me the way I am.”
  - “My family is okay with my weight.”
  - “My boyfriend thinks I’m gorgeous.”
- Acceptance of heavier body size by self:
  - “Bigger women are good people.”
  - “I’m okay with the way I look.”
  - “[I’m] not interested in losing weight right now”
- Cultural foods that impact heavier body size:
  - “I cook fried chicken.”
  - “I had a spoonful of chitlins.”
  - “[I] like country cooking”
- Sedentary lifestyles that impact heavier body size:
  - “I just feel like I don’t have the energy to exercise.”
  - “I’m just not interested right now.”
  - “No time to exercise”

FIGURE 1. Overarching Theme, Subthemes, Data bits

**Overarching Theme – “I’m Okay with Me”**

“I’m Okay with Me” emerged as the overarching theme from the data. Although the women in this study were cognizant of Western social norms of acceptable body size, the women (n=8) during the interviews expressed that these were not obtainable or realistic goals. Instead,
the women described contentment and pride of self despite Western social norms of acceptable body size.

Some of the women (n=6) were not interested in losing any weight or a significant amount of weight stating that they look good, their family and/or significant other found them attractive, or they only needed to change a specific aspect of their body such as losing weight in their stomach. These women also felt that although they were “overweight”; if they could lose some weight they would be happy with that result. One participant expressed it by saying “…180 [pounds] would be good. I really don’t want to lose less than 180 [pounds]…” Another participant said, “If I could get down to 170 [pounds] I would be fine. I can see myself at 170 [pounds]. That is a good weight for me.”

“I’m Okay with Me” is also apparent when the participants reported losing weight in a specific body area as a way to feel better about their perceived body size. Participants (n=2) described in detail how they felt that losing weight around a specific body part was important in their overall perception of how they saw their bodies.

For example one participant said, “….my belly, I don’t like it. It’s too big, but the rest of me is okay. When I look in the mirror I pretty much like what I see. I could do some exercising to get rid of my belly.”

Another participant said:

The part of my body I feel disgusted with, well I am not disgusted even with that, but want to change, is my stomach after having two children. I don’t have any issue with the rest of my body. Maybe when I was younger I looked at it differently, but now I am okay with the way I look…..

“I’m Okay with Me” is found in AAW’s description of their eating habits. Many of the women described eating small portions and/or eating one or two times a day as “normal” daily
eating habits (n=4). These “normal” daily eating habits described to me were emphasized as important for me to understand on the first and second interviews by many of the participants.

One woman described her New Year’s meal and meal habits in the following manner:

I had a spoonful of chitlins, a spoonful of macaroni, a spoonful of rice. That’s it. I did not hardly eat. My doctor is saying I am not getting in enough calories and that’s why I am anemic or something like that … I don’t eat not like I am supposed to.

Another participant described her daily eating habits by saying, “I get me a little bowl. A little bowl will keep me full. I’ll eat out a little bowl in the morning time instead of a big plate to keep me full. I will drink a cup of coffee in the morning time and I am good for the morning.”

On the other hand, while observing participants (n=3) at two banquet events, the participants were seen eating high fat and high calorie foods and returning to the banquet food at least twice during the course of the night.

Acceptance of Heavier Body Size by Others

Acceptance of heavier body size by others was a sub-theme expressed by participants in the study. There was a cultural acceptance of participants being obese by others (partners, siblings, adult children, and parents) and its impact on the conventional thinking of obese AAW. Views of the women’s bodies were influenced by their interpretation of partner and family norms. A tolerance and acceptance of obesity was ascribed by others. There was little to no family or significant others’ pressure to lose weight. Most of the women said that partners and family members as supporting their current weight (n=7).

Participants reported that their family members including parents and siblings were overweight or obese as well, suggesting a cultural transfer of acceptance of heavier body size. Cultural transfer is the social influence of beliefs and values shared and transmitted from one
person to another within a group (Halbert et al., 2007). Thus, there was a sense of acceptance of body size within families. These predominant attitudes were described throughout the study and valued by the participants as an important factor in perceived body size.

The findings suggested that acceptance of weight is influenced by external factors such as other people within their social support network. Acceptance of physical appearance by others influenced AAW’s perception of acceptable body size, body image, and if there was a need to lose weight. The participants acknowledged the need to lose weight but often said that significant family members and/or a partner were accepting of their current body weight or body size. Participants expressed acceptance of their current body size and body image.

A participant described the acceptance of her current body size the following way:

My boyfriend, he is happy with my size. He isn’t complaining. My mom is a lot bigger than I am. My mom never fusses at us to eat a certain way or lose weight. She accept us – my sisters and me – the way we are.

Another expressed the concept in the following way by saying, “He [boyfriend] thinks I’m gorgeous. He tells me not to lose weight at all……I’m okay with the way I look and he’s okay with the way I look.” Another participant said, “My family is okay with my weight.” Thus, views of how they perceived their body size by some of the women were largely based on family and partner expectations and views.

The women in this study indicated that a partner and/or family members played an integral role in the way they felt about their body size. When a partner and/or family members provided them positive feedback about their current body size, it gave the women in this study a sense of affirmation that their bodies were okay (n=7). It gave them a positive self-definition and self-worth.
Acceptance of Heavier Body Size by Self

Although many of the participants in the study recognized the need to lose weight, they also felt they were unable meet the goal of losing a significant amount of weight. The participants, despite identifying a need to lose weight, described a positive body image perception and/or an overall positive self-image. The women overall had a tendency to claim acceptance of their current body size, placing a lower value on thinness and an emphasis on their overall appearance. They concluded they were happy with their current body size despite acknowledging the need to lose weight. The women expressed preference to maintain a heavier body size and/or weight, believing this was acceptable.

This acceptance of their current body size and/or weight was expressed verbally and non-verbally during the interviews. Reasons given for this decision included: (a) good health; (b) family okay with health; (c) not interested in losing weight; and (d) lack of time. Non-verbally, the women smiled and laughed when talking about their current weight and discussing reasons they were not currently interested in losing weight. These non-verbal cues gave a sense of pride, empowerment, and contentment. These descriptions also showed how their pride and contentment played a role in those lived experiences that molded their self-definition and influenced their self-worth.

One participant, when discussing what she liked and disliked about her body, said:

I like the way things are going in my life. I really don’t have the time [to lose weight] and not interested right now. I mean I am doing good. My family is happy. My health is good (laughing). I guess if I had diabetes or high blood then I would feel different but I don’t have any of those things so I am not worried so much about my weight.
One participant said “bigger women are good people” while describing her body size. Another participant said, “I’m just not interested right now. I don’t know why. Just not interested. I’m okay with the way I look.”

**Cultural Foods that Impact Heavier Body Size**

The subtheme cultural foods that impacted heavier body size were also identified. Although participants (n=6) claimed they ate very little on a day-to-day basis during interviews, their intake observed during two church cultural banquet events indicated that they consumed high caloric cultural foods including: fried chicken, fried turkey, ham, potato salad, candied yams, collard greens with salt pork, string beans with salt pork, bread, and assorted desserts.

While observing some of the women (n=3) during the church banquets, I also observed other African Americans who attended the church banquets. Men, women, and children, including the participants in the study, who participated in the events, were observed making more than one trip through the buffet line during the event. This suggested that dietary habits including nutrients and dietary lifestyles – both food choices and portion size – are established over a lifetime and factors such as culture have played an important role.

Some of the women (n=2) during the interviews described eating foods such as chitterlings, also called chitlins, fried chicken, oxtails, wiener, steak, grits, macaroni and cheese, and carrot cake as dietary choices. These foods were described as eaten frequently. These food types prepared in the Southern tradition of high fat content and described by one participant as “country cooking” are often eaten in the African American community.

When I asked one woman what kinds of foods she chose to eat she responded:

Fried chicken, baked chicken steak, oxtails, wieners, carrot cake, all kinds of meats and fish. I eat what I like not because it is all the time healthy. Matter of
fact, I know I don’t always eat healthy but I eat what I like. I never got around to
changing my diet.

Only one of the women explicitly attributed her weight or body size to dietary intake. She
stated, “When I drink the sodas and stuff like the 24 ounce sodas which are the regular sodas and
I can drink about three of those a day. I think that is where the weight is coming from.” Other
participants did not associate weight and dietary intake. One woman who described eating
“steak, fried chicken, ham, potatoes, rice, pound cake, and Chinese food,” also stated, “I am not
doing anything to try not to get bigger. Just, I just don’t look at myself getting any bigger. I don’t
see myself getting any bigger.”

This study showed that food as a cultural influence has ties through family members and
church events. Traditional foods and traditional social events within the African American
cultural are strongly interrelated. The observed patterns of many of the women during social
events along with their family and friends fashioned a pattern of self-identification and
confidence. The women smiled, laughed, and enjoyed socializing with others while eating
traditional African American cuisine when observed. The women did not tell me that they
associated their food choices with obesity yet interjected comments indicating their ambivalence.
During the personal interviews, the women were not as forthcoming with the quantity of foods
they ate, but often described eating traditional cultural foods.

Sedentary Lifestyles that Impact Heavier Body Size

Although the women (n=6) acknowledged being overweight, they did not want to engage
in any regular exercise regimen. Two women expressed disinterest in any kind of exercise. The
women expressed acceptance of a sedentary lifestyle and choosing not to exercise.
Two women expressed health reasons for not being able to exercise. One woman stated, “I got depressed after my mom died. I guess I got depressed and did not want to exercise so I gained all this weight. Now I sit around because my legs are hurting.”

Other reasons given as to why they were unable to exercise or exercised very little included: (a) the weather; (b) too tired; and (c) prefer to exercise with someone. One of the participants stated that she had some interest in “exercise in the future” but it was “too cold right now.” Another participant stated, “[I exercise] once or twice a week but I be tired. I can’t do no more than that. Taking care of the kids, doing what I got to do during the day. Just no time for exercise more than that.” Another stated, “I just feel like I don’t have the energy to exercise.”

Another participant stated:

I don’t really exercise especially now. I kinda stop after stopping school. I just have not wanted to exercise since getting out of school. I’m just not interested right now. I don’t know why. Just not interested. When I was in high school, I ran track. Um, ah every now and then I would go to the park and run with my boyfriend. Now, we don’t do a whole lot of those things. Maybe me and my boyfriend will go somewhere and park far and walk to it to get some exercise. I prefer to exercise with someone.

The women indicated that their weight had not had a negative impact on their lives. Instead, overall the women described being “proud, happy with [my]self, and good with [my] weight,” for example. Thus, the AAW’s perceptions of how they viewed their bodies and managed weight impacted their decision to lose weight. It also impacted how much weight they lost and their perception of ideal body size.
Contrasting Findings

There were some findings that contrasted with the general cultural descriptions of this study. This section will discuss these findings. They are: “My Husband Did Not Like When I Was Real Big” and “Sometimes Good, Sometimes Ugh.”

“My Husband Did Not Like When I Was Real Big”

In contrast to the subtheme – Acceptance of Heavier Body Size by Others - most of the women’s partners and/or family members supported their current weight and body size. One participant stated that her former husband during the time she was married did not like her being obese. She stated in an interview:

I tell you when I was married, my husband did not like when I was real big. We tried the Martha Vineyard diet for 2 weeks. He thought I needed to lose the weight and we even tried to exercise together sometimes. On that Martha Vineyard diet he loss more than me but I lost some weight. I was hungry. Since her divorce, though, she said that she felt that she “look good” despite the fact that she was still obese. This contrast finding also supports the overarching theme of “I’m Ok with Me.”

“Sometimes Good, Sometimes Ugh”

The second contrasting cultural description was, “Sometimes Good, Sometimes Ugh.” Although the perception of acceptable larger body size as a cultural norm enabled the AAW in this study to embrace their weight and body size, some of the women expressed conflicting views. Although their primary attitude and behavior were positive and accepting, a few of them expressed this conflict together with their positive self-esteem. One woman expressed this by saying, “I try and avoid looking in the mirror most of the time ‘cause it’s like ugh. Sometimes I look and I say you look good and then sometimes it’s ugh.”
Summary

This study revealed that AAW were cognitively aware of having a larger body size, but perceived a heavier body size as acceptable. “I’m Okay with Me” was the overarching theme that emerged from the data. Four subthemes emerged to support the overarching theme including: (a) Acceptance of heavier body size by others; (b) Acceptance of heavier body size by self; (c) Cultural foods that impact body size; and (d) Sedentary lifestyles that impact body size. Each of the subthemes supported the overarching theme. Data bits were used to support each of the subthemes.

The AAW in this study revealed that partners and family played an important role in their perception of ideal body size. Also, partners’ and family support had an important implication for motivation in weight loss and exercise regimens. The women in this study described an overall sense of pride. The women were able to describe their self-definition and self-worth as positive. Contrasting findings were reported, but were not considered strong enough to represent the cultural meaning of being obese for AAW.
CHAPTER VI: DISCUSSION AND CONCLUSION

Chapter VI presents a discussion of the descriptive focused ethnographic study. This chapter is divided into the following sections: (a) findings related to the research questions; (b) implications for nursing research; (c) implications for nursing practice; (d) limitations of the study; and (e) summary.

Findings Related to the Research Questions

Obese AAW face many challenges with their perception of body size. The purpose of the study was to describe obese AAW’s cultural norms about perceived body size and describe obese AAW’s self-definition and self-worth that relate to perceived body size. As previously discussed in Chapter I, the research questions guiding this study were: (a) What are obese AAW’s cultural norms relevant to perception of body size? and (b) What are obese AAW’s self-definition and self-worth in relation to perceived body size?

Black Feminist Theory

Black Feminist Theory and its concepts, self-definition and self-worth, were used as the theoretical foundation to provide an organizing theoretical framework for this study. The data were closely examined to determine how the concepts were manifested among the participants in the study. Traditional cultural practices were exemplified by three characteristics - being female (gender), being a subordinate culture (class), and African American (race). I answered the research questions by putting the obese African American woman at the center of analysis. Using Black Feminist Theory as a theoretical framework, I was able to describe the cultural beliefs and practices, based on data from my interviews and observations and relate Black Feminist Theory specifically to obese AAW in my study.
Culture is neither static nor monolithic (Blixen, Singh, & Thacker, 2006). Despite the differences in backgrounds and SES of the women in the study, I found that all of the women were able to articulate a sense of confidence and pride about themselves in relation to perceived body size. It was important to them to verbalize to me how they perceived themselves positively. Their perception of their body size came both from a cultural perspective as well as a Western society perspective. This supports current literature that AAW are able to self-define themselves and give credence to their self-worth as they grow in their economic, social, and political world view (Hooks, 2000). In this study, the women’s personal idea of self and confidence seemed to serve as an empowering tool in their ability to define themselves and describe their self-worth.

**Self-Definition**

The perceptions of body size by family and significant others were an important motivator in the participants’ ability to self-define their own body size and body image. This finding supports current literature that body size is often validated by family and significant others within the African American family. Non-Hispanic white women value thinness while culturally, AAW reject those values and base how they define themselves on feedback from family and significant others (Hesse-Biber, Howling, Leavy, & Lovejoy, 2004). Yet, some narratives revealed at least a partial internalization of non-Hispanic white values of thinness (Caldwell et al., 1997; Davis et al., 2010). How the women self-defined themselves had a significant impact on how they felt about their body size. My findings are consistent with Paquette’s and Raine’s (2004) findings that AAW’s body size and body image can be influenced by a partner’s or significant other’s perception.
Some of the women in the study identified chronic illnesses or stress as motivators for improving their eating habits and/or attempting to lose weight as they defined themselves. I found that a few of the women were self-motivated to try and improve their overall health when their health was at risk because of being obese. Other participants expressed a lack of motivation to lose weight if their health was good. The literature supports that defined beliefs and values of a culture influence its perception of illness and health-related outcomes (Blixen et al., 2006; Halbert et al., 2007; Wilson, 2011). It also may suggest a lack of conceptualizing health prevention which has been a finding in the Mexican-American culture (Crist, 2002). A lack of conceptualizing health prevention may indicate that some obese AAW are not ready to consider healthy behavior such as frequent exercise and healthy food choices.

While observing a few of the participants in my study at two church social gatherings, I saw evidence of a positive self-definition displayed through laughing, talking, eating, and socializing with family and friends. This supports current literature that describes African American culture from slavery to present day hinging on the strength of social/cultural gatherings which are used as a symbol of strength, unity, and survival (Borum, 2007; Wilson, 2011).

**Self-Worth**

A person’s confidence is influenced by his or her values and beliefs (Blixen et al., 2006). Many of the women in this study expressed their self-worth by concluding they “look good” despite their perceived body size. I was also able to observe the commonality of confidence at the two social gatherings. Much of the current literature does not discuss self-worth within the African American culture or with obese AAW. The concept of empowerment - which is strongly
linked to self-worth - for AAW, is found sparsely among literary sources designed to enhance the knowledge of the African American struggle. However, Hooks (1984) did acknowledge the common struggle that AAW have experienced, as they forged ahead despite their skin color, class, and gender. Again, the importance of positive self-worth must be acknowledged and preserved during any nursing interventions focused on obesity with AAW.

Although the focus of this study was not weight loss, during the interviews I found that the participants acknowledged needing to lose weight although they did not use the term “obese.” Not using the term “obese” may indicate the word carries a negative connotation. This may also give a sense of disempowerment and a feeling of negative self-worth. It may also suggest that the participants’ confidence level impacted their perceptions of weight and perceived body size. Black Feminist Theory, which guided my study, suggests that the words AAW choose to describe themselves have an impact on their self-definition and self-worth (Collins, 2000). It was important to the women in my study that they chose a word other than “obese” to describe themselves such as “overweight,” “bigger,” and “curves.” I learned that within the African American culture “overweight,” ”bigger,” and “curves,” for example, are acceptable, flattering terms used by obese AAW to describe their body size. The terminology chosen by the participants had a huge impact on the participants’ positive self-worth, self-definition, and feelings of attractiveness by empowering them to have control of their perception of themselves and their ability to say, “I’m Okay with Me.”

**Overarching Theme – “I’m Okay with Me”**

The overarching theme, “I’m Okay with Me,” emerged from the data. Four subthemes supported the overarching theme. The subthemes included: (a) acceptance of heavier body size
by family members; (b) acceptance of heavier body size by self; (c) cultural foods that impact heavier body size; and (d) sedentary lifestyles that impact heavier body size. Supportive quotation examples were used to indicate the richness of the data.

In this study, the women recognized dominant Western social norms of ideal body size, but despite their recognition of ideal body size, cultural traditions of body size norms played an important role in how they perceived themselves, how they defined themselves, and how they measured their self-worth. “I’m Okay with Me” was perceived by the women of this study as empowerment, strength, and dignity.

Although participants of this study described being “overweight” by Western society standards, they described being “okay” overall with their body, often rationalizing their body size and weight by: (a) lessening the importance of weight loss; (b) accepting their current body size by self and family members; and (c) describing a lack of time for healthful habits such as exercise. Cultural traditions such as cultural foods, accepting of family and significant other influences of body size, and sedentary lifestyles and dominant Western social norms of “ideal” body size influenced obese AAW perception of body size. My findings support current research that cultural perspectives and factors due to life experiences and interpretation of cultural values can strongly impact behavior (Blixen et al., 2006).

The obese AAW within the study verbally acknowledged Western society norms of ideal body size while they maintained the cultural traditions that impact body size. Although the participants acknowledged needing to lose weight as reflective of Western society norms, the women felt these were not obtainable objectives. This correlates with Black Feminist Theory that suggests that AAW’s perception of self correlates with their ability to control their environment
(Collins, 2000). The participants also easily discussed the cultural traditional strength of the family (Saloy, 1998) and its influence on their perception of weight.

The women in this study came from different SES backgrounds, age groups, and educational levels, yet the themes were similar among each of the women interviewed and observed. Researchers and practitioners continue to use class as a basis for correlates with perception of body size, decision-making values, obesity, and weight loss (Borum, 2007) for obese AAW. While other studies have shown genetics (Cheng et al., 2009), culture, SES, and educational level (Corral et al., 2012) as correlates to obesity and/or factors for weight loss, the findings of this study indicate that cultural traditions (family and significant others, and cultural food) along with self-definition and self-worth play a pivotal role in perception of body size, and the decision to lose weight.

Therefore, my research findings shows that despite different socioeconomic status, age, and educational levels, the participants had similar perceptions about perceived body size, views on weight loss, exercise, and cultural influences of family and significant others. The study also showed that despite different backgrounds, all of the participants in the study described themselves as being okay with their perceived body size despite knowledge of being “overweight” and Western society viewpoint of obesity.

Cognitive Dissonance

As noted in the contrasting findings, there were some indications that some of the women in this study showed some evidence of cognitive dissonance, by rationalizing their personal beliefs and attitudes (McLeod, 2008) about body size and weight loss. Cognitive dissonance is defined as a discomfort resulting from having conflict beliefs simultaneously, resulting in an
individual rationalizing or making excuses in order to reduce anxiety about conflicting beliefs or thoughts. An individual then attempts to resolve cognitive dissonance by altering current beliefs or thoughts or altering the importance of certain beliefs or thoughts in order to reduce anxiety and resolve their conflict (Barker, 2003). People cognitively reduce psychological tension or anxiety resulting from two opposing beliefs in order to protect their own view of the world or themselves (Grohol, 2008). A well-known example of cognitive dissonance is *The Fox and the Grapes*. The fox wants the grapes found higher on the vine; but he is unable to reach the grapes. He concludes that they are probably sour (Aesop’s Fables, trans. 2007).

This was shown through some participants in the study acknowledging their body size yet lessening the importance of weight loss. One participant described the struggle between her overall positive body size perceptions, yet she acknowledged the need to lose weight.

**Implications for Nursing Research**

The findings of this study showed that although obese AAW are cognizant of their body size by Western society norms, they still demonstrated the perceptions “I’m Okay with Me.” There are multiple factors that impact obese AAW’s perception of body size such as self, family and significant others, cultural foods, and sedentary lifestyles. These findings have strong implications for future nursing research. Although the AAW in this research study were cognitively aware of being obese, they were not interested in losing weight or a significant amount of weight. Interviews and observations during social gatherings indicate that perception of body size is multifaceted and self-defined based on cultural and societal influences.

The participants verbalized a sense of being proud, content, or as one woman described herself, “wanting curves” as they self-defined themselves and described their self-worth.
Consistent with Black Feminist Theory as a theoretical model, the women in this study may use the descriptors as an empowering tool and not as a result of being lower socioeconomically or having limited education as is often stated in the research literature (Collins, 2000). More research needs to be done on the challenges obese AAW face in a Western society dominated culture related to perceptions of body size. AAW have distinct viewpoints that need to be considered from an AAW’s specific viewpoint.

Transtheoretical Model of Behavior Change (TTM) should also be considered for future research with obese AAW. TTM integrates constructs from other theories to conceptualize a comprehensive model that can be applied to different populations and setting. The model includes five stages of changes including: (1) precontemplation; (2) contemplation; (3) preparation; (4) action; and (5) maintenance. In the precontemplation stage, individuals are not thinking about initiating a healthy behavior. In the contemplation stage, individuals are ready to change a behavior. In the preparation stage, action is intended. In the action stage, change occurs. In the maintenance stage, behavior change is successful for at least six months (Sutton, 2008). The obese AAW in this study are at the precontemplation stage where they are not thinking about initiating a change in behavior at this time. The model may be considered for future research with obese AAW in behavior change. Using culturally appropriate theoretical frameworks will help guide future scientific research among obese AAW.

Implications for Nursing Practice

This study could have an important impact on future nursing practice. The participants in my study were cognizant of being “overweight.” It is essential that health-care professionals are aware of how obese AAW perceive their body size when providing health education and health
care services for obese AAW. Health-care professionals will need to be aware that their patients
may struggle with cultural traditions as well as Western social expectations in regards to body
size and weight loss and this may impact their health-care decision making. Health-care
professionals will need to be acutely aware of how obese AAW perceive their body prior to
offering any education and interventions on weight loss. The nurse should assess culturally
specific questions such as support systems and current food choices. Other issues to assess are
previous weight-loss experiences and a reasonable weight loss goal for the client. Health-care
professionals can have a greater cultural sensitivity and understanding, thus providing a more
supportive environment and encouraging healthful choices to obese AAW. The positive self-
definition and self-worth displayed by the women in this study despite acknowledging Western
society norms of thinness may be an important opportunity for interventions in supportive obese
AAW self-definition and self-worth. Self-definition and self-worth will need to be nurtured and
encouraged in order that obese AAW will follow through with their goals. Finally, health care
professionals will need to be acutely aware of their own cultural perceptions of “acceptable”
body size imposed by Western society and the Medical Model to ensure these preconceptions are
not imposed upon obese AAW.

Limitations of the Study

One limitation of the study was recruitment of obese AAW within a small catchment
area. The obese women in this study were recruited within a small community. Two of the
women were members of the same church and knew one another. Although confidentiality was
maintained, the women may have learned of each other and shared information of the study. I
was not aware of this happening, but it could potentially have influenced what was said in the interviews.

Although the participants of this small sample were diverse in their income, age, and educational level, living in the same catchment area may reflect similar attitudes, values, and beliefs. Although strategies were used to establish trustworthiness, the participants’ similarities may decrease transferability to other obese AAW.

Another potential limitation of the study was the women may not have always been forthcoming describing their perceptions and feelings about body size during interviews. Although as the principal investigator of this study, I used gatekeepers to gain entrée and to develop a rapport within the community prior to recruitment, interviewing, and observing the participants, the participants may have still viewed me as a stranger which could have impacted the ability to develop a full trusting relationship with the participants.

**Summary**

This descriptive focused ethnographic study was a first step in describing obese AAW’s cultural norms about perceived body size and describing obese AAW’s self-definition and self-worth that relate to perceived body size. Describing the cultural norms that affect obese AAWs’ perceptions of body size is important in helping to eliminate health disparities with this vulnerable population.

The findings in this study showed that obese AAW, despite different educational and demographics, shared feelings of pride and contentment. The women were aware of Western social norms of acceptable body size, but the overarching theme emerged, “I’m Okay with Me,” from the data.
As an African American woman and a nurse, this study helped me to learn that although you are a part of a culture, you do not necessarily know all about that culture. I learned how powerful family members and significant others have over health-care decision-making within the African American culture. I also learned how important it was for obese AAW to maintain pride in themselves.

Black Feminist Theory and its concepts, self-definition and self-worth were used as the theoretical foundation for the study. This theory placed the obese AAW of this study at the center of analysis. Future research should be done utilizing culturally appropriate theoretical models for obese AAW. More research needs to be done in the area of cognitive dissonance with obese AAW. Also, more research needs to be done utilizing TTM with obese AAW.
APPENDIX A: RECRUITMENT FLYER
RESEARCH STUDY: DESCRIBING CULTURAL PERCEPTIONS OF WEIGHT AND PERCEIVED BODY SIZE IN AFRICAN AMERICAN WOMEN

SEEKING VOLUNTEERS..................

To participate in a Research Study studying:

How African American Women perceive their bodies and things in your life that may influence body image.

Patricia Speaks, RN, APRN-BC, PhD Candidate, from the College of Nursing, University of Arizona is recruiting participants for this very important research study.

Who’s Eligible:  *Must be 18 years of age or older
*African American Woman
*Overweight
*Currently Not Pregnant

What’s Involved:  *2 Private Interviews
(Each interview will be 60-90 minutes long)

*Some participants may be asked to be interviewed a 3rd time

*A small monetary gift will be given for your time after the first and second interview

Benefits of Joining:  Help people gain insight on how African American women perceive their body.

If you would be interested in hearing more about the research study, please contact: Patricia Speaks - 803-622-0705
APPENDIX B: IRB APPROVAL
Date: 11/30/11

Investigator: Patricia Speaks, Doctoral Candidate
Advisor: Janice Crist, PhD
Project No./Title: 11-0915-00 Describing Cultural Perceptions of Weight and Perceived Body Size with Obese African American Women: A Descriptive Focused Ethnography Study

Current Period of Approval: 11/30/11 – No Expiration

**Documents Reviewed Concurrently**

F200: Application for Human Research (signed 11/09/11; received 11/27/11)

Consenting Instruments:
- Informed Consent (version 11/27/11)
- F107: VOTF (version 11/15/11)

Site Authorizations:
- Mount Pleasant Baptist Church
- Zion Mill Creek Baptist Church

Recruitment Materials:
- Flyer

Data Collection Instruments:
- Demographic Question
- Interview Question

Other (define):
- COI Determination
- PICV

**Determination**

Approved as submitted effective 11/30/11

**Regulatory Determination(s)**

- Exempt Approval 45 CFR 46.101(b)(2): Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior.

11/30/11

Sheryl Wurl, PhD
Director, Human Subjects Protection Program
Office for the Responsible Conduct of Research

cc: Departmental/ College Review Committee

Reminders: No changes to a project may be made prior to IRB approval except to eliminate apparent immediate hazard to subjects.
APPENDIX C: INFORMED CONSENT FORM
INFORMED CONSENT

PROJECT TITLE: Describing Cultural Perceptions of Weight and Perceived Body Size with Obese African American Women: A Descriptive Focused Ethnography Study

INTRODUCTION:
You are invited to join a research study to look at the perceptions of body size among African American women. Please take whatever time you need to discuss the study with your family and friends, or anyone else you wish to. The decision to join or not to join is up to you.

PURPOSE:
In this research study, I aim describing cultural perceptions of weight and body size among African American women.

WHAT IS INVOLVED IN THE STUDY?
You will be asked to be interviewed at a time and place that is convenient for you. You will be interviewed at least twice. The interviews will take 60 to 90 minutes each. You may be asked to be interviewed a third time. Each interview will be tape recorded. Also, as you and your family participate in church or community events, you may be observed by the investigator as you go about participating in the event(s).

The investigator may stop the research study or take you out of the study at any time they judge it is in your best interest. The investigator may also remove you from the research study for various other reasons. This can be done without your consent. Reasons you may be removed from the research study include not available to be interviewed or pregnancy.

You can stop participating in the research study at any time.

Version 11/27/11
RISKS

This study involves minimal risk. The interviews require 60 to 90 minutes of your time. You will be asked to participate in at least 2 interviews. You may be asked to be interviewed a third time.

BENEFITS TO TAKING PART IN THE STUDY

It is reasonable to expect the following future benefits from this research study: increasing knowledge about cultural influences on perceived body size. However, I cannot guarantee that you will personally experience benefits from participating in this study. Others may benefit in the future from the information we find in this study.

CONFIDENTIALITY

Your name or any other personal identifying information will not be used when data from this research study are published. Every effort will be made to keep your research records and other personal information confidential. I will take the following steps to keep information about you confidential, and to protect it from unauthorized disclosure, tampering, or damage: maintaining tape recorders, transcripts, and notes in a locked cabinet. Your code number will be kept in a separate locked cabinet.

An Institutional Review Board responsible for human subjects research at The University of Arizona reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

PARTICIPANT COMPENSATION

A small monetary gift of $10.00 for time and inconvenience will be dispensed to you at the end of the second interview.

YOUR RIGHTS AS A RESEARCH PARTICIPANT

Participation in this study is voluntary. You have the right not to participate at all or to leave the study at any time. Deciding not to participate or choosing to leave the study will not result in any penalty or loss of benefits to which you are entitled.

Version 11/27/11
If you have questions, concerns, complaints regarding the research study or if you decide to leave the study, the procedure is to contact the investigator at 803-622-0705. You may contact Dr. Janice Crist, Advisor at The University of Arizona College of Nursing at 520-626-8768 for any questions, concerns, or complaints. You may also contact the University of Arizona College of Nursing Office of Nursing Research at 520-626-7124. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled.

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact the Human Subjects Protection Program at 520-626-6721 or online at http://ocrvpr.arizona.edu/irb.

Consent of Participant

Signature of Participant: ___________________________ Date: ______________

Upon signing, the participant will receive a copy of this form.

Investigator Consent

Signature of Investigator: ___________________________ Date: ______________

Version 11/27/11
APPENDIX D: DEMOGRAPHIC QUESTIONNAIRE
Demographic Questionnaire

1. What is your current weight? __________________________
2. What is your height? __________________________
3. Are you currently pregnant? ______________
4. What is your current age?___________________________
5. What country were you born in?______________________
6. What is your primary spoken language?________________
7. What is your current income?_______________________
8. What is your ethnicity/race?_________________________
9. What is your current marital status? Please circle – single
   divorced
   separated
   widowed
10. What is your current education? Please circle – less than high school
    high school graduate
    some college
    college graduate
    graduate degree
APPENDIX E: INTERVIEW GUIDE QUESTIONS
Interview Guide Questions for Initial Interview

1. How do you see yourself when you look in the mirror?
2. Describe how your family sees your body size?
3. Describe how you think your body has changed over time?
4. Describe what do you like about yourself?
5. What do you value about you?
REFERENCES


