12-2020

The Lived Experience of Obesity, Spirituality, and Health Behaviors in African American Women

Andrea S. Poynter
East Tennessee State University

The Lived Experience of Obesity, Spirituality, and Health Behaviors in African American Women

---

A dissertation

presented to

the faculty of the College of Nursing

East Tennessee State University

In partial fulfillment

of the requirements for the degree

Doctorate of Philosophy in Nursing

---

by

Andrea S. Poynter

December 2020

Florence M. Weierbach, Chair

Jean Croce Hemphill

Georgita Tolbert Washington

Deborah L. Slawson

Keywords: obesity, spirituality, health behaviors, African American women, phenomenology, content analysis, qualitative research

ABSTRACT

The Lived Experience of Obesity, Spirituality, and Health Behaviors in African American Women

by

Andrea S. Poynter

Obesity is one of the fastest growing health concerns impacting all racial, ethnic, gender, and socioeconomic groups in the United States of America. More than one-third of the U.S. adult population is classified as being obese (Obesity Society, 2014). Novak and Brownell (2012) identified that "obesity rates are consistently rising higher each year than in previous years" (p. 2345). Obesity has reached epidemic proportions in all races and genders within the US with African American women comprising a majority of those impacted by this chronic health condition. Obesity rates are well documented within the literature but what is lacking is the role spirituality may play in obese African American women and their health behaviors. The purpose of this qualitative, phenomenological study was to explore and describe the lived experiences of obese African American women with attention and focus on weight, health behaviors, and spirituality.

This study consisted of participant recruitment from various social organizations, beauty salons, and faith-based organizations. A naturalistic setting with a descriptive approach was taken to interview the participants and all recorded interviews were transcribed and utilized for data analysis. The analysis method for this study was the qualitative content analysis process. Upon completion of data analysis, the identification of three themes, who I am, the weight I bear, and power struggles, assisted with recognizing the gaps and concerns that supported the researcher in painting a picture of the lived experiences of obese African American women. Recommendations included diversifying healthcare providers, implementing community based interventions and research, and completing knowledge assessments before education. A future research opportunity includes utilizing beauticians as lay community members of a research study to provide education and initiate hard conversations regarding weight, health behaviors, and interventions to their clientele.

DEDICATION

This work is dedicated to my sister Valishia ‘Lisa’ Nicole Wade-Evans. She started me on my nursing path by helping to finance many of my educational costs. She believed that I was greater than I realized I was at the time. Lisa fought and struggled with her weight my entire life and ultimately died from cardiac issues related to obesity at the age of 42. She didn’t get to see me reach my destination but I believe that she knew I would. I also dedicate this work to my husband, Christopher N. Poynter. He gave me room to be great and took on many roles and responsibilities to give me the space that I needed. Lastly, I dedicate this work to my children, Nylah Joi, Layla Gabrielle, and Christian Isaiah, for making me want more for myself so that I can be more for them. Now you can call me Dr. Nurse Mom!

TABLE OF CONTENTS

Chapter 1. Introduction

Obesity has gained nationwide attention due to its health-related disorders such as heart disease, stroke, diabetes, and various cancer types that increase the annual medical cost on a financially stressed health system (CDC, 2015). This health concern has garnered national attention. Each state must monitor obesity rates by providing data to be analyzed and interpreted to identify specific health outcomes regarding future health predictions (Centers for Disease Control and Prevention (CDC), 2015). Personnel in all government levels are responsible for monitoring and managing the obesity epidemic, but more responsibility has been shifted to the states to improve the accountability of health outcomes.

The obesity rates in African American women are higher than in any other ethnic group. The current estimate is that four out of five African American women are considered overweight or obese (U.S. Department of Health and Human Services Offices of Minority Health (OMH). The obesity rates in African American women represent a health disparity that includes a range of factors that impact the ability to combat this health concern. Some of the factors identified through research are socioeconomic status, affordable housing, and quality health education from health professionals (The State of Obesity, 2014). All contribute to one's ability to choose healthier options and activities.

To further complicate the ability to address obesity health concerns, more recent research has identified obesity is still prevalent independent of one's income level, educational matriculation, or other factors associated with obesity in other ethnic groups (Ard et al., 2013; Assari, 2018). Data has shown the factors that encourage and motivate Caucasian and Asian women to have no impact on changing African American women's weight status. In a study by Talleyrand et al. (2017) the African American women highlighted that when it comes to the

perception of their body image, which was mostly driven by significant others, family members, and the media (Talleyrand et al., 2017, p. 485). Full figured body images are culturally more acceptable in the African American community, thereby removing the negative connotation of being overweight.

The obesity epidemic has produced numerous health initiatives, but none have demonstrated sustainable, long-term maintenance for African American women (Davis, Dutton, et al., 2014). Therefore identifying the missing link for this population is imperative to bring about meaningful change. Government nutritional assistance programs are available to help lower-income families receive financial vouchers, learn about eating healthier, and increase their activity (Women Infant and Children, WIC). These programs intend to encourage more nutritious foods and improve physical activity (The State of Obesity, 2014; Zimmer et al., 2019). All of which should be sufficient in providing a substantial impact on slowing the obesity epidemic, but the opposite is true. Many African American women who receive government benefits cannot access healthy, affordable foods, and physical fitness facilities. Research has identified a positive correlation between having limited access due to location or lack of transportation to supermarkets and their ability to participate in physical activities (The State of Obesity, 2014).

Research studies have recognized the impact of various health promotion interventions beneficial in assisting with weight loss. Community participation and ownership have been proposed and utilized as a meaningful solution to various health disparities in diverse populations. The results have identified various flaws throughout the numerous research interventions. A significant flaw was the differing goals and objectives between the researchers and the community members (Merzel & D'Affitti, 2003). A struggle of power and control was

identified, which demonstrated the difficulty of developing community collaborations, especially from individuals considered 'outsiders' (Merzel & D'Affitti, 2003). In recent obesity research studies, the disconnect remains in that health care professionals tend to adhere to their understanding of weight management with little consideration towards what attitudes and beliefs influence this population's behavior (Lopez et al., 2014; Ojukwu et al., 2018). An increase of evaluation studies was requested to identify which intervention methods are effective before haphazardly initiating plans for the sake of 'doing something' without first identifying what has measurable outcomes (Department of Health and Human Services, 2010, p. 13).

Healthcare has often underestimated the impact of spirituality and the African American church's capacity to engage and improve health outcomes in the African American community (Giger et al., 2008; Ojukwu et al., 2018). Spirituality is an essential aspect of all social and cultural systems (Carter, 2002). In every ethnic group, "spirituality serves as a source of meaning and purpose, a framework within which people interpret their lives and experiences" (Johnson, Elbert-Avila, et al., 2005, p. 712). Spirituality is a consistent variable in the literature linked to African Americans as it pertains to understanding and coping with illnesses, and ultimately making treatment decisions (Johnson et al., 2005). For the African American community, the historical healthcare barriers that were the product of "discriminatory practices in the larger social arena" (Braithwaite & Taylor, 2001, p. 130) provided entry for faith-based organizations to take the initiative to provide not only faith and spiritual interventions but also health initiatives.

African American-focused research examining the issue of faith, spirituality, and or religiosity identified that participants were more likely to strive to meet developed goals if the goals were spiritual (Davis, Dutton, et al., 2014, p. 4). Greer and Abel (2017) identified that

older African American women with illnesses utilized spirituality to cope with chronic diseases (p. 254). For younger African American women (18- 40-year-old), there was more of a secular perspective. However, the knowledge, information, and actions they instituted stemmed from older African American women (Coe et al., 2015, p. 58). Literature indicates that once a person recognizes being in tune with one's mind, body, and soul, they will consciously and subconsciously become better stewards of the body entrusted to them (Greenwood & Delgado, 2011).

Statement of the Problem

Obesity is a multifaceted, pervasive, chronic health condition influenced by "biological, individual, environmental, social, and economic determinants" (Sutherland, 2013, p. 847). Obesity, defined by the World Health Organization (WHO) as an excessive amount of body fat, may impair one's health. The Obesity Society (2016) defined obesity as excess adipose tissue most commonly measured by Body Mass Index (BMI). The CDC has identified obesity as straining to the healthcare system with an estimated excess of 112,000 deaths each year attributed to obesity with a healthcare cost of approximately $190 billion yearly (Obesity Society, 2016). Obesity has reached epidemic proportions in all races and genders within the U.S., with African American women comprising a majority of those impacted by this chronic health condition.

The Centers for Disease Control and Prevention (CDC, 2015) released a report that contained the top ten causes of death in the African American population. Heart disease, stroke, and diabetes are three diseases listed as the causes of death for African Americans, and all are linked to obesity. The health-related impact of obesity is evident in that more than 80 percent of people who have been diagnosed with type 2 diabetes are obese (OMH, 2014). Research studies

have identified that obese people are disproportionately impacted by hypertension, high cholesterol, and higher death rates due to heart disease and stroke (WHO, 2016). These factors are risk factors for developing various heart diseases and disorders, which increase morbidity and mortality in all populations. The health-related risks associated with obesity increase as one's BMI increases, and African American women are disproportionally impacted by obesity (OMH, 2011; WHO, 2016).

Efforts to reduce and prevent obesity are ongoing through various community initiatives that demonstrate some success; however, they tend to be labor-intensive and have inconsistent funding (Halbert et al., 2014, p. 125). Health care initiatives and weight loss programs have not proven to be as beneficial as expected due to various cultural beliefs, views, and biases of the health care system (Davis, Clark, et al., 2005; Notaro, 2012). Research has identified specific tolerances regarding how African Americans perceive the terms overweight and obese, which contradict the healthcare professional's identified norms. Notaro (2012) has identified numerous barriers to healthcare beliefs, utilization, and compliance in African Americans due to the historical perceptions passed through generations that built distrust of healthcare professionals and their recommendations (p. 265).

Within the African American community, a culture exists that "places less emphasis on weight issues and accepts different body sizes and shapes" (Sutherland, 2013, 850). The worldview regarding beauty standards, health regimens, physical activity, and meal selections is far from the "American" mainstream's perception. Sutherland (2013) identified higher levels of self-esteem, body satisfaction, and decreased eating disturbances in African American women who did not fit the mainstream media's classification of health and beauty. The classification of obesity did not appear to impact African American women's self-esteem and self-worth, which

were most often obtained from communal acceptance and religious/spiritual beliefs (Sutherland, 2013, p. 852). By approaching and understanding African American women as an independent culture within the African American community helps to "provide a framework for understanding collective health behaviors" (Knox-Kazimierczuk, Geller, et al., 2017, p. 372).

A lack of relevant literature exists regarding the relationship between spirituality and obesity of African American women. The lack of literature is complicated by the multidimensional, complex nature of the concept of spirituality. The relationship between African American women's spirituality and weight status regarding their involvement with health promotion activities has not been studied. However, numerous studies focus on spirituality and coping with chronic illnesses and health promotion and weight status. In a study by Pierre-Louis et al. (2011) African American women with the theistic approach to spirituality stated "God was a major source of support and consolation that could see them through all of life's trials and tribulations" as it pertained to disease processes and progression (p. 232). In their study, African American women's belief in God was utilized as a motivator and a barrier to managing chronic illnesses. In a study by Sterba et al., (2014), the role of spirituality and religiosity impacted the quality of life positively of African American breast cancer survivors, which is a monumental finding for health care providers concerned with holistic patient care (p. 1917). Numerous research articles and studies are available that document the risks associated with obesity in African American women. However, a gap exists as it pertains to the role spirituality may play in African American women's unhealthy weight status and their utilization of health promotion activities.

Purpose of the Study

Obesity has made a name for itself as being one of the most inescapable public health problems nationally. The relationship between obesity and numerous chronic diseases propels obesity towards being as deadly for individuals as tobacco was and is for smokers. The purpose of this qualitative, phenomenological content analysis study was to explore and describe the lived experiences of obese African American women with attention and focus on weight, health behaviors, and spirituality. Despite the extra attention and incentives provided towards weight management initiatives, significant gains have not been identified in this population. Numerous research studies have been conducted to assess obesity, African American women's lived experience with obesity, and various health promotion interventions. Research done with African American women over health promotion behaviors regarding their beliefs are very few; however, the context of where the interventions occur is within the religious organization.

Obesity in African American women is a pervasive issue that is studied immensely; however, interventions beneficial in shifting the course have not been identified. Causative factors associated with obesity for all populations are dietary selections, decreased physical activities, and socioeconomic statuses (Knox-Kazimierczuk & Shockly-Smith, 2017). The same causative factors impact African American women, but they are being explored more in-depth due to the disparities. Knox-Kazimierczuk and Shockly-Smith (2017) identified the need to review this "explanation" about African American women primarily since the disparity lies within this population more than any other population in America. Sutherland (2013) has also expressed concern about how obesity is addressed regarding African American women using the BMI index to define and address obesity. Genetically African Americans are comprised of a higher lean mass and lower fat mass when compared to other races, but BMI does not distinguish

between fat or lean tissue (Sutherland, 2013, 847-848). The research is limited regarding meaningful, culturally relevant health promotion activities for this population or what motivates or prevents health-promoting behaviors.

It is believed that the perception of obesity and being overweight is developed by one's family and by society's labels (Davis, Clark, et al., 2005, p. 1540). The perception varies based on educational level and financial status because African Americans tend to embrace having larger bodies. Instead of conforming to the standard of beauty, an alternative is created (Di Noia et al., 2013, p. 227). Being overweight should not be perceived as a positive but, in fact, a coping mechanism for a culture of women who feel that one must conform since there is no way out. The inability to maintain one's weight loss consistently paved the way for emotions such as pain, desperation, frustration, and even depression (Davis, Clark, et al., 2005, p. 1540). In women with comorbid obesity, there were high levels of depression that further complicated the lived experience, especially when this is combined with being an ethnic minority, with a low income, and low literacy level (Davis, Dutton, et al., 2014, p. 5).

Spirituality is such a complex topic in that it is multidimensional and often used interchangeably with religion. A clear distinction is limited in the research regarding African American spiritual beliefs (Ojukwu et al., 2018, p. 401). The current data suggest that being involved in a faith community engenders support that impacts health outcomes (Holt et al., 2013, p. 280). Research participants were more likely to strive to meet developed goals if the goals were spiritual in nature (Davis, Dutton, et al., 2014, p. 4). The literature identified that "positive religious coping may protect individuals with emotional distress from increased obesity by providing an alternative to unhealthy eating" (Pirutinsky et al., 2012, p. 395).

Significance of the Study

The lack of consistent guidance and sustainable approaches to impact obese African American women with real-world feasible and practical interventions are currently non-existent (Seale et al., 2013, p. 153). Research on spirituality about African American women can provide insight into one's unique expression of spirituality and health promotion behaviors. This study is significant because it can identify relevant, motivating factors and barriers for African American women to change the obesity epidemic trajectory. It is challenging to respond effectively to an individual's spiritual needs without understanding the cultural context. Effective communication is the bridge to respond to a particular culture's spiritual needs to provide culturally competent care (Johnson, 2006, p. 1163). Effective interventions and practices can potentially evolve by establishing a significant understanding of the impact of spirituality on obesity in the African American woman's motivation and behavioral health choices. Recommendations for future research will be obtained from the data obtained from the research participants.

Research Questions

This study aimed to explore and describe the lived experiences of obese African American women and the role that spirituality played regarding their health behaviors. The specific research questions that guided the study were obtained from identified gaps in the literature. Throughout this study, the following questions were explored:

1. What is the lived experience of obese African American women?

    A. What are obese African American women's perceptions of spirituality?
    B. What are obese African American women's perceptions of weight status (obesity) and its impact on health?

C. What are obese African American women's perceptions of health behaviors?

Summary

In summary, it has been universally recognized that obesity is a health issue of epic proportions for all races, nationalities, and genders across the United States. The increased focus and intense incentives directed towards obesity steers from the increased morbidity, mortality, and increasing health care costs associated with this entirely preventable health issue. This paper addresses multiple preventative health perceptions, barriers, and recommendations to identify gaps in the literature. Information obtained in this paper will facilitate future research studies that work towards interventions to reduce this epidemic health crisis in African American women, which would improve or decrease the various health disparities that also impact this population disproportionately.

Chapter 2. Literature Review

In the United States of America, obesity is a health concern of epidemic proportions impacting every racial, ethnic, gender, and socioeconomic group. Obesity has proven to be a complicated, persistent, chronic health condition influenced by "biological, individual, environmental, social, and economic determinants" (Sutherland, 2013, p. 847). Obesity has gained national attention due to the increased incidence of health-related disorders such as heart disease, stroke, diabetes, and various cancer types that also increase taxpayers' annual medical costs (Bhattacharya & Sood, 2011; CDC, 2015). Aside from the national attention obesity has gained, the driving forces behind this study were the societal and community burdens such as morbidity due to chronic disorders, the impact on the quality of life, and premature mortality in African American women (Mzayek et al., 2019; Powell et al., 2016; Wang et al., 2011).

The perspective and lived experience of obese African American women must be examined because their perception, experiences, and beliefs determine their behaviors and, ultimately, their actions. The research is limited concerning meaningful, culturally relevant weight reduction, health promotion activities for this population, or what motivates or prevents improved health behaviors in obese African American women. The purpose of this chapter is to identify some of the gaps and inconsistencies that exist regarding obesity, spirituality, and health behaviors in African American women. The literature helped develop the interview questions used further to explore obese African American women's lived experiences.

Theoretical Underpinnings

A theoretical framework is not necessary for developing a qualitative study, but health and behavior theories were examined to determine their roles with this population. Identifying

potential theoretical frameworks can assist with determining the direction for future research and healthcare practice changes. The problem addressed in this paper is obesity in African American women, and the utilization of theory is beneficial for nursing care to "explain the dynamics of health behaviors, including processes for changing them, and the influences of the many forces that affect health behaviors" (Glanz & Rimer, 2005, p. 5). Critical Social Theory is utilized in this study and it is discussed in further detail in the chapters 3 and 4 of this study.

Literature Search Method

A computerized search was done utilizing medical and social science databases that included the following: CINAHL/Nursing, PsychINFO, Proquest, PubMed, and Dissertation databases. Keywords were varied, used individually, and in various combinations: obesity, spirituality, health behaviors, African American women, African American women and obesity, African American women and health behaviors, and African American women and spirituality. Additional literature articles were found within reference lists of articles utilized in the study.

A systematic literature search was conducted that was limited to (a) English language, (b) peer-reviewed, or clinical practice guidelines, or book chapters, or national organization approved websites, (c) specific to African American women, and (d) published from 2000 to the present. Accessing literature that addressed this study's key components, the search timeline was extended from 2000- present to ensure that all the topics, particularly the theories, were adequately addressed in this paper. A combined total of 217 peer-reviewed articles, book chapters, dissertations, and websites were reviewed. In total, 53 articles were reviewed and utilized in this study that met the inclusion and exclusion criteria for this study.

Review of Literature

African American Women

The African American ethnic group is defined as an American of black African descent (Merriam-Webster, 2018). In 2016 the total percentage of black American women was 13.7%, including black women from all demographic backgrounds (Catalyst, 2018). This study made distinctions between the Black American subgroups because there are differences in health outcomes. The distinction is needed due to Black Americans' current demographic population being comprised of people from various countries such as Haiti, Brazil, the Caribbean, Jamaica, and various countries in Africa (Berlin, 2010). The literature identifies a significant difference regarding nutrition, health, and wellness among Black American immigrants that is distinctly unique and different than African Americans. The differences identified between the Black American subgroups are nutrition, physical activity, spirituality, and socioeconomic status, with better health outcomes, such as life expectancy rates, compared to African American women (Griffith et al., 2011). This distinction is relevant due to the impact of slavery and its influence towards cultural preferences (meal selection, consumption, lack of access, and physical activity) and the current health disparities that exist amongst African American women (Di Noia et al., 2013; Lopez et al., 2014). Current census reports do not distinguish a variance between the black ethnic subgroups, but the differences are apparent and relevant for the pursuit of reliability within this qualitative study.

Obesity

Obesity is not an abstract concept conceived by health professionals' minds, but it is a measurable medical condition with harmful associated risk factors. Defined by the World Health Organization (WHO), obesity is excessive body fat that may impair one's health (2016). In the literature, obesity is considered an excess amount of body fat for a specified height that has confirmed association with increased morbidity and mortality rates (Acosta & Camilleri, 2014; Gadde et al., 2018; Obesity Society, 2016). Several methods are available to measure one's body fat, such as Dual Energy X-Ray Absorptiometry (DXA) and Bioelectrical Impedance Analysis (BIA), but the most commonly used is body mass index or BMI.

BMI is currently the gold standard and method of choice for determining one's body composition, but there are concerns regarding its utilization in African American women. Body Mass Index or BMI is a mathematical calculation involving height and weight, irrespective of family history, gender, age, or race. BMI is calculated by dividing a person's body weight into kilograms by their height in meters squared or using the conversion with pounds and inches squared (The Obesity Society, 2016). This study's focus was on obesity in African American women. BMI has been identified as the choice method for obesity due to its ease of use within research and its consistency in communication amongst health professionals regarding patients' health statuses (Bhattacharya & Sood, 2011). Minor concerns have been voiced regarding BMI being utilized as the source for determining weight status for African American women considering differences with their genetic makeup women. Genetically African Americans are comprised of a higher lean mass and lower fat mass when compared to other races, but the BMI does not distinguish between fat or lean tissue (Sutherland, 2013). As discussed, utilizing the BMI scale is currently the gold standard, but the body composition differences that exist

genetically should not be overlooked. It may warrant a different approach and interventions more suitable for this population.

Obesity in African American Women

Obesity has reached epidemic magnitudes in all races and genders within the U.S., with African American women consisting of a majority of those impacted by this chronic health condition. African American women make up the largest percentage of obesity rates, with four out of five being classified as overweight or obese (U.S. Department of Health and Human Services Offices of Minority Health (OMH). In African American women, healthy weight status was not congruent with how healthcare or society currently classifies or defines healthy weight (Bowen et al., 2015; Bramble et al., 2009). Older African American women identified obesity as a preventable and treatable condition, but even if they qualified as obese, they did not perceive themselves as obese (Bowen et al., 2015).

Perception is often perceived as reality, which adds to the complexity of addressing the obesity epidemic in African American women. A consistent theme noted in the literature was that overweight or obese African American women were comfortable with their body sizes, even considering them more attractive (Bowen et al., 2015; Di Noia et al., 2013; Gentles-Peart, 2020). Also highlighted in the literature was the role that significant others, family members, and the media plays on one's perception of their body image (Talleyrand et al., 2017, p. 485). Full figured body images are culturally more acceptable in the African American community, thereby removing the negative connotation of being overweight. The obesity epidemic must be addressed, but first, researchers must understand how African American women perceive obesity and then identify what factors motivate this population.

Countless weight loss strategies are available to be implemented in this population with demonstrable results but what motivates African American women is still a mystery. Various motivating factors have been identified to encourage participation in healthy behaviors in other cultural and ethnic groups (Caucasian, Asian). In general, women are more likely to be body conscious and more often affected by others' thoughts and opinions regarding their weight, which alone could be a motivator for other cultural and ethnic groups. Motivational factors for participating in health behaviors for women from other ethnic groups did not apply to African American women. Being classified as obese, did not appear to impact African American women's self-esteem and self-worth, which were most often obtained from communal acceptance and religious/spiritual beliefs (Sutherland, 2013). Even though body image concerns did not impact African American women, there were concerns about physical appearance (clothes, hair, or makeup) (Cash et al., 2012; Rowe, 2019). Weight may not have an impact on how African American women perceive themselves or act as a motivator. However, health behaviors, such as exercise, have been distinguished as a barrier due to its impact on the African American woman's physical appearance.

A significant barrier identified was the impact of health behaviors on hair care for African American women. African American women with a lower economic status believed health promotion behaviors were too costly when it impacted their cultural identity. The "sociocultural identity" referenced in the literature related to African American women's hair care and the additional cost that would be incurred due to exercising thereby becoming a barrier for this population (Ard et al., 2013). The importance of hair for African American women is discussed to provide an alternative understanding of the differences in motivation to pursue health with beauty holding higher regard than health. The perceived barrier, hair care, has been

viewed as an excuse not to participate in health promotion behaviors, but in an effort to maintain their cultural identity their decision is justified. The social importance of maintaining one's hairstyle and also the cost associated with having to consistently fix hairstyles due to 'sweating out hair' caused by increased physical activity created the barrier by which this health behavior is avoided (Huebschmann et al., 2015; Pekmezi et al., 2013; Versey, 2014). Bringing this seemingly slight issue to the forefront improves the opportunities to start having meaningful discussions on the real barriers impacting African American women.

Healthcare for Obese African American Women

Trust is paramount in the pursuit of healthcare, but African American women's historical experiences have impacted how healthcare professionals are perceived. In interviewing various physicians, they reported having less respect and tolerance for their obese patients and perceived them as noncompliant with proven health promoting behaviors. Among obese patients interviewed, it is estimated that 68% of obese women delayed healthcare treatment due to past experiences of embarrassment and disrespect from healthcare providers (Dietz et al., 2015). Systematic discrimination instances have created a non-trusting healthcare environment for African American women (Belgrave & Abrams, 2016; Jerald et al., 2017). African American women describe sensing and experiencing discrimination or disrespect suggesting these obese women have lost confidence in healthcare professionals and are not as likely to pursue health care services (Belgrave & Abrams, 2016; Davis et al., 2014; Jerald et al., 2017).

The location for this research study will be taking place in the southern region of the U.S. The feeling of mistrust may be more robust than in any other area of the country. The obesity rates in the southern United States are higher than in any other region, and African Americans in southern states also demonstrate a higher mistrust level amongst healthcare professionals. The

rural southern states, Alabama, Mississippi & Georgia, were identified as problematic when it pertained to seeking health care from providers that they viewed as different culturally, racially, and socioeconomically (Caldwell et al., 2017; Giger et al., 2008). In the southern region, older African Americans relate their past experiences with healthcare during the 1950s and 1960s to current healthcare providers. The level of respect remains, but the trust impacts their willingness to seek care unless necessary to sustain life. To assist in improving interpersonal influences, health care professionals must be aware of their personal biases and become skilled with the cultural nuances of the African American community (Di Noia et al., 2013; Maina et al., 2018). Past traumas must be acknowledged, and cultural perceptions and differences must be addressed to restore African Americans' trust in healthcare professionals.

Financial Cost of Obesity

Obesity is costly financially to the U.S., the individuals, and taxpayers. The Centers for Disease Control (CDC) has identified obesity as straining to the healthcare system with an estimated excess of 112,000 deaths each year attributed to obesity with a healthcare cost of approximately $190 billion yearly (Obesity Society, 2016). Obesity-related treatment in 2030 is expected to add up to 66 billion dollars to an already taxing and expensive healthcare industry (Biener et al., 2018; Voelker, 2012; Wang et al., 2011). The impact of obesity is not limited to the financial burden placed on healthcare, but it also impacts the workforce and productivity. The impact of obesity is multifaceted. It impacts one's health and impacts productivity at work, retirement potential, and quality of life for obese African American women (Wang et al., 2011). In addition to the already growing financial costs associated with the obesity epidemic amongst adults, this often becomes generational. African American adolescents living in households with lower family income and lower levels of neighborhood resources diminish the priority of health

promotion behaviors, which perpetuates the cycle experienced by the women in their lives (Di Noia et al., 2013; Giger et al., 2008; Kemp et al., 2011; Lee & Hicken, 2013; Routh et al., 2019). The development of public and healthcare policies is needed to address this healthcare crisis, especially the financial burden of healthcare in a population associated with a high poverty rate.

Disparities exist amongst African American women regardless of economic status. Poverty is not responsible for obesity in African American women, but it decreases the likelihood of seeking help for those under that category. The United States poverty rate is estimated to be 15.1%, with African American women's poverty rate at 27.4%. A strong correlation exists between health outcomes and economic opportunities for African American women (Di Noia et al., 2013; Venkataramani et al., 2016). In contrast, a discrepancy exists regarding African American women with a higher socioeconomic class and similar obesity rates in comparison to women from other races.

The belief is that African American women may still miss out on economic advancement and opportunities that women from other races are offered (Qobadi & Payton, 2017). Family dynamics also play a significant role in economic outcomes due to many families' makeup in African American communities. The likelihood of African American women to be single mothers, the sole providers, and live in strained economic conditions with decreased healthcare access places them at a higher risk for health problems such as obesity (Capers et al., 2011; Giger et al., 2008). Difficult decisions must be made when considering one's health and well-being and one's family's needs. The family's needs usually supersede the individual's needs, and healthcare becomes a luxury instead of a necessity.

Spirituality

Everyone believes in something, and it is that belief or lack of belief that determines the role health behaviors play in the individual's life. For many individuals, the belief in a supreme being and that relationship, commonly referred to as spirituality, is essential, especially when attempting to find meaning and purpose in life. For this study, spirituality is defined as a sacred human experience encompassing all three levels: religious, theistic, and existential spirituality. Spirituality is vital to people regardless of race, religion, or ethnicity, but it has meaningful implications regarding behavior changes for African Americans (Carter, 2002; Clark et al., 2018). Spirituality is identified as a consistent variable in the literature linked to African Americans as it pertains to understanding and coping with illnesses, and ultimately making treatment decisions (Johnson et al., 2005). In a 2018 survey of religious research, the African American participants' responses indicated more religious ritual involvement than any other ethnicity in the survey. The survey concluded that African Americans perceived themselves to be more religious due to regular church attendance, praying, and faith-based participation, which framed their reference for lifestyle, behaviors, and decisions made (Pew Religious Research, 2018). Faith-based organizations are not dedicated to only meeting the spiritual needs of the African American community. However, for years these organizations had played a pivotal role in healthcare for this population, primarily when historical healthcare barriers existed that prevented access to needed care.

African American churches are an essential partner in the healthcare of African Americans. Historically, African American churches have been the leader in disease management for African American communities significantly when discriminatory practices prevented African Americans from accessing much-needed care (Braithwaite & Taylor, 2001;

Chatters et al., 2009; Dondani & Fields, 2015; Giger et al., 2008). The healthcare community has often underestimated the impact of the faith-based organizations for the African American community, but African American church participants are adamant on addressing the importance of integrating God into all aspects of life, even health (Giger et al., 2008; Pekmezi et al., 2013). Recognizing the role of faith-based organizations provides health care providers with the opportunity to collaborate to make the most significant impact in research, management, and treatment of obesity.

Faith-based research for African Americans could provide a different lens by which chronic health diseases, disorders, and treatments are approached and integrated into one's life. Ritualistic spirituality is the term given to believing in a higher power expressed through prayer or meditation, church attendance, and worship activities. The research built around ritualist spirituality demonstrated an increased likelihood of attained goals if they were spiritual and increased compliance with health behaviors (Davis, Dutton, et al., 2014; Cogbill et al., 2011). Ritualistic spirituality is consistent with the spiritual beliefs and practices of black slaves in America who identified a connection between the physical and the spiritual. Both had to be addressed for either to function adequately (Fett, 2002). The younger African American woman (18- 40-year-old) demonstrates more of a secular perspective, but the knowledge, information, and actions they institute are derived from older African American women (Coe et al., 2015). The spiritual nature of African American women should be integrated into obesity research because obesity is involved. All avenues must be exhausted to identify which method works best for this population.

A lack of relevant literature exists regarding the relationship between spirituality and obesity of African American women. It is further complicated by the multidimensional, complex

nature of the concept of spirituality. The relationship between spirituality and obesity of African American women about their involvement with health promotion activities has not been specifically studied. However, numerous studies focus on spirituality and coping with chronic illnesses and church-based health promotion activities. The African American woman's belief in God could be viewed as a motivator and a barrier to managing chronic illnesses. African American women with a theistic approach to spirituality believed that because of their belief, their quality of life was positively impacted when faced with chronic diseases or diagnoses regardless of the prognosis along with an enhanced ability to cope with their diagnoses (Greer & Abel, 2017; Pierre-Louis et al., 2011; Sterba et al., 2014). Theistic belief is a motivating factor and a barrier because medical technology and resources were not always utilized to its fullest potential. This dependency must be examined because it is not clear if African American women have the level of faith they are demonstrating or if the lack or absence of resources forces them into a spiritual dependency. Spirituality should be factored in to determine its role in how African American women confront diseases and disorders, its role in obese African American women, and the implementation of health promotion activities.

Health Behavior

Health is in the beholder's eye, and currently, how African Americans define health is contradictory to how healthcare professionals define health. Health is a broad term with numerous meanings that encompass the physical health and well-being of one's mind, body, and soul (Bramble et al., 2009). All three are identified as equally important in determining when one has obtained the whole person's optimal health. An imbalance in either of those areas could potentially create an imbalance or domino effect in the remaining components. The pursuit of health for African American women should be a holistic approach that helps develop perceived

interventions as beneficial. Older, obese, African American women acknowledged that obesity was a health concern, but their weight was not enough to motivate their participation in health promotion activities, but maintaining independence for as long as possible (Bowen et al., 2015; Merzel & D'Aflitti, 2003; Pekmezi et al., 2013). As it is with older, obese African American women, it is with younger and middle-aged obese African American women. If the motivator for behavior change can be identified, then the focus will not revolve around weight loss but sustain the quality and quantity of life.

Health Behavior in African American Communities

Self-efficacy looks at one's ability to complete the task at hand independently, which may not always apply or pertain to overweight and obese African American women. Health promotion behavior (exercise, nutrition) studies with African American participants produced a low success rate. Participants acknowledged that they had difficulty controlling or maintaining health behaviors due to a lack of support. The lack of support was complicated by family members and friends who chose not to participate in health promotion behaviors because a heavier weight is considered culturally acceptable (Gentles- Peart, 2020; Mastin et al., 2012; Pekmezi et al., 2013). Health promotion behaviors are attainable when pursued by the collective instead of the individual (Cogbill et al., 2011; Sattin et al., 2016). Self-efficacy is a concept that one attains as an individual. However, as it pertains to African American women, they are more successful when pursuing health as a community instead of individually.

There is a significant push towards person-centered care and providing individualized care for one's needs in healthcare. Regarding preventative health, the focus has to shift in the African American population from the individual to the community. Community-based interventions have demonstrated more success than individuals based in African American

communities because they comprise friends and family members that provide accountability and motivation to commit to and continue with interventions (Cooper et al., 2015; Dodani & Fields, 2015; Merzel & D'Afflitti, 2003). There is limited data regarding the various health promotion programs' continuous success that incorporates a community approach, improved participation with community-based approaches was evident.

Health Behaviors: Physical Activity

Similarities identified amongst various populations (different age ranges and locations) of African American women who are aware of the benefits of health promotion behaviors, such as exercise, but their perception of what those behaviors do not translate into health behaviors. The terminology has a significant impact on one's perception in determining if an action is a barrier or a benefit. In various research studies, participants utilized the terminology of exercise and physical activity interchangeably until asked to define or identify the differences between them. Physical activity was perceived to be an easy activity or recreational for children but exercise was deemed to be hard and torturous, which caused African American women to avoid this particular health behavior (Bowen et al., 2015; Eugeni et al., 2011; Pekmezi et al., 2013). Defining the differences could be a pivotal educational opportunity in which African American women can be educated on physical activity, the intended purpose, and the various forms of activity classified as physical activity.

Health Behaviors: Nutrition

The food that one consumes is just as important as participating in physical activity. The obesity epidemic has produced numerous nutritional health initiatives, but none have demonstrated sustainable, long-term maintenance for African American women (Davis et al.,

2014). Government nutritional assistance programs are available to help lower-income families receive financial vouchers, learn about eating healthier, and increase their activity (Women Infant and Children, WIC). These programs intend to encourage more nutritious foods and improve physical activity (The State of Obesity, 2014; Zimmer et al., 2019). All of which should be sufficient to impact the obesity epidemic substantially, but the opposite is true. Many African American women who receive government benefits are unable to access healthy, affordable foods and physical fitness facilities. Research has identified a positive correlation between having limited access due to location or lack of transportation to supermarkets and their ability to participate in physical activities (The State of Obesity, 2014). The various initiatives in place, without evidence of objective, demonstrable success, indicate that other factors are at play regarding African American women's health.

One factor identified is the discrepancy between foods encouraged by governmental nutritional programs versus the culturally approved foods consumed by African Americans. The first concern identified was dietary recommendations and how they could be perceived as restrictive and culturally inappropriate (Baker et al., 2016; Eugeni et al., 2011). The makeup of the dietary habits of African Americans should be viewed through a historical lens regarding the impact of slavery in America on food options that were passed through generations, traditions that makeup dinner time in this community, and culturally identifiable foods (Bramble et al., 2009; Di Noia et al., 2013; Eugeni et al., 2011; Hawkes et al., 2015). In lower-income environments where access to supermarkets and healthy food options existed, obesity was still prevalent, shifting the blame from access to individual choice or the pursuit of culturally appropriate food choices (Budzynska et al,. 2013; Pruchno et al., 2014). Access is still a

significant hindrance for most African American communities; therefore, blame cannot be shifted until all communities have a level playing field.

The second concern identified was access to healthy food options in African American communities. The lack of fruits and vegetables in communities or neighborhoods with a high population of African Americans due to fewer supermarkets and also price gouging when healthier food options were available, could potentially play a role in food choices (Bramble, et al., 2009; Capers et al., 2011; Hawkes et al., 2015; Mastin et.al, Campo & Askelson, 2012; Qobadi & Payton, 2017). To complicate access to adequate nutrition, other constraints such as inadequate transportation, child care, time constraints, skills to prepare meals, and inadequate food storage add to inadequate food practices (Ard et al., 2013; Di Noia et al., 2013; Hawkes et al., 2015).

Access and availability of healthy food options are imperative to shift the nutritional aspect of health promotion behaviors. However, nutritional habits and behaviors are more complex and multifaceted than the overall availability of healthy food in various environments (Bauer et al., 2019; Budzynska et al., 2013). There is a need for public policies that call for a change in marketing techniques and healthy food options. Policies that address how pricing decisions are made, maintaining prices at a fair rate and public education make healthier food options culturally acceptable (Chopra et al., 2002, p. 953). To effectively address price manipulation, policies should be passed nationwide to provide incentives to cut prices of healthier food options.

Recommendations for Future

Future practice recommendations were identified from the various research articles' limitations and anticipated continuation plans for their prospective research studies. The development of community-based research was recommended to allow the community leaders and members to identify their needs and create a plan that would best fit their needs (Di Noia et al., 2013; Kim et al., 2008). The expectation would be for the community leaders and members to take control and maintain the interventions to ensure sustainability for their communities. Bowen et al. (2015) recommended developing culturally, age-appropriate, and cost-effective interventions that promote physical activity, not just merely exercise, to maintain independence.

There is not a one size fits all approach to preventative health. The approach should be dependent upon the population and the expected goals and outcomes of the participants. Public health initiatives that focus on the community and the individual are needed to create a multifaceted approach to combating obesity in this population (Budzynska et al., 2013; Chopra et al., 2002; Merzel & D'Afflitti, 2003). The emphasis on preventative health should not be solely focused on weight maintenance but on preventing continuous relapse and weight cycling (Davis et al., 2005; Rogers et al., 2016). Information provided should cross all language barriers or deficiencies that exist to ensure that the intended message is relayed, and healthier options become the societal norm and not an unreachable or unaffordable option.

Investors understand the impact that television plays on this population. Television publications and ads are instrumental in driving lifestyle and nutritional choices in this population, but culturally relevant educational television commercials could prove beneficial (Risica et al., 2013). Educational television intervention has been successful in changing participants eating habits and physical activity levels. The recommendation was for educational

programs to be provided not only on the television during scheduled airing times but also streaming online to provide repeat viewing opportunities (Risica et al., 2013). Even though it has limited associated data, the impact of hair maintenance and its power to prevent preventative health activities should be investigated further. Developing partnerships with hair salons could prove beneficial, mainly since African American women invest time and money towards their outward appearance. Lastly, there should be a consideration for taking preventative health activities back to faith-based organizations due to past success of screening for disorders such as hypertension and breast cancer and by providing educational programs against smoking and the reduction of cardiovascular risks (Dodani & Fields, 2015; Giger et al., 2008). Especially in southern states where trust issues tend to impact one's likelihood of seeking additional health or adhering to the medical regimen.

Summary

In summary, it has been universally recognized that obesity is a health issue of epic proportions for all races, nationalities, and genders across the United States. The increased focus and intense incentives directed towards obesity steers from the increased morbidity, mortality, and increasing health care costs associated with this utterly preventable health issue. This literature review addressed multiple preventative health perceptions, barriers, and recommendations to identify gaps in the literature. Information obtained in this study will facilitate conversations amongst health care professionals and develop new ideas from the lived experience of obese African American women.

Chapter 3. Methodology

The purpose of this qualitative, phenomenological study was to describe the lived experiences of obese African American women. This study's epistemological assumption assumed that the participants, obese African American women, have beneficial information regarding their lived experiences, health behaviors, and spirituality's effect on their experiences. The obesity rates have reached epidemic proportions in the United States, and its effects are disproportionately impacting African American women. Numerous health initiatives have been launched, but none have demonstrated sustainable, long-term maintenance for African American women (Davis et al., 2014). This epistemological perspective, the limited research regarding spirituality concerning obesity for African American women, directed this study's methodology in the direction of a phenomenological, naturalistic inquiry. The gaps identified in the literature regarding the motivating factors for African American women as it pertains to health behaviors and how it is perceived by this population further assisted the research design of this study. By examining the lived experience of obese African American women, this study could provide valuable insight into alternative methods and interventions that may spark change for this population.

Research Designs

Qualitative research is a research method that can produce textual data and analysis by exploring participants' understanding of their lived experiences and how they impact the investigation (Holloway, 2005, p. 3). Phenomenology is the qualitative research method, grounded in a naturalistic inquiry selected for this study to examine obese African American women's lived experience. Phenomenology was the method of choice for this study because when it pertains to individuals' health, it is a "subjective phenomenon that is understood, enacted

and experienced by human beings" (McWilliam, 2010, p. 229). The human experience is complex, and the participant's perception of reality is their truth; therefore, pursuing a naturalistic inquiry allows for collecting and analyzing subjective and narrative data as it is experienced (Polit & Beck, 2004, p. 16). Naturalistic inquiry encompasses researching the participant's natural setting (i.e., home/church/community center rather than a laboratory) to pursue the participant's views, approach, and understanding of their experiences (Frey, 2018). Naturalistic inquiry acknowledges the participant as the expert of their experiences. Phenomenology was integrated to study those lived experiences to describe and elucidate those meanings as they develop (Frey, 2018; Given, 2008).

Phenomenology was developed through a German philosopher, Edmund Husserl (1859-1938), whose intent focused on philosophical questions about one's reality as they experience it and not research (Burns & Grove, 2009; McWilliam, 2012; Usher & Jackson, 2017). Husserl's phenomenology has since been defined as descriptive/transcendental phenomenology, which recognizes the importance of one's consciousness and the various perspectives of a particular event because this provides insight into one's behaviors and actions. Transcendental phenomenology focuses on the description of the experiences of the participants (Creswell, 2007). In an attempt to describe and give meaning to one's lived experience, phenomenology interprets those experiences as being "shaped by consciousness, language, our cognitive and noncognitive sensibilities, and by our preunderstandings and presuppositions." (Given, 2008). Groenewald's (2004) definition of phenomenology, as stated by Husserl, is "the science of pure phenomena" (p. 43). Husserl believed that reality should be treated as pure phenomena, and that is the only unlimited data. This view considers each participants' lived experience, which is their truth, which is pure phenomena.

Since its inception, phenomenology has had numerous versions developed, but descriptive phenomenology will be utilized for this research study. Interpretive phenomenology, another basic version of phenomenology, was developed by Martin Heidegger (1889- 1976), a Husserl student. Heidegger's phenomenology, also known as hermeneutic phenomenology, transitioned from not just describing one's experience to focusing on interpreting and understanding one's experience (Burns & Grove, 2009, p. 253). Significant differences exist between descriptive and interpretive phenomenology, with one of the most significant distinctions between the two being bracket's ability. Epoche, the German word for bracketing, is described by Husserl as a method by which one would refrain from making assumptions or judgments about the phenomenon that is being studied (Creswell, 2007; Frey, 2018).

Bracketing is described by Polit and Beck (2004) as the "process of identifying and holding in abeyance preconceived beliefs and opinions" (p. 253). Heidegger's hermeneutic method approached phenomenology from the perspective that the human experience is embedded and incapable of being removed from the study (McWilliam, 2012; Usher & Jackson, 2017). Husserl's phenomenological stance undergirded this study, with the understanding that complete neutrality is impossible. Steps were integrated into this study, i.e., bracketing and reflexive journaling used to maintain the study's trustworthiness. This will be discussed later in the chapter. The following chapter discusses the ontology, research design, participant inclusion/exclusion criteria, recruitment methods, human subjects protection, procedures to obtain consent, plan for data analysis, and the plan to ensure study trustworthiness.

Research Questions

The purpose of this study was to explore and describe the lived experiences of obese African American women and the role that spirituality plays regarding their health behaviors. The specific research questions that guided the study were obtained from identified gaps in the literature. Throughout this study, the following questions were explored:

1. What is the lived experience of obese African American women?

    A. What are obese African American women's perceptions of spirituality?
    B. What are obese African American women's perceptions of weight status (obesity) and its impact on health?
    C. What are obese African American women's perceptions of health behaviors?

Ontology/Epistemology

This study assumed the ontological stance of critical social theory (CST) with the belief that truth is "universal and independent of human perception of it" (Weaver & Olson, 2006, p. 462). The tenets of CST listed by Brown (2000) attempt to display the power imbalance, the role society plays in maintaining oppressive behaviors, and the emancipatory power found in the knowledge. CST is increasingly being utilized in nursing research with the focus on "socio-political context of nursing practice, domination within the discipline of nursing, liberalism within nursing education, power dynamics within communities and families, and structural constraints within the health-care system" (Browne, 2000, p. 42). Numerous studies have identified the power struggle and health disparities that exist in minorities. African American women collectively exceed all other ethnic groups in obesity rates (CDC, 2015). CST is

instrumental in that it "emphasizes the collective rather than the individual," which meets this qualitative study (Carnegie & Kiger, 2009, p. 1978).

The epistemological assertions provided by Mack (2010) stated that "knowledge is socially constructed through media, institutions, and society; what counts as worthwhile knowledge is determined by the social and positional power of the advocates of that knowledge" (p. 9-10). Reality is shaped by the media and society where one lives, which explains the behaviors exhibited due to an oppressive environment. The nature of truth is taken for granted when a conflict exists, and the truth is viewed as universal but is not available to everyone. Research studies have indicated the impact of marketing on this population, especially regarding more ethnically relatable advertising of foods and beverages of low nutritional value with no healthy lifestyle alternatives (The State of Obesity, 2014). The nature of one's reality/truth is determined by various factors such as sex, culture, economics, and political environment. CST's ultimate goal is to be mindful of the power struggles when examining the relationships between obesity, spirituality, and health promotion behaviors concerning African American women's perception of their health status.

Study Concepts

Obesity. For this study, weight was classified utilizing the Body Mass Index (BMI) categories. BMI is the most utilized mathematical calculating system that involves using the height and weight with disregard for "family history, gender, age or race" (The Obesity Society, 2016). Regardless of the BMI tool's specificity, research documents are available to support the validity of an elevated BMI in association with increased morbidity and mortality (Gadde et al., 2018, p. 72).

Spirituality. Spirituality is a psychological need that was extensively identified in the literature with varying definitions. The "large number of definitions points to a lack of conceptual clarity in this field" (Reinert & Koenig, 2013, p. 2623). Spirituality was imperative for this study. The literature indicates that the African American population is more likely to be engaged, participate, and strive to meet developed goals if the goals were spiritual in nature (Davis et al., 2014). For this study, spirituality was defined as a sacred human experience encompassing all three levels: religious, theistic, and existential spirituality. Religious spirituality changed to ritualistic, "was conceptualized as a structured, ritualistic connection with deity" (Webb et al., 2013, p. 973). Theistic spirituality was defined as "a non-structured connection with deity, including little to no affiliation with organized religion (Webb et al., 2013, p. 973). Existential spirituality is "a non-theistic search for meaning and purpose" (Webb et al., 2013, p. 973). The study stated the term precisely spirituality, without attempting to differentiate between the three levels.

Health Behaviors. Health behaviors are "the desired behavioral endpoint or outcome of health decision-making and preparation for action" (Pender, 1996). Health responsibility "involves an active sense of accountability for one's own well-being" (Walker et al., 1996). Physical activity "involves regular participation in light, moderate, and/or vigorous activity" (Walker et al., 1996). Nutrition "involves knowledgeable selection and consumption of foods essential for sustenance, health, and well-being" (Walker et al., 1996). Interpersonal relations are essential because they help the clients recognize "sources of support and identify barriers in social relationships that may block desirable health actions" (Pender, Murdaugh, et al., 2011). Stress management is vital because "ongoing efforts to manage specific internal and external demands that exceed personal resources" (Pender, Murdaugh et al., 2011, p. 89). Health

behaviors (health responsibility, physical activity, nutrition, interpersonal relations, and stress management) will be viewed through a holistic lens encompassing the singular concept of health behaviors without expounding upon each behavior.

Study Design

Study Population

This study's population of interest was African American women between 18 and 64 years, located in the southern, middle Tennessee area. This study must make distinctions between the black American ethnic groups. Black Americans' current demographic population comprises people from various countries such as Haiti, Brazil, the Caribbean, Jamaica, and various countries in Africa (Berlin, 2010). Literature indicates a significant difference regarding nutrition, health, and wellness among Black American immigrants that is distinctly unique and different than African Americans. The difference is identified in nutrition, physical activity, spirituality, and socio-economic status with better health outcomes for Black American immigrants than African American women (Griffith et al., 2011). The thought is that Black American immigrants arrive with a more nutritional diet, increased physical activity, and perception of health from their homelands that is uniquely different from the African American historical and cultural experience. The specifically sought-out population was African American women whose lineage is identified with slavery and the civil rights movement in America. Research studies have identified the impact that historical culture plays in that African Americans differ consistently regarding their behavioral response to nutrition, physical activity, and spirituality, which is expounded upon in the literature review (Bramble et al., 2009; Chatters et al., 2010; Encyclopedia of the North American Colonies, 1993).

Inclusion and Exclusion Criteria

Inclusion Criteria. The following inclusion criterion was established to identify participants for the study.

- Ensuring ethnic self-identification as African American, post-slavery and civil rights ancestry
- Adult women between the ages of 18- 64 years
- They are currently identified as being obese or with a BMI of 30mg/k^2 or greater.

Exclusion Criteria. The following exclusion criterion was established to identify participants not suitable for the study.

- Women identified as a Black American immigrant from another ancestral heritage.
- Adult women that are the age of 65 or greater
- They identify as being overweight or less, with a BMI equal to or less than 29.5mg/k$^{2.}$

Participant Recruitment

Recruitment in qualitative studies is of the utmost importance, especially considering the importance of procuring participants that fit the targeted population to ensure the research (Mariampolski, 2001). The researcher recruited the participants from the various faith-based organizations, social clubs, friends/family, and beauty salons in the southern, middle Tennessee area. Research recruitment letters (Appendix C) were mailed to the organizations and businesses asking permission to recruit participants in the study. Follow up phone calls or visits were made when no response was received at least two weeks after the correspondence went out. Meetings

were scheduled with faith-based leaders, social clubs, and beauty salons agreeing to allow recruitment to outline the research process and how their members were recruited. Flyers (Appendix B) were provided to the various organizations and businesses to promote participation from their customers, clients, friends, and family members who meet the inclusion criteria. Participants had the opportunity to talk to the primary investigator at the scheduled recruitment events once permission was obtained from the leaders, social clubs, and salon owners.

The initial conversation determined if the participant met the inclusion criteria, and an interview was scheduled that best fit the participants' schedule. The participant received a confirmation phone call two days after the verbal agreement to participate in the study. The participant was provided with a brief overview of the study, the participants' expectations, advantages or disadvantages, and a follow-up phone call the day before the scheduled interview to confirm the date, time, and location. Interested participants were provided with a flyer and contact information for the primary investigator to recruit additional participants from their friends and family. Participants who made primary contact by calling, their contact information, and the inclusion criteria will be confirmed before offering interview scheduling dates. All phone calls were made from a password-protected phone to ensure participant confidentiality.

Setting

The logistics of setting up interviews are frequently overlooked as unimportant for research studies. However, the location can either hinder a participant's comfort level or encourage their engagement and participation with the study. This study utilized a real-world, naturalistic setting to develop and maintain the participant's rapport and comfort (Herzog, 2014; Polit & Beck, 2004). The initial interview locations were at the participants' homes or workplaces, where they had a sense of comfort. That comfort also provided for a quiet one-on-

one interview. The purpose behind these locations was to provide the participants with familiar environments to decrease the money needed to travel, decrease the anxiety of participating in a study, and improve their comfort level. In March 2020, the Covid-19 pandemic shifted how interviews would be conducted for this research study. The social distance mandates allowed for the interviews to be held virtually via Zoom, and participants were able to log in from their homes, their cars, or their offices at work.

Sample

The target population was obese African American women in the south, central Tennessee region encompassing counties below Nashville, TN. The sampling techniques used were purposeful sampling and snowball strategies. Purposeful sampling is defined as selecting individuals that the researcher identifies as a good representation of the study (Polit & Beck, 2004). Snowball sampling is a method by which participants in the study can reach out to potential study participants who meet the same inclusion criteria.

Human Subjects Protection

The protection of human subjects is of the highest priority. This study was submitted to East Tennessee State University's Internal Review Board (IRB), and it was approved. Study procedures beginning with recruitment did not occur until after IRB approval was obtained. After IRB approval was obtained, recruitment began, and the participants received a hard copy of the consent form to sign. All participants were informed of the study details, the expectations of participating, assurance of confidentiality and anonymity, and that at any time, they could withdraw from the study. Privacy and security of all data were ensured to include no participant identifiers. After data collection, the recordings were locked with restricted access. The audio

recordings were sent to a trained transcriptionist, with all identifying names removed from the transcription. In the final analysis, the cumulative characteristics of the study participants were utilized.

Data Collection Procedures

Interviews

Interviews were conducted after informed consent had been obtained. The participants reviewed and agreed to participate in the study by signing the consent form. The participants were provided with time to complete the demographic research questions before beginning the study's interview portion (Appendix E). The demographic research questionnaire provided the researcher with the data needed to ensure the participants met the inclusion criteria and collected socio-economic and educational data to determine how those statuses impact the participant's lived experiences. The data collection method was an in-depth conversational interview that was guided by a pre-developed interview guide. The interview guide was developed from gaps identified in the literature. The interview guide comprised open-ended questions to help facilitate discussions on their lived experiences (Appendix F). Conversational interviewing is a technique used by researchers to generate verbal data by helping the participant feel free to expand on the topics discussed without feeling like they are confined to structured interview settings (Given, 2008, p. 127).

The participants were notified that the expected timeline was 45- 90 minutes for the interviews and dependent upon the participant. Interviews were audio-recorded, transcribed verbatim (excluding names or identifiable information), and reviewed for accuracy before starting the data analysis. Covid-19 impacted in-person interviews, and they were shifted to

virtual interviews via Zoom. A modification was submitted and approved by the IRB at ETSU to continue with interviews via the Zoom platform and recording. After each interview, the recording was played to ensure clarity and compare with field notes (Appendix G) documented. Once the transcribed documents were completed, the interviews were replayed to compare with the transcribed data to ensure accuracy and completion before data analysis was started.

Data Analysis

The expectation was that there would be massive amounts of data to transcribe to reach data saturation. Data saturation happens once no new themes are identified from the data, and it has been confirmed that the same or similar themes are consistently emerging (Usher & Jackson, 2017). The analysis method for this study was the qualitative content analysis process. Content analysis is a categorical thinking process that collects textual data into groups to identify consistent patterns and relationships amongst the themes (Given, 2012). Content analysis has its beginnings in quantitative research, during the first half of the twentieth century, as a technique to observe, measure, objectively, and systematically quantify data with no regard to the textual data containing rich meaning (Krippendorff, 2012; Schreier, 2013). Qualitative content analysis is systematic in its method, but it is unlike any other method in that it is flexible, and it reduces data while deriving meaning from the data (Schreier, 2013). For example, health behaviors consist of complex, poorly understood, subjective experiences. However, analysis of the content is an iterative process that is continuous until meaning emerges while providing the structure and rigor needed to ensure validity and reliability (Schreier, 2013).

Three approaches to qualitative content analysis were identified in the literature: conventional and directed approach, thematic approach, and type-building approach. Each is similar regarding its method of methodically describing and interpreting the meaning of the text;

they differ in the development of categories and coding procedures (Schreier, 2019). This research study has adopted the conventional and directed approach for qualitative content analysis, but this approach has further been reduced to a conventional (inductive approach) or directed (deductive approach). The conventional inductive approach (CIA) is applied when there is a lack of knowledge regarding a particular phenomenon of interest; therefore, the codes and themes are produced from the data (Frey, 2018; Hsieh & Shannon, 2005). The directed deductive approach (DDA) is applicable when there is sufficient data on particular interest phenomena. The intent is to add to, confirm, or expound upon that particular body of knowledge (Frey, 2018). This research study applied the CIA due to the phenomenon of interest and the lack of data available to adequately conceptualize obesity and spirituality and how African American women experience it.

The CIA method allowed the codes and categories to stem from the data collected during the interview process without imposing predetermined viewpoints. Open-ended questions with probes, specific to the participant's responses, were utilized during the interview process due to the lack of established theories solely to obtain new knowledge (Hsieh & Shannon, 2005). During the interview process, field notes (Appendix G) written captured the environment, interactions, and what was not said by the participant to understand the information being disclosed (Allen, 2017). Words, phrases, responses were jotted down to stay engaged with the interview process. Once the interview was complete, more descriptive, detailed field notes were filled in because it "can be thought of as the tangible, physical, objective interpretation of what was going on during the observation period" (Allen, 2017, p. 565). The field notes were also instrumental as supplemental information in the coding process before analyzing the data.

Qualitative content analysis requires that the data be segmented into codes and categories to develop or build a coding frame. A coding frame consists of the following steps: "selecting material, structuring and generating categories, defining categories, and revising and expanding the frame" (Schreier, 2013). The coding frame was developed as interviews were completed and analyzed. The main category selected was subjective data, which was identified from the data (for each question or topic) before breaking down the information into subcategories. The first transcribed interview was coded independently by the researcher with assistance from the faculty advisor.

The second transcribed interview was coded by the researcher with assistance from the faculty advisor to ensure consistency. NVivo 12 Pro's was utilized by the researcher to assist with data organization, sorting, and storage after codes and categories were identified. NVivo allows for the data to be organized based on common themes, expressions, and ideas with the capability of drawing inferences, all while providing the option for the researcher to add to or change any codebase that is not mutually agreed upon by the researcher and faculty advisor (Salkind, 2010). Inferences are imperative in the data analysis process because they provide context for the questions answered and allow for an in-depth discussion during the analysis process to enhance the study's validity (Druckman, 2005). The coding frame developed as the material was broken down and as categories emerged with subsequent interviews.

Trustworthiness

Trustworthiness refers to various dimensions to evaluate and validate the study data (Polit & Beck, 2004). These trustworthiness dimensions are credible, transferable, dependable, and confirmable (Polit & Beck, 2004; Toma, 2011). Credibility is identified when the researcher remains authentic and consistent with the research method, and the data is rich and consistent

with the participant's lived experience (Polit & Beck, 2004; Toma, 2011). Transferability pertains to the data's ability to apply to another setting or group of individuals with similar experiences (Toma, 2011). Dependability looks at the data's consistency and making accommodations and changes in the environment or even the design dependent upon the participant (Polit & Beck, 2004; Toma, 2011). Lastly, outside researchers review the data, and when the data can be confirmed, confirmability exists (Toma, 2011). Confirmability will be accomplished by the dissertation committee members overseeing the study.

Scientific Rigor

Scientific rigor is defined as striving for quality research by instituting attention to detail, accuracy, and discipline in research practices (Burns & Grove, 2009, p. 34). As viewed by Husserl, phenomenology was considered the most rigorous human science because it contained pure data in how the human consciousness experiences phenomenon (Given, 2008). Field notes were utilized to document the environment, the participant's behaviors, and body language during the interviews. Field notes were completed with each interview to maintain consistency of practice. The field notes were reviewed during the replaying of the recording to ensure that all thoughts and ideas were noted. The field notes were also utilized while reviewing the transcribed interviews with voice recordings to ensure complete thoughts and ideas.

Bracketing, a process embedded in Husserl's transcendental phenomenology, was utilized in this study to increase the validity of the collection and analysis of data (Ahern, 1999). Bracketing intends to be as objective as possible to remove as many preconceived assumptions, personal feelings, and values from influencing the study. Bracketing is of the utmost importance in this study, considering that the researcher meets the inclusion criteria set forth by this study. The researcher recognizes the potential impact of their experience; therefore, reflexive journaling

was initiated to identify potential biases in this research study. Reflexive is defined as a self-reflection, questioning, and understanding of one's personal feelings, values, cultural beliefs, and experiences, all while engaging a research participant (Cumming-Potvin, 2013; Jootun et al., 2009). The following paragraph will discuss the steps taken to build towards reflexive journaling.

Reflexive journaling entails ten suggestions, as outlined by Ahern (1999). The first step suggested improving the bracket's ability is to identify interests that could be taken for granted as a researcher (Ahern, 1999, p. 408). The researcher's issues were concerns about obtaining permission from church leaders to allow recruitment of congregants, being considered to be at an advantage and having a higher socio-economic status than the research participants, and lastly, not being considered credible due to meeting the research inclusion criteria. The second step suggested is to explain the researcher's value system and subjectivity (Ahern, 1999, p. 408). The researcher has a belief system built around the Christian religion, with a robust spiritual backing currently struggling with consistently engaging in health behaviors. The third step suggested identifying possible role conflicts (Ahern, 1999, p. 409). This step looks at how emotions can influence the interview process and the likelihood of issues arising from the research study objectives. These reflexive bracketing suggestions were utilized with journaling to identify potential biases with the research study.

Summary

This study aimed to explore and describe the lived experiences of obese African American women and their perception of health behaviors and their role in health decisions. Phenomenology was selected as the method of choice because it allows the researcher to witness health behaviors and spirituality through obese African American women's lived experiences.

The information obtained can help health care professionals understand obese African American women's experiences and reality before attempting to prescribe health regimens or educate about health care concerns. The proposal has been submitted, approved, and IRB approval was granted; data collection is complete, and the results are analyzed and presented in Chapter 4.

Chapter 4. Findings

The purpose of this qualitative, phenomenological content analysis study was to explore and describe the lived experiences of obese African American women with attention and focus on weight, health behaviors, and spirituality. The data analysis was conducted to answer the following question(s):

RQ1: What is the lived experience of obese African American women?

A. What are obese African American women's perceptions of spirituality?
B. What are obese African American women's perceptions of weight status (obesity) and its impact on health?
C. What are obese African American women's perceptions of health behaviors?

The analysis procedures resulted in the identification of three central themes: who I am, the weight I carry, and double-mindedness. Each of the three central themes were further divided into two to three sub-themes that will be discussed later in this chapter. The following paragraphs were organized into sections that described the research sample, defined the three main themes with their corresponding sub-theme, and the process utilized to analyze the fifteen transcripts is detailed in this chapter.

Recruitment and Sample

Research approval was obtained from the East Tennessee State University Institutional Review Board and recruitment of participants began from two African American churches, one hair salon, and two predominately African American social clubs in three south central Tennessee counties. Letters were sent out to three churches, three beauty salons, and three social

clubs via email to their leadership in order to obtain consent to solicit participants from a variety of organizations. Follow up phone calls were made from which consent to recruit participants was obtained from two churches, one beauty salon, and two social clubs. Flyers were provided to each church, salon, and social club once consent was granted. Over a twelve-month period, several women stated interest in contributing to this research study of which fifteen were screened for eligibility with each woman giving consent to participate in the study. Four participants were recruited from the churches, two participants were recruited from the beauty salon, and three participants were recruited from the social clubs. Additionally, six women were recruited to participate in the research study through snowball sampling as previous research participants referred eligible friends and family members to be in the study.

A total of fifteen participants were enrolled to ensure diversity of thought and to ensure data saturation was obtained. All of the participants met the research inclusion criteria, with all of the participants being identified as either obese or morbidly obese based off on the participant's self-reported weight, and subsequently researcher calculated BMI. The sample consisted of five participants under the age of thirty-five, six participants between the ages of thirty-six to forty-five, and four participants over the age of forty-six. The relationship status of the participants were nine single/divorced and six married. Eleven of the fifteen participants had children which was significant for the study due to the increased likelihood for African American women to be single mothers and the sole providers which places them at a higher risk for health problems such as obesity (Capers et al., 2011; Giger et al., 2008). Lastly, thirteen of the fifteen participants worked full-time with all participants having at least a high school degree, and ten having a degree from a college or university. Obesity health concerns are still prevalent in the African American community independent of one's income level or educational matriculation

(Ard et al., 2013; Assari, 2018). Other ethnic groups demonstrate a decrease in weight when there is an increased educational and income level, but the same is not true for African American women.

Data Collection

As discussed in Chapter 3, the phenomenological research design grounded in a naturalistic inquiry was used in this study. Phenomenology was the method of choice for this study because when it pertains to individuals' health, it is a "subjective phenomenon that is understood, enacted and experienced by human beings" (McWilliam, 2010, p. 229). Naturalistic inquiry encompasses researching the participant's natural setting (i.e., home/church/community center rather than a laboratory) to pursue the participant's views, approach, and understanding of their experiences (Frey, 2018). The initial seven interviews occurred at the participant's homes or in their offices at work. Due to the restrictions placed because of Covid-19, the remaining eight interviews were conducted via Zoom with the participants being at home, in their offices, or in their vehicles during their work breaks.

All of the participants completed the demographic questionnaire which provided information that is useful research data. Recorded interviews were uploaded via a secure network to the transcriptionist who transcribed all fifteen interviews. Data analysis started at the completion of the first interview and subsequent transcripts were analyzed after they were checked for clarity and completeness. An overall analysis was performed once all interviews were completed to allow the researcher an opportunity to be immersed in the data and dedicate time towards identifying relational themes from all of the interviews collectively.

Research Data and Analysis

The analysis method for this study was the qualitative content analysis process. Content analysis is a categorical thinking process that collects textual data into groups to identify consistent patterns and relationships amongst the themes (Given, 2012). This research study applied the conventional inductive approach (CIA) due to the phenomenon of interest and the lack of data available to adequately conceptualize obesity and spirituality and how African American women experience it (Frey, 2018; Hsieh & Shannon, 2005). The first transcribed interview was coded independently by the researcher with assistance from the faculty advisor. The second transcribed interview and subsequent interviews uploaded into the computer program NVivo 12 Pro, to assist with organization and further data analysis.

Qualitative content analysis requires that the data be segmented into codes and categories to develop or build a coding frame. The coding frame consisted of the following steps: "selecting material, structuring and generating categories, defining categories, and revising and expanding the frame" (Schreier, 2013). During the data analysis, the transcribed data produced one-hundred and eighty codes. With further data reduction those codes were evaluated, relationships established, and the end result was twenty categories. The categories were further analyzed for relationships and revised until major themes were identified from the data. Three themes are present with each having two to three subthemes. Theme one is who I am, and it has three subthemes (a) spiritual and religious guidance, b) shaped by my family and history, and c) cultural and environmental influences. Theme two is the weight I carry with two subthemes (a) the burden on my life, and (b) burden on my family. The third theme is power struggles: double-mindedness, with three subthemes (a) intrinsic factors, (b) extrinsic factors, and (c) health care

experiences. These themes and sub-themes are examined and defined more closely in the following section.

Themes Identified

The research findings discovered numerous intrinsic and extrinsic dynamics that demonstrated the impact spirituality had on the health behaviors of obese African American women. Intrinsic is defined by Ryan and Deci (2000) as, "the doing of an activity for its inherent satisfactions rather than for some separable consequence" (p. 56). In contrast extrinsic is defined as, "a construct that pertains whenever an activity is done in order to attain some separable outcome" (Ryan & Deci, 2000, p. 60). All of the women in the study viewed being obese as an unhealthy state with negative impacts not only on their lives, but also on their friends and families. All participants were aware of what was required in order to implement better health behaviors but translating that knowledge into practice proved to be daunting for the participants. In an attempt to identify what motivated their actions and behaviors, this study provided the women with the opportunity to voice their perspectives and experiences on issues that have a huge impact on their future well-being. The three themes identified from the data analysis are who I am, the weight I carry, and the power struggle identified as double-mindedness. Each theme has two to three sub-themes which provides a clearer description of the participants lived experiences.

Who I Am

Who I am, encompasses the most frequently described attributes of how these women see themselves, who they are, and why they do what they do. These attributes are represented in the three subthemes: spiritual and religious guidance, shaped by my family and history, and cultural

and environmental influences which are responsible for shaping these women into who they are. Holism is defined by the Oxford (2020) dictionary as "the theory that parts of a whole are in intimate interconnection, such that they cannot exist independently of the whole, or cannot be understood without reference to the whole, which is thus regarded as greater than the sum of its part." The women provide a brief but real glimpse into their lived experience and how those experiences shaped and molded them into who they are. This glimpse of their lived experience is merged into the historicism as described by critical theory. Historicism identifies the individual as the historical agents who are not only the participants but also the subject of particular actions that is currently impacting those individuals in a society (Given, 2012). This historical examination focuses on how people behave or interact with the world as a culture and that is identified through critical social theory. The historical experiences of African American women can be seen generationally through the decisions and actions made not only by the participants but their parents and family members.

Spiritual and Religious Guidance. The women in general described themselves as believers in a higher power and because of that belief there were certain 'religious or spiritual' actions expected of them. The women believed that God required certain things from them: prayer, attending church, tithing, providing service to others, self-sacrifice, and having faith. This can be defined as ritualistic spirituality which is the term given to believing in a higher power expressed through prayer or meditation, church attendance, and worship activities. All of these attributes the women equated to being a part of their spiritual duty because of their faith and belief in God. Spiritual and religious guidance were merged together because these activities are the outward expression of their internal beliefs which motivate their actions.

A spiritual/religious being:

> "I believe in treat others as you would want to be treated. And so spirituality is very important to me. That is a part of me trying to live. And then sometimes I don't always get it right, but every day He wake me up I try my best to get it right."

> "Being a well-rounded and just a good, nurturing person, uh, you know. Slow to anger, not quick to judge. Uh, understanding that we are human and, as humans, we are naturally going to mess up every single day, but providing grace for others and then giving grace to yourself when that happens. And using your talents and gifts so, at the end of the day, glorify your person or person that you consider your spiritual beings."

God requires certain things from me:

> "Trying to live right, the best way I know how, reading, studying in his Word, going to church, being involved in church."

> "I work to make sure I am living a life of integrity and goodness."

> "I know that I did not get myself up. I know that. I know that. I just -- I didn't get myself up this morning. That's the grace of God that God allows us another day. And I stand firm on that. So I have to extend grace to others because of grace that is given to me"

Shaped by my Family and History. How these women defined themselves and how they related to their environment seemed to stem from how their families perceived them. Their identities were derived from their families. Dependent upon their family's beliefs and ideals about health, spirituality, and weight often times was imitated in the life of these participants. In

most cases what the women believed and their daily practices were passed down through their families. The women saw themselves repeating the same patterns and making the same life decisions as their mothers, sisters, aunts, or grandmothers. The pressures and stresses experienced by these women was the direct result of the collateral damage for the opportunity of being an African American woman in today's society.

> "My mother was that way and that made me that way I think, too."
>
> "I think we -- some of us are taught to be so strong because let's be honest, most -- most African-American women, single parents, and so then it's like that generation. For me it was that generation. My mom was a single parent and she taught me to be strong and to be -- be stubborn pretty much. Don't -- don't depend on no man. And, uh, so you're taught in life to -- to be strong, be motivated. Nobody has to go and do it but you, and I don't know -- I guess that's like a generational thing. That's how I feel."
>
> "It just -- it feels like that you take -- that you, as a black woman, have to take the world and then also the plight and responsibilities of black America and put it on your back and you have to soar because it is -- you are owed that -- because somebody in your family has gone through transatlantic slave trade. Survived that. Went through slavery. Survived that. Went through Jim Crow--ism. Survived that. Went through Civil Rights Movement. Survived that. Got to the crack cocaine era. Survived that, and now you are here. So you have an obligation to be strong and mighty, uh, and you have to be the best cook. If you get married you have to be the best wife. You have to raise you kids to speak five languages. You have to know how to work/life balance. You have to -- you just -- you have to encompass all that because we did it so you can do it."

Cultural and Environmental Influences. The cultural impacts were centered on what defines beauty for the African American woman. Health and beauty are not words used simultaneously. Beauty defined in the African American culture is centered on appearance: clothing and hair styles. Cultural influences come from a variety of television shows, commercials, African American stars, and even reality television. The importance of hair for African American women must be discussed to provide an alternative understanding for the lack of motivation to pursue health with beauty holding higher regard than health. The cultural expectations were set and the women have to conform to their cultures definition of beauty or challenge the norms. Pursuing a health stance was a challenge against the norms for a few of my participants because there was little to no support from the collective African American community. Self-efficacy, one's ability to complete the task at hand independently, was paramount for the women who made the conscious decision to pursue health over the cultures definition of beauty.

> "I got less money than they have, but they see me going on trips. They'll see me with a new hair style. They'll see me with a new outfit. They see me and my sister with different vehicles before and they think that I have certain things. But it's called I know how to save my money, I know how to manage my money."
>
> "I spend a lot of time at the hair dresser so the thought of sweating out my hair is stressful to me."
>
> "It's a process to get the look I want to get and exercise requires so much more of me, more of what I already don't have, time."
>
> "taking care of my temple because of what God has done for me. Making sure that I'm doing all that I can because I know He has a job for me to do and I can't do what he

asked me to do if I'm bound in all kind of sickness and stuff that I brought on to my own self, you know what I mean?"

The Weight I Carry

The weight I carry is represented as the consequences of who I am. The consequences include the struggles, the problems, and the disappointments experienced by these women. All of which are consequences of the decisions made by the women. The decisions made by the women not only impact them but also their families. Difficult decisions are made when considering one's health and well-being against one's family's needs. For the participants, self-care was nearly non-existent because the family's needs usually superseded their individual needs, and self-care became a luxury instead of a necessity. The impact of critical social theory is relevant in this theme in that its intent is to bring awareness to contradictions that exist in the participants social practices (Polit & Beck, 2004, p. 263). The weight carried I carry was broken down into two subthemes, the burden on my life and burden on my family. Even though many of the actions by the women were passed down, the women now carried the burden of how their choices now impacted their families. The families that the participants would give, offer, or dedicate themselves for is also instrumental in some of the poor health behaviors and choices experienced by the participants.

Burden on my Life. Burden on my life reveals a decreased quality of life. The women report that the decisions and choices made create many of the situations and health concerns that they now struggle with. Various chronic health diseases were listed by the participants such as: heart disease, hypertension, high cholesterol, diabetes, aneurysm, arthritis and joint pains, and kidney failure. The consequences of the participant's lived experiences not only impact them, but it also impacts their families.

"I feel like that's probably my purpose here is because I've noticed I'm always taking care of somebody else"

"Everybody needs a supportive environment. Everybody needs -- I guess why that is -- I give everybody what they need because I know I'm not getting it. So somebody needs to get it."

"I'm just good at what I do in the sense of taking care of others so I just stick with that."

"I don't think about myself, it's not about me"

"I want to be in the bed all times, but also, too, I know being in the bed stiffens me up even more to where it's harder to move and function."

Burden on my Family. This impacts their ability to be fully engaged and involved in events and activities with their families. The women also provide a glimpse into the lives of their parents and grandparents, and it appears that the same struggles these women deal with their parents have also. It appears the women express the ability to witness and experience a vicious cycle of repeated events, same script different cast within the lives of the family unit.

"I've never taken care of myself. And even to this day -- yeah, even to this day, with everything that I've got going on, it doesn't matter how much I'm hurting or how much pain I'm in or how sick I am, if somebody was to call me and say right now in need you, I'm up and I'm gone."

"I can't go many places and my family doesn't understand"

"my family wants to go on trips and they don't understand why I can't go it's just that my body hurts to much"

"I just want to be here for my family but if I don't change then I won't be able to help"

Power Struggles: Double-mindedness

Power struggle is defined as the disagreement between situations and concepts be it in thought, word, or behavior stemming from the same individual. In this study the overarching power struggle identified was double-mindedness. This theme of double-mindedness was evaluated from two points of view: a secular view point and a religious view point. Smethurst (2007) examines articles and books written by prolific African American story tellers that expound on the idea of double-mindedness or dualism as it pertains to African Americans. Dualism is defined by the Oxford dictionary (2020) as, "the division of something conceptually into two opposed or contrasted aspects, or the state of being divided." What makes this so intriguing within the realms of this study is that the division is occurring internally. Within one individual resides two identities that are needed in order to successfully be accepted in the mainstream American culture.

The notion of double consciousness was termed by W.E.B. Du Bois, due to the cultural conflict that exists due to the differing ideals "associated with being Negro and a different set of ideals associated with being American" (Allen, 2003, p. 32). Because of implicit biases, stereotypes, and unmerited perceptions, African Americans have to maintain two identity's so that they are not alienate from their cultural heritage or the main stream culture. Depending on where they are and who they are interacting with they must be able to transition between these two cultures. The struggle between these identities were identified within the themes as a power struggle experienced by the participants. Critical social theory is interwoven throughout this final theme. Carnegie and Kiger (2009) state that "critical social theory seeks to understand a situation and to alter conditions, thus leading to emancipation, equality and freedom for

individuals" (p. 1977). Identifying and discussing this power struggle is instrumental in addressing not only obesity but various societal factors that may play a role in promoting it. Adding the pressure of choosing one's identity only complicates the disparities experienced by African American women. The two identities will be discussed more in depth with external behaviors and healthcare experiences.

The second definition of double-mindedness will be evaluated from a religious view point. Double mindedness defined by the King James Bible:

James 1:3 - 8

"**3** knowing that the testing of your faith produces patience. **4** But let patience have *its* perfect work, that you may be perfect and complete, lacking nothing. **5** If any of you lacks wisdom, let him ask of God, who gives to all liberally and without reproach, and it will be given to him. **6** But let him ask in faith, with no doubting, for he who doubts is like a wave of the sea driven and tossed by the wind. **7** For let not that man suppose that he will receive anything from the Lord; **8** *he is* a double-minded man, unstable in all his ways."

In this study there were numerous themes identified that demonstrate double-mindedness. There was a contrast with how the themes started with statements of confidence in what God can and will do, the participants abilities, and also what healthcare providers are capable of doing for the women. Within the same interview the participants casted an air of doubt as they are actively experiencing conflicts with certain beliefs, their abilities, and healthcare issues.

Intrinsic Factors. The participants started off strong discussing their spirituality and religiosity regarding their faith behaviors and God's ability to intervene for them. Their

experiences, life choices, and consequences impact the struggles that the participants are going through.

> "He's gonna show you how you need to take care of yourself so that's how we get to this place. We don't want to realize that our temple is supposed to be pure and sanctified and we supposed to put in it the riches, the purest of things."

> "Younger in life, I probably was worrying and it caused some problems to my body. I realized I had to give it over. And when I gave it over, He brings things to my concern, my awareness but I can't worry. I gave it to Him, saying, Lord I hand this to you! So what I need you to help me do is go on to the next thing and show me how to deal with it. I'm not gonna worry about it. Because it's out of my control."

> "I have congestive heart failure, I have cholesterol problems. Uh, it hasn't moved and it hasn't gone because God's not going to allow that to happen. This is happening to me because it's supposed to."

> "I'm not saying God don't grant miracles because I know He can, but I also think He gives us the knowledge, too, as well to do what we need to do for ourselves."

Extrinsic Factors. Health promotion behaviors (exercise, nutrition) are often performed because of the expected rewards or outcomes of the action. The makeup of the dietary habits of African Americans should be viewed through a historical lens regarding the impact of slavery in America on food options that were passed through generations, traditions that makeup dinner time in this community, and culturally identifiable foods (Bramble et al., 2009; Di Noia et al., 2013; Eugeni et al., 2011; Hawkes et al., 2015). This power struggle is instrumental in addressing the weight concerns and issues in African American women.

"Soul food is my comfort food, it's not good for you but it taste good to you"

"I cook how my momma cooked and that's just how my granny cooked too"

"soul food, it is just in my DNA."

"I know what I'm supposed to eat but what I grew up on just tastes better"

"I have to prep to eat right but most of the time I don't and then I'm forced to buy fast food because I just don't have the time"

"Healthy food don't taste good"

A crossroads exists as it pertains to health behaviors and cultural beauty standards for African American women. A significant barrier identified was the impact of health behaviors on hair care for African American women. African American women with a lower economic status believed health promotion behaviors were too costly significantly when it impacted their cultural identity. The cultural beauty standards tend to win out over the proven benefits of health promotion behaviors.

"It's hard to exercise because I have to go to work and my hair is a process"

"I don't have wash and go hair"

The health promotion studies with African American participants tended to produce a low success rate. Participants acknowledged that they had difficulty controlling or maintaining health behaviors due to a lack of support. The lack of support was complicated by family members and friends who chose not to participate in health promotion behaviors because a heavier weight is considered culturally acceptable (Gentles- Peart, 2020; Mastin et al., 2012; Pekmezi et al., 2013).

"I just can't go to the gym with so many other people there"

"I would exercise if I had someone to exercise with me"

"I was losing weight when I was exercising with my friends but when they stopped I stopped and the weight came back"

Health Care Experiences. Health care initiatives and weight loss programs have not proven to be as beneficial as expected due to various cultural beliefs, views, and biases of the health care system (Davis, Clark, et al., 2005; Notaro, 2012). African American women describe sensing and experiencing discrimination or disrespect could potentially explain why these obese women have lost confidence in healthcare professionals and are not as likely to pursue health care services (Belgrave & Abrams, 2016; Davis et al., 2014; Jerald et al., 2017). McEwen and Wills (2011) define critical social theory as bringing "societal awareness to expose social inequalities that keep people from reaching their full potential" (p. 264). This theory brings awareness to various health disparities that prevent individuals from gaining adequate health care, treatment, or education due to either societal or political impediments. The problem that minority groups experience in regards to inequality in healthcare is further complicated when there is no representation available from healthcare providers that resemble the group that is currently experiencing the inequality. Past traumas must be acknowledged, and cultural perceptions and differences must be addressed to restore African Americans' trust in healthcare professionals.

"The care that I receive got better once I got insurance"

"My parents won't go to the doctor because of things that happened a long time ago. The trust just don't exist. They just prefer to wait on God to do whatever He's going to do."

"It's rare to have a doctor that's really concerned about my well-being"

"I don't like going because they judge me before they even talk to me."

"When I go because I have a problem, I know when something is off with my body. The doctors just don't listen. They just prescribe a lot of medicine to get rid of me but it doesn't fix why I went to see them in the first place."

"Since I moved to Nashville my care is better than it was back home."

"My care is better because I have a doctor that has experience with diverse backgrounds"

Summary

This chapter described the demographic characteristics of the female participants and the three main themes and sub-themes identified with data analysis. Direct quotes were provided from the participants in order to enrich and illustrate the meaning of the themes and sub-themes. Detailed interpretations of the themes and sub-themes were analyzed, while attempting to stay true to the participant's lived experiences. The participants defined themselves which included their spiritual make-up, the influence their family had on their lives, and the role of culture in their behavioral choices. The participants also identified their burdens which not only impacts their lives but also the lives of their family members. Lastly, there is a duality that exist that is intrinsic and extrinsic in nature, and also demonstrates concerns that the participants have with health care. In chapter five the three themes and the sub-themes, conclusions, implications, and recommendations for future research will be discussed in depth.

Chapter 5. Discussion, Implications, Conclusions and Recommendations

The purpose of this qualitative, phenomenological study was to explore and describe the lived experiences of obese African American women with attention and focus on weight, health behaviors, and spirituality. Qualitative research is a research method that can produce textual data and analysis by exploring participants' understanding of their lived experiences and how they impact the investigation (Holloway, 2005, p. 3). Phenomenology was integrated to study the lived experiences to describe and elucidate those meanings as they develop (Frey, 2018; Given, 2008). Phenomenology was selected as the method of choice because it allows the researcher to witness health behaviors and spirituality through the lived experiences of obese African American women. The research study participants provided in-depth details and stories regarding their lived experiences. The following is presented in this chapter: (a) discussion of the themes, (b) implications, (c) recommendations for the future research, (d) and the conclusion.

Discussion

The first theme that was identified from the data analysis was, Who I Am. Who I am, encompassed the most frequently described attributes of how these women saw themselves based on their spiritual experiences, family expectations, and the role that culture played in their lives. There were a lot of similarities among the women in this study and other research studies of how African American women approached their relationship with God. In an article by Woods-Giscombe et al. (2016), African American women listed God as their source of strength in dealing with all of their problems, and that was the only way in which they could be healed or comforted from whatever trials they were facing in life (p. 1139). The participant's spiritual identity is the core of who they identified themselves as and all participants regardless of their

age or experiences identified their relationship with God as being the greatest motivator for their behaviors.

When looking at the role that the family plays in the lives of these women this is also instrumental in defining who these women are and the impact their family relationships have on their weight and behaviors. Similar accounts were found in the literature where African American women discussed having a lack of social support to assist and encourage them with healthy behaviors. It is believed that the high levels of stress and poor coping mechanisms that have been passed from generation to generation could be the link to explaining many of the health disparities African American women are experiencing (Turner-McGrievy et al., 2020; Woods-Giscombé, 2010). Due to the power struggles identified by these participants and numerous others, it is believed that without this innate coping mechanism, African American women may not have been able to endure many of the historical adversities experienced (Woods-Giscombé, 2010, p. 669). In the literature, there was evidence of the same behavior exhibited with this study's participants such as excessive attunement to the needs of others, and denial of one's own needs (Gothe & Kendall, 2016; Woods-Giscombé, 2010). The women's priorities always shifted to the needs of others and the countless family responsibilities hampered the participant's ability to provide much needed self-care.

The generational family impact has a monumental effect on how these women see themselves and the roles they are expected to play. The phrase, Superwoman role, was defined by Woods-Giscombé (2010) when describing the attributes of African American women as displaying characteristics such as "obligation to manifest strength, emotional suppression, resistance to vulnerability and dependence, determination to succeed, and obligation to help others" (p. 678- 679). This potentiates the pressures and stresses experienced by these women as

the direct result of being an African American woman in today's society all while meeting and maintaining their family's and society's expectations. The historical contributions of segregation and the struggle for civil rights have all played a role in promoting this 'Superwoman' phenomenon in African American women. One of the demographic requirements to participate in this study was to be of African American heritage with a family lineage to post-slavery and civil rights ancestry. In an attempt to understand behaviors and actions, historical context is important because it can assist in identifying potential generational impacts and behaviors that often time go unnoticed or unappreciated.

The impacts on culture were centered on what defines beauty for the African American woman. Beauty defined in the African American culture is centered on external appearances: clothing and hair styles. A research article by Huebschmann et al. (2015) identified the strong cultural desire by African American women to maintain 'presentable hair' while in public locations because their natural hair wasn't considered acceptable (p. 438). There is a lot of emphasis placed on whether or not the African American woman's hair is aesthetically pleasing, thereby creating a level of shame and vulnerability when their hair is considered unkempt and undone (Rowe, 2019, p. 22). This pursuit of vanity is a major hindrance with encouraging physical activity in African American women. The time commitment and cost associated with the upkeep of hair is a major hurdle for African American women, therefore identifying realistic goals and expectations is instrumental in creating change for this population.

Often overlooked is how African Americans view or define beauty as it pertains to weight. In a study by Nelson et al. (2016) the researchers discovered that "the perception of the "curvy" woman was attractive" (p. 564). The overweight body image that is the focus of major health initiatives and interventions is the very image being pursued or maintained by the African

American community. This demonstrates a disconnect that exist between the desires of the healthcare community and the at risk African American community. Before any major changes can be made regarding weight concerns, both vested partners must identify it as an issue that needs addressing. Changes that need to be made in the African American community requires an active engagement of the community as a whole and not just on an individual level (Gothe & Kendall, 2016, p. 6). Addressing the weight disparities must start with acknowledging that weight is an issue by the entire African American community because it will require a complete paradigm shift.

The next theme identified was "The Weight I Carry" which displays the consequences of choices and decisions made by the study participants that demonstrate the struggles, problems, and disappointments experienced by these women. The two subthemes pulled from the data evaluated the burden placed on the participant's lives and also on their family's lives because of their weight. When looking at the burden placed on African American women due to weight the greatest burden expressed is the inability to participate in family activities and outings. In a study by Nelson et al. (2016) the women only expressed interest in participating in exercise when they recognized the positive impact it could have on their "ability to move around and be physically active (p. 564)." The participants in the Nelson et.al. (2016) study recognized physical activity as a means to an end in order to enjoy life with their families but not with it pertaining to improving their health (p. 564). Any decision made by the women was made in consideration of someone other than themselves. Their concerns with their family's well-being always superseded the basic need to care for themselves. The health of the women was a stressor for their families but the women tended to view their actions for others as acts of sacrifice or love more so than the neglect of themselves.

Power struggle is defined as the disagreement between situations and concepts be it in thought, word, or behavior stemming from the same individual. Power struggle was the last theme identified in the data analysis and there were three sub-themes identified: intrinsic, extrinsic, and health care experiences. Power struggle examined the conflict experienced by these participants that has been termed double-mindedness. The double-mindedness became evident during the conversations and was even more profound while analyzing the data.

Intrinsic: In this study there were numerous themes identified that demonstrate double-mindedness, but this is focused on the double-mindedness that occurred internally within the participants. A fairly new term that is starting to appear in the literature is, black female interiority. This is a powerful concept when defined "articulates the existence of that which Black women have covered or suppressed, in the interest of self-preservation and self-protection" (Rowe, 2019, p. 23). This concept is an internalization of the African American woman's very nature, values, and expectations all in the hopes of self-preservation. Regarding the struggles experienced by these women, many often retreat and question the situations they are experiencing and being uncertain as to whether God will or will not intervene. Even after identifying themselves as being spiritual/religious with God being the source of their hopes and strength there is a wavering of faith in the face of tough trials and circumstances. This double-mindedness appears contradictory considering how the participants described their spiritual relationship and works associated with their belief in God. Instead the bigger issue to be addressed is why African Americans feel the need to maintain two identities in an effort to feel accepted not only within their own culture but the mainstream American culture?

Extrinsic: Health promotion behaviors (exercise, nutrition) are often performed because of the expected rewards or outcomes of the action. These behaviors are considered extrinsic in

nature due to the expected external results but what motivates African American women differs from what motivates the mainstream American culture. The first extrinsic factor to be discussed is nutrition. When it comes to nutrition the food that one consumes is just as important as participating in physical activity. In order to understand African Americans relationship with food, it is important to discuss the historical implications of slavery pertaining to food practices in African American Women (Sumlin & Brown, 2017, pg. 573). The makeup of the dietary habits of African Americans should be viewed through a historical lens regarding the impact of slavery in America on food options that were passed through generations, traditions that makeup dinner time in this community, and culturally identifiable foods (Bramble et al., 2009; Di Noia et al., 2013; Eugeni et al., 2011; Hawkes et al., 2015). Food is displayed as a sense of pride and an act of love for one's friends and family and an attempt to change that is viewed as dishonorable to the struggles experienced by African Americans and the cultural identity derived from their ancestors (Nelson et al., 2016; Sumlin & Brown, 2017).

There is a health movement on the horizon as it pertains to nutritional choices for African Americans in an attempt to shift historical food practices. Education has been provided regarding healthy food options but preference continuously triumphs even when there are health concerns that strictly prohibit foods that have a tendency to worsen chronic health diseases such as diabetes and cardiovascular issues (Sumlin & Brown, 2017. p. 569). In a study by Turner-McGrievy et al. (2020) a shift is coming with an increase in plant based diets but limitations exist due to adequately preparing and the lack of access to fruit and vegetable options for certain African American communities (p. 55). Studies are beginning to demonstrate that when healthier nutritional options are prepared with attention to maintaining taste, people were more apt to increase their healthy meal selections and consume those meals at home instead of giving

in to the last minute fast food options (Sumlin & Brown, 2017, p. 570). Eating healthier is going to continually be a struggle for the African American community unless there is a communal agreement to change how food is viewed and adopt and integrate those behaviors not only in the homes but also in the African American churches.

The second extrinsic fact to be evaluated is exercise and how it is perceived and used in the African American community. One of the greatest barriers identified as it pertains to exercise is the impact that it has on the African American woman's hair. Often times exercise is avoided due to perspiration, which damages hair styles and increases the cost associated with more frequent hair salon visits for this population (Huebschmann et al., 2015). Hair as discussed earlier is considered to be one's identity and there is a vulnerability around what is considered 'acceptable' hair in the African American community. This identity around hair is a major hurdle as it pertains to pursing health promoting behaviors like exercising. The research participants in an article by Gothe and Kendall (2016) collectively stated that "these barriers were just self-imposed or a mindset" and if there was a true desire to make changes then change was possible (p. 5).

Outside of issues identified with hair concerns, a different motivation is needed to encourage African American women to exercise. Healthcare providers tend to encourage physical activity in an effort to maintain good physical and mental health, and also as a means to prevent or treat chronic health disease that are disproportionate in this population (Gothe & Kendall, 2016; Huebschmann et al., 2015). The pursuit of health is not a motivator for African American women but being able to actively engage in various activities with friends and family members is the greatest motivator (Nelson et al., 2016, 564). By identifying the motivating factor significant strides can be made in shifting weight outcomes for African American women.

Health Care Experiences. In the southern region, older African Americans relate their past experiences with healthcare during the 1950s and 1960s to current healthcare providers. This is pertinent for current research because past traumas must be acknowledged, and cultural perceptions and differences must be addressed to restore African Americans' trust in healthcare professionals. Not only for the older African Americans, but also the younger generation because their stories, their fears, and concerns are passed on to their children and grandchildren. The 'Superwoman' phenomenon discussed earlier is used as a shield to cover the tensions, stresses, and distress experienced by African American women. All of which are signs and symptoms of mental suffering, which tends to be downplayed or overlooked in the African American community. An article by Woods-Giscombe et al. (2016) discussed the underutilization of mental health services by African American women because of the past history of mistrust in healthcare providers (p. 1126). To add insult to injury many of the African American women who identified as needing to seek mental services chose not to because they felt that the providers "did not understand the complexities or social contexts of their lives or seemed lacking in compassion, patience, or cultural sensitivity and competence" (Woods-Giscombe et al., 2016, p. 1138). These issues must be addressed and brought to light because the intent is to encourage better overall health behaviors, therefore the focus should be a holistic one and not just a physical one.

Implications for Practice

The presence of consistent guidance and sustainable approaches to impact obese African American women with real-world feasible and practical interventions are currently non-existent (Seale et al., 2013, p. 153). This study is significant because it identified relevant, motivating factors and barriers for African American women to change the obesity epidemic trajectory. One

of the first implications for practice would be to diversify healthcare providers (Woods-Giscombe et al., 2016, p. 1140). Recognizing the difficulty with this, it would be beneficial to at least ensure that all providers receive culturally sensitive training in an effort to ensure their patients receive adequate care not just physically but also mentally and emotionally (Woods-Giscombe et al., 2016, p. 1140). The second implication for practice is to improve direct community interactions. Research studies, interventions, and education should all occur at the community level with buy-in from community leaders (Nelson et al., 2016, p. 560- 561). African Americans tend to participate in activities as a community, therefore, interventions that target the group as a whole tend to be more successful.

The final implication for practice is to encourage focus groups to identify any knowledge gaps that may exist with this population. In a research study by Nelson et al. (2016), the investigators learned that the participants did not understand the relevance of obesity, BMI, or the need to exercise as an act to promote health and wellness (p. 564). Having these open and honest dialogues will remove any confusion that may further promote health disparities in this population. It also provides clarity with identifying the desires of this population. The motivation to exercise for this population has nothing to do with weight loss or disease prevention. Their motivation is built around the ability to meet their daily needs by maintaining their mobility and by having the energy and strength to be present with and for their families. (Turner-McGrievy et al., 2020, p. 57). Often times assumptions are made that people all have the same aspirations and goals, but we must first provide people with the opportunity to decide what's best for them and also provide education in the process.

Implications for Policy

Government nutritional assistance programs are available to help lower-income families receive financial vouchers, learn about eating healthier, and increase their activity (Women Infant and Children, WIC). These programs tend to encourage more nutritious foods and improve physical activity (The State of Obesity, 2014; Zimmer et al., 2019). There is a need for public policies that address how pricing decisions are made, maintaining prices at a fair rate and public education make healthier food options culturally acceptable (Chopra et al., 2002, p. 953). To effectively address price manipulation, policies should be passed nationwide to provide incentives to cut prices of healthier food options. An additional recommendation for potential policy change would be to integrate cooking courses on how to prepare and season healthier meal options in an effort to keep African Americans committed to the healthier diet options.

Another recommendation for policy would be to extend government provided health insurance to also cover behavioral activities. This will provide the participants with the opportunity to participate in health promoting activities without the added barrier of not being able to afford the gym memberships. The final policy recommendation is to provide rural areas with wider roads and sidewalks. Safety is not only important in urban areas but also rural communities. Outside walking is not optimal because the environment is not conducive to safe walking environments. If health care professionals are going to encourage increased levels of activity then there needs to be an intentional push to provide those in need an opportunity to meet those expectations.

Limitations

A few limitations were noted with this study. First, the study only pursued obese African American women so there is no way to determine if normal weight or overweight women had similar or contrasting concerns. Second, the study was conducted in the southern middle region of Tennessee which excludes other populations of women from various other locations not in the southern region of the United States. Third, a world-wide pandemic impacted the original study plan and outline. The study was adjusted and permission was granted from ETSU's IRB department in order to continue with the research project.

Recommendations for Future Research

Future practice recommendations were identified from the various research articles' limitations and anticipated continuation plans for their prospective research studies. The development of community-based research was recommended to allow the community leaders and members to identify their needs and create a plan that would best fit their needs (Di Noia et al., 2013; Kim et al., 2008). The expectation would be for the community leaders and members to take control and maintain the interventions to ensure sustainability for their communities. Bowen et al. (2015) recommended developing culturally, age-appropriate, and cost-effective interventions that promote physical activity, not just merely exercise, to maintain independence.

There is not a one size fits all approach to preventative health. The approach should be dependent upon the population and the expected goals and outcomes of the participants. Public health initiatives that focus on the community and the individual are needed to create a multifaceted approach to combating obesity in this population (Budzynska et al., 2013; Chopra et al., 2002; Merzel & D'Afflitti, 2003). The emphasis on preventative health should not be solely

focused on weight maintenance but on preventing continuous relapse and weight cycling (Davis et al., 2005; Rogers et al., 2016). Information provided should cross all language barriers or deficiencies that exist to ensure that the intended message is relayed, and healthier options become the societal norm and not an unreachable or unaffordable option.

Corporations understand the impact that television plays on this population. There needs to be an investment in public service announcements that shed light on African American women's epidemic. Television publications and ads are instrumental in driving lifestyle and nutritional choices in this population, but culturally relevant educational television commercials could prove beneficial (Risica et al., 2013). Educational television intervention has been successful in changing participants eating habits and physical activity levels. The recommendation was for educational programs to be provided not only on the television during scheduled airing times but also streaming online to provide repeat viewing opportunities (Risica et al., 2013).

The impact of hair maintenance and its power to prevent preventative health activities should be investigated further. The development of partnerships with hair salons could prove beneficial, especially since African American women invest a lot of time and money towards their outward appearance. Beauticians can be used as the lay community members that are educated and trained on having the hard health conversations with their clients and also provide health education that could potentially be life altering for African American women. Lastly, there should be a consideration for taking preventative health activities back to faith-based organizations due to past success of screening for disorders such as hypertension and breast cancer and by providing educational programs against smoking and the reduction of cardiovascular risks (Dodani & Fields, 2015; Giger et al., 2008). Especially in southern states

where trust issues tend to impact one's likelihood of seeking additional health or adhering to the medical regimen.

Conclusion

In summary, it has been universally recognized that obesity is a health issue of epic proportions for all races, nationalities, and genders across the United States. The increased focus and intense incentives directed towards obesity steers from the increased morbidity, mortality, and increasing health care costs associated with this utterly preventable health issue. This study identified major factors that need to be considered when providing care or educating African American women. One factor identified was the need to clarify medical terminology, because what healthcare providers mean by certain terms does not always convey the same meaning for African American women. The second factor identified was the need to determine what the goals for weight are for African American women. A heavier, curvy appearance is the preferred look therefore finding a middle ground where both health and a voluptuous appearance can co-exist. The third factor identified is the need to develop initiatives that are community focused instead of individually. The final factor discovered was the need to increase community participatory research. In the African American community there must be buy-in from key stake holders if one hopes to get access to this population with the intent to bring for information, education, and hopefully change. The information obtained in this study will facilitate conversations amongst health care professionals and develop new ideas from the lived experience of obese African American women.

References

Acosta, A., & Camilleri, M. (2014). Gastrointestinal morbidity in obesity. *Annals of the New York Academy of Sciences*, *1311*(1), 42–56. http://doi.org/10.1111/nyas.12385

Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research, 9*, 407- 411.

Ajzen, I. (2017). Theory of Planned Behavior: TPB Model with Background Factors. Retrieved from: http://people.umass.edu/aizen/tpb.html

Allen, E. (2003). Du Boisian Double Consciousness: The Unsustainable Argument. *The Black Scholar: Black Identity, Black Perspectives*, *33*(2), 25–43. https://doi.org/10.1080/00064246.2003.11413214

Allen, M. (2017). *The sage encyclopedia of communication research methods* (Vols. 1-4). Thousand Oaks, CA: SAGE Publications, Inc doi: 10.4135/9781483381411

Ard, J. D., Zunker, C., Qu, H., Cox, T., Wingo, B., Jefferson, W., Shewchuk, R. (2013). American and Caucasian Women. *American Journal of Health Behavior*, *37*(1), 3–13. http://dx.doi.org/10.5993/AJHB.37.1.1

Assari, S. (2018). Family Income Reduces Risk of Obesity for White but Not Black Children. Children, 5, 73. https://doi.org/10.3390/children5060073

Baker, B., Barnidge, E.K., Schootman, M., Sawicki, M. & Motton-Kershaw, F.L. (2016). Adaptation of a Modified DASH Diet to a Rural African American Community Setting. *American Journal of Preventive Medicine*, *51*(6), 967–974.

https://doi.org/10.1016/j.amepre.2016.07.014

Bandura, A. (2004). Health promotion by social cognitive means. *Health Education & Behavior*, *31*(2), 143-164.

Bauer, A., Berkley-Patton, J., Bennett, K., Catley, D., Bowe-Thompson, C., Lister, S., & Christensen, K. (2019). Dietary Intake Among Church-Affiliated African Americans: The Role of Intentions and Beliefs. *Journal of Black Psychology*, *46*(1), 009579841988762–54. https://doi.org/10.1177/0095798419887629

Belgrave, F. Z., & Abrams, J. A. (2016). Reducing disparities and achieving equity in African American women's health. *American Psychologist, 71*(8), 723–733. https://doi.org/10.1037/amp0000081

Berlin, I. (2010). The Making of African America: The Four Great Migrations. Viking, New York. https://www.smithsonianmag.com/history/the-changing-definition-of-african-american-4905887/

Bhattacharya, J., & Sood, N. (2011). Who Pays for Obesity? *Journal of Economic Perspectives*, *25*(1), 139–158. http://doi.org/10.1257/jep.25.1.139

Biener, A., Cawley, J., & Meyerhoefer, C. (2018). The Impact of Obesity on Medical Care Costs and Labor Market Outcomes in the US. *Clinical Chemistry*, *64*(1), 108–117. https://doi.org/10.1373/clinchem.2017.272450

Bowen, P. G., Eaves, Y. D., Vance, D. E., & Moneyham, L. D. (2015). A Phenomenological

Study of Obesity and Physical Activity in Southern African American Older Women. *Journal of Aging & Physical Activity*, *23*(2), 221-229.

Braithwaite, R.L. and Taylor, S.E. 2001. *Health issues in the Black community*, San Francisco, CA: Jossey-Bass.

Bramble, J., Cornelius, L. J., & Simpson, G. (2009). Eating as a cultural expression of caring among Afro-Caribbean and African American women: understanding the cultural dimensions of obesity. *Journal of Health Care for the Poor and Underserved*, *20*(2 Suppl), 53–68. doi:10.1353/hpu.0.0158

Browne, A. (2000). The potential contributions of critical social theory to nursing science. *Canadian Journal of Nursing Research*, *32*(2), 35–55.

Budzynska, K., West, P., Savoy-Moore, R. T., Lindsey, D., Winter, M., & Newby, P. K. (2013). A food desert in Detroit: associations with food shopping and eating behaviours, dietary intakes and obesity. Public Health Nutrition, 16(12), 2114–23. http://doi.org/10.1017/S1368980013000967

Burns, N., & Grove, S. K. (2009). The Practice of Nursing Research: Appraisal, Synthesis, and Generation of Evidence: Saunders/Elsevier.

Caldwell, J., Ford, C., Wallace, S., Wang, M., & Takahashi, L. (2017). Racial and ethnic residential segregation and access to health care in rural areas. Health & Place, 43, 104–

112. https://doi.org/10.1016/j.healthplace.2016.11.015

Cantrell, M. A. (2011). Demystifying the research process: Understanding a descriptive comparative research design. Pediatric Nursing, 37(4), 188–189.

Capers, C. F., Baughman, K., & Logue, E. (2011). Behaviors and characteristics of African American and European American females that impact weight management. Journal of Nursing Scholarship : An Official Publication of Sigma Theta Tau International Honor Society of Nursing / Sigma Theta Tau, 43, 133–144. http://doi.org/10.1111/j.1547-5069.2011.01393.x

Carnegie, E. & Kiger, A. (2009). Being and doing politics: an outdated model or 21st century reality? *Journal of Advanced Nursing*, *65(9)*, 1976-1984.

Carter J. H. (2002). Religion/spirituality in African-American culture: an essential aspect of psychiatric care. *Journal of the National Medical Association*, *94*(5), 371–375.

Cash, S. W., Beresford, S. A. A., Henderson, J. A., McTiernan, A., Xiao, L., Wang, C. Y., & Patrick, D. L. (2012). Dietary and physical activity behaviours related to obesity-specific quality of life and work productivity: baseline results from a worksite trial. The British Journal of Nutrition, 108(6), 1134–42. http://doi.org/10.1017/S0007114511006258

Catalyst. (2018). *Quick Take: Women of Color in the United States* https://www.catalyst.org/research/women-of-color-in-the-united-states/

Centers for Disease Control and Prevention. (2015). Adult Obesity Facts. Retrieved from

https://www.cdc.gov/obesity/data/adult.html

Centers for Disease Control and Prevention. (2015). Overweight & Obesity: Data & Statistics. Retrieved from https://www.cdc.gov/obesity/data/index.html

Chatters, T., Taylor, R.J., Bullard, K.M. & Jackson, J.S. (2009). Race and ethnic differences in religious involvement: African Americans, Caribbean blacks and non-Hispanic whites. *Ethnic and Racial Studies*, *32*(7), 1143–1163. https://doi.org/10.1080/01419870802334531

Chopra, M., Galbraith, S., & Darnton-Hill, I. (2002). A global response to a global problem: the epidemic of overnutrition. Bull World Health Organ, 80(12), 952–958. Retrieved from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=12571723

Clark, E., Williams, B., Huang, J., Roth, D., & Holt, C. (2018). A Longitudinal Study of Religiosity, Spiritual Health Locus of Control, and Health Behaviors in a National Sample of African Americans. Journal of Religion and Health, 57(6), 2258–2278. https://doi.org/10.1007/s10943-017-0548-0

Coe, K., Keller, C. & Walker, J.R. Religion, Kinship and Health Behaviors of African American Women. *J Relig Health* **54,** 46–60 (2015). https://doi.org/10.1007/s10943-013-9784-0

Cogbill, S. A., Sanders Thompson, V. L., & Deshpande, A. D. (2011). Selected sociocultural correlates of physical activity among African-American adults. *Ethnicity &*

Health, *16*(6), 625–641. https://doi.org/10.1080/13557858.2011.603040

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), *Existential phenomenological alternative for psychology* (pp. 48-71). New York: Oxford University Press.

Cooke, J. (1993). *Encyclopedia of the North American Colonies*. C. Scribner's Sons.

Cooper, K. C., King, M. A., & Sarpong, D. F. (2015). Tipping the Scales on Obesity. Journal of Christian Nursing, 32(1), 41–45. http://doi.org/10.1097/CNJ.0000000000000132

Creswell, J. W. (2007). Five Qualitative Approaches to Inquiry. In J. W. Creswell (Eds.), *Qualitative Inquiry and Research Design: Choosing among five Approaches* (pp. 53-84). Thousands Oaks: Sage Publications.

Cumming-Potvin, W. (2013). "New basics" and literacies: Deepening reflexivity in qualitative research. *Qualitative Research Journal, 13*(2), 214-230. Retrieved from https://login.iris.etsu.edu:3443/login?url=https://search.proquest.com/docview/1945760609?accountid=10771

Davis, C., Dutton, W. B., Durant, T., Annunziato, R. A., & Marcotte, D. (2014). Achieving cultural congruency in weight loss interventions: Can a spirituality-based program attract and retain an inner-city community sample? Journal of Obesity, 2014. http://doi.org/10.1155/2014/641939

Davis, E. M., Clark, J. M., Carrese, J. A., Gary, T. L., & Cooper, L. A. (2005). Racial and

socioeconomic differences in the weight-loss experiences of obese women. American Journal of Public Health, 95(9), 1539–1543. http://doi.org/10.2105/AJPH.2004.047050

Dietz, W. H., Baur, L. A., Hall, K., Puhl, R. M., Taveras, E. M., Uauy, R., & Kopelman, P. (2015). Management of obesity: improvement of health-care training and systems for prevention and care. The Lancet, 385(9986), 2521–2533. http://doi.org/10.1016/S0140-6736(14)61748-7

Di Noia, J., Furst, G., Park, K., & Byrd-Bredbenner, C. (2013). Designing culturally sensitive dietary interventions for African Americans: Review and recommendations. Nutrition Reviews, 71(4), 224–238. http://doi.org/10.1111/nure.12009

Dodani, S., & Fields, J. Z. (2015). Implementation of the fit body and soul, a church-based life style program for diabetes prevention in high-risk African Americans: a feasibility study. The Diabetes Educator, 36(3), 465–472. http://doi.org/10.1177/0145721710366756

Druckman, D. (2005). *Doing research*. Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412983969

Dulchavsky, S. A., Ruffin, W. J., Johnson, D. A., Cogan, C., & Joseph, C. L. M. (2014). Use of an Interactive, Faith-Based Kiosk by Congregants of Four Predominantly, African American Churches in a Metropolitan Area. Frontiers in Public Health, 2(August), 1–6. http://doi.org/10.3389/fpubh.2014.00106

Eugeni, M. L., Baxter, M., Mama, S. K., & Lee, R. E. (2011). Disconnections of African American Public Housing Residents: Connections to Physical Activity, Dietary Habits and Obesity. American Journal of Community Psychology, 47(3–4), 264–276. http://doi.org/10.1007/s10464-010-9402-1

Felton, G.M., Parsons, M. A., Misener, T. R. & Oldaker, S. (1997). Health-promoting behaviors of black and white college women. *Western Journal of Nursing Research, 19* (5). Retrieved from http://go.galegroup.com.iris.etsu.edu:2048/ps/i.do?&id=GALE|A19938550&v=2.1&u=tel_a_etsul&it=r&p=AONE&sw=w#

Fett, S. (2002). Working cures : healing, health, and power on southern slave plantations. Chapel Hill: University of North Carolina Press.

Frey, B. (2018). *The SAGE encyclopedia of educational research, measurement, and evaluation* (Vols. 1-4). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781506326139

Gadde, K. M., Martin, C. K., Berthoud, H. R., & Heymsfield, S. B. (2018). Obesity: Pathophysiology and Management. *Journal of the American College of Cardiology*, *71*(1), 69–84. http://doi.org/10.1016/j.jacc.2017.11.011

Geanellos, R. (1998). Hermeneutic philosophy. Part II: A nursing research example of the hermeneutic imperative to address forestructures/pre-understandings. Nursing Inquiry,

5(4), 238.

Gentles-Peart, K. (2020). “Fearfully and wonderfully made”: Black Caribbean women and the decolonization of thick Black female bodies. *Feminism & Psychology*, *30*(3), 306–323. https://doi.org/10.1177/0959353520912983

Glanz, K., & Rimer, B. K. (2005). Theory at a Glance: A Guide for Health Promotion Practice. U.S. Department of Health and Human Services, National Institutes of Health, 83, 52.

Giger, J. N., Appel, S. J., Davidhizar, R., & Davis, C. (2008). Church and spirituality in the lives of the African American community. Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society / Transcultural Nursing Society, 19(4), 375–383. http://doi.org/10.1177/1043659608322502

Giorgi, A. (2010). Phenomenological psychology: A brief history and its challenges. *Journal of Phenomenological Psychology*, *41*(2), 145-179. Retrieved from https://login.iris.etsu.edu:3443/login?url=https://search.proquest.com/docview/878587057?accountid=10771

Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. *Journal of Phenomenological Psychology*, *28*(2), 235. Retrieved from https://login.iris.etsu.edu:3443/login?url=https://search.proquest.com/docview/211498419?accountid=10771

Giorgi, A., Giorgi, B. & Morley, J. (2017), "The descriptive phenomenological psychological method", in Willig, C. and Stainton Rogers, W. (Eds), The SAGE Handbook of Qualitative Research in Psychology, Sage, London, pp. 176-192. Retrieved from: http://www.easewellbeing.co.uk/PDF_Downloads/Giorgi-2017-the-descriptive-phenomenological-psychological-method.pdf

Given, L. M. (2008). *The SAGE encyclopedia of qualitative research methods* (Vols. 1-0). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412963909

Gochman, D. (1997). *Handbook of Health Behavior Research*.

Gothe, N. P., & Kendall, B. J. (2016). Barriers, Motivations, and Preferences for Physical Activity Among Female African American Older Adults. *Gerontology and Geriatric Medicine*. https://doi.org/10.1177/2333721416677399

Greenwood, T.C. & Delgado, T. (2013). A Journey Toward Wholeness, a Journey to God: Physical Fitness as Embodied Spirituality. *J Relig Health* **52,** 941–954 https://doi.org/10.1007/s10943-011-9546-9

Greer, D., & Abel, W. (2017). Religious/spiritual coping in older African American women. The Qualitative Report, 22(1), 237-260.

Griffith, D. M., Johnson, J. L., Zhang, R., Neighbors, H. W., & Jackson, J. S. (2011). Ethnicity, nativity, and the health of american blacks. *Journal of Health Care for the Poor and Underserved, 22*(1), 142-156.

Groenewald, T. (2004). A Phenomenological Research Design Illustrated. *International Journal of Qualitative Methods*, 42–55. https://doi.org/10.1177/160940690400300104

Halbert, C. H., Bellamy, S., Briggs, V., Bowman, M., Delmoor, E., Kumanyika, S., Rogers, R., Purnell, J., Weathers, B., & Johnson, J. C. (2014). Collective efficacy and obesity-related health behaviors in a community sample of african americans. *Journal of Community Health*, *39*(1), 124-31. http://dx.doi.org.iris.etsu.edu:2048/10.1007/s10900-013-9748-z

Hawkes, C., Smith, T. G., Jewell, J., Wardle, J., Hammond, R. A., Friel, S., Thow, A. M. & Kain, J. (2015). Smart food policies for obesity prevention. The Lancet, 385(9985), 2410–2421. http://doi.org/10.1016/S0140-6736(14)61745-1

Herzog, H. (2012). Interview location and its social meaning. In Gubrium, J. F., Holstein, J. A., Marvasti, A. B., & McKinney, K. D. *The SAGE handbook of interview research: The complexity of the craft* (pp. 207-218). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781452218403

Holloway, I. (2005). Qualitative research in health care. Oxford, UK: Blackwell Science.

Holt, C., Wang, M., Clark, E., Williams, B., & Schulz, E. (2013). Religious involvement and physical and emotional functioning among African Americans: The mediating role of religious support. *Psychology & Health*, *28*(3), 267–283. https://doi.org/10.1080/08870446.2012.717624

Hsieh, H., & Shannon, S. (2005). Three Approaches to Qualitative Content Analysis. In *Qualitative Health Research* (Vol. 15, pp. 1277–1288).

Huebschmann, A., Campbell, L., Brown, C., & Dunn, A. (2015). "My hair or my health:" Overcoming barriers to physical activity in African American women with a focus on hairstyle-related factors. Women & Health, 56(4), 428–447. https://doi.org/10.1080/03630242.2015.1101743

Hurt, R. T., Kulisek, C., Buchanan, L. A., & McClave, S. A. (2010). The obesity epidemic: Challenges, health initiatives, and implications for gastroenterologists. Gastroenterology and Hepatology, 6(12), 780–792.

Jerald, M., Cole, E., Ward, L., & Avery, L. (2017). Controlling images: How awareness of group stereotypes affects Black women's well-being. Journal of Counseling Psychology, 64(5), 487–499. https://doi.org/10.1037/cou0000233

Johnson, K.S. (2006). "You just do your part. God will do the rest.": spirituality and culture in the medical encounter. *Southern Medical Journal, 99* (10): p. 1163.

Johnson, K. S., Elbert-Avila, K. I., & Tulsky, J. A. (2005). The influence of spiritual beliefs and practices on the treatment preferences of African Americans: A review of the literature. *Journal of the American Geriatrics Society, 53*(4), 711–719. http://doi.org/10.1111/j.1532-5415.2005.53224.x

Jootun, D., McGhee, G., & Marland, G. R. (2009). Reflexivity: Promoting rigour in qualitative research. Nursing Standard (through 2013), 23(23), 42-6. Retrieved from https://login.iris.etsu.edu:3443/login?url=https://search.proquest.com/docview/219890344?accountid=10771

Kemp, E., Bui, M., & Grier, S. (2011). Eating Their Feelings: Examining Emotional Eating in At-Risk Groups in the United States. Journal of Consumer Policy, 34(2), 211–229. http://doi.org/10.1007/s10603-010-9149-y

Kim, K. H., Linnan, L., Campbell, M. K., Brooks, C., Koenig, H. G., & Wiesen, C. (2008). The WORD (wholeness, oneness, righteousness, deliverance): a faith-based weight-loss program utilizing a community-based participatory research approach. *Health Education & Behavior : The Official Publication of the Society for Public Health Education*, *35*(5), 634–650. doi:10.1177/1090198106291985

Knox-Kazimierczuk, G., Geller, K., Sellers, S., Taliaferro Baszile, D. & Smith-Shockley, M. (2017). African American Women and Obesity Through the Prism of Race. *Health Education & Behavior*, *45*(3), 371–380. https://doi.org/10.1177/1090198117721610

Knox-Kazimierczuk, S. & Shockly-Smith, M. (2017). African American Women and the Obesity Epidemic: A Systematic Review. The Journal of Pan African Studies, 10(1), 76–110.

Krippendorff, K. (2012). Content Analysis: An Introduction to Its Methodology (3rd ed.). Thousand Oaks, CA: Sage Publications.

Lancaster, K. J., Carter-Edwards, L., Grilo, S., Shen, C., & Schoenthaler, A. M. (2014). Obesity interventions in African American faith-based organizations: a systematic review. Obesity Reviews, 15(October), 159–176. http://doi.org/10.1111/obr.12207

Langellier, B., Glik, D., Ortega, A., & Prelip, M. (2015). Trends in racial/ethnic disparities in overweight self-perception among US adults, 1988–1994 and 1999–2008. Public Health Nutrition, 18(12), 2115–2125. https://doi.org/10.1017/S1368980014002560

Lee, H., & Hicken, M. T. (2013). Cumulative social risk and racial/ethnic disparities in obesity during the transition to adulthood. Journal of Health Care for the Poor and Underserved, 24(2), 907–27. http://doi.org/10.1353/hpu.2013.0090

Levin, J.S., Taylor, R.J., & Chatters, L.M. (1994). Race and gender differences in religiosity among older adults. Findings from four national surveys. *Journal of Gerontologist*, 49: 137–145.

López, I. A., Boston, P. Q., Dutton, M., Jones, C. G., Mitchell, M. M., & Vilme, H. (2014). Obesity Literacy and Culture among African American Women in Florida. *American Journal of Health Behavior*, *38*(4), 541–552.

Ludwig, J., Sanbonmatsu, L., Gennetian, L., Adam, E., Duncan, G. J., Katz, L. F., Kessler, R. C., Kling, J. R., Lindau, S. T., Whitaker, R. C. & McDade, T. W. (2011). Neighborhoods, Obesity, and Diabetes — A Randomized Social Experiment. *New England Journal of*

Medicine, *365*(16), 1509–1519. http://doi.org/10.1056/NEJMsa1103216

Mack, L. (2010). The philosophical underpinnings of educational research. Polyglossia, 19, 1-11.

Maina, I., Belton, T., Ginzberg, S., Singh, A., & Johnson, T. (2018). A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. Social Science & Medicine (1982), 199, 219–229. https://doi.org/10.1016/j.socscimed.2017.05.009

Mariampolski, H. (2001). Qualitative market research. Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412985529

Mastin, T., Campo, S., & Askelson, N. M. (2012). African American Women and Weight Loss: Disregarding Environmental Challenges. *Journal of Transcultural Nursing*, *23*(1), 38–45. https://doi.org/10.1177/1043659611414140

McEwen, M., & Wills, E.M. (2014). Theoretical basis for nursing (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

McNeill, J. A., Cook, J. D. M., Mahon, M., Allwein, D., Rauschhuber, M., Richardson, C. O., Muñoz, L.R., Estrada, R. & Jones, M. E. (2015). A Family History Intervention. American Association of Occupational Health Nurses, Inc., 59(4), 181–194.

McWilliam, C. (2010). Phenomenology. In Bourgeault, I., Dingwall, R., & De Vries, R. *The*

SAGE handbook of qualitative methods in health research (pp. 229-248). London: SAGE Publications Ltd doi: 10.4135/9781446268247

Merriam-Webster. (n.d.). African American. In *Merriam-Webster.com dictionary*. Retrieved November 5, 2018, from https://www.merriam-webster.com/dictionary/African%20American

Merzel, C., & D'Afflitti, J. (2003). Reconsidering community-based health promotion: Promise, performance, and potential. *American Journal of Public Health*, *93*(4), 557–574. http://doi.org/10.2105/AJPH.93.4.557

Mzayek, F., Wang, L., Relyea, G., Yu, X., Terry, J., Carr, J., Hundley, G., Hall, M., & Correa, A. (2019). Impact of Abdominal Obesity on Proximal and Distal Aorta Wall Thickness in African Americans: The Jackson Heart Study. Obesity (Silver Spring, Md.), 27(9), 1527–1532. https://doi.org/10.1002/oby.22563

Nam, S. (2013). Effects of social support and spirituality on weight loss for rural African-American women. The ABNF Journal: Official Journal Of The Association Of Black Nursing Faculty In Higher Education, Inc, 24, 71–76.

National Heart Lung and Blood Institute. (2012). What are overweight and obesity. Washington, DC: U.S. Department of Health and Human Services. http://www.nhlbi.nih.gov/health/health-topics/topics/obe

Nelson, D., Harris, A., Horner-Ibler, B., Harris, K., & Burns, E. (2016). Hearing the Community: Evolution of a Nutrition and Physical Activity Program for African American Women to Improve Weight. *Journal of Health Care for the Poor and Underserved*, *27*(2), 560–567. https://doi.org/10.1353/hpu.2016.0088

Notaro, S. R. (2012). *Health Disparities Among Under-Served Populations: Implications for Research, Policy and Praxis*. Bingley: Emerald Group Publishing Limited.

Novak, N. L., & Brownell, K. D. (2012). Role of policy and government in the obesity epidemic. *Circulation*, *126*(19), 2345–2352. doi:10.1161/CIRCULATIONAHA.111.037929

Office of Disease Prevention and Health Promotion. (2018). Social determinants of health. Retrieved from: https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health#top

Ojukwu, E., Powell, L.R., Person, S.D., Rosal, M.C., Lemon, S.C., & Allison, J. (2018). Spirituality and Willingness to Participate in Health-Related Research Among African Americans. *Journal of Health Care for the Poor and Underserved 29*(1), 400-414. doi:10.1353/hpu.2018.0027

Pekmezi, D., Marcus, B., Meneses, K., Baskin, M. L., Ard, J. D., Martin, M. Y., Adams, N., Robinson, C., & Demark-Wahnefried, W. (2013). Developing an intervention to address physical activity barriers for African-American women in the deep south (USA). *Women's Health (London, England)*, *9*(3), 301–12. http://doi.org/10.2217/whe.13.20

Pender, N. J. (1996). Health Promotion in Nursing Practice (3rd ed.). Connecticut: Appleton & Lange Stanford.

Pender, N.J., Murdaugh, C. L., & Parsons, M.A. (2011). Health Promotion in Nursing Practice (6th Edition). Boston, MA: Pearson. Retrieved from https://deepblue.lib.umich.edu/bitstream/handle/2027.42/85350/HEALTH_PROMOTION_MANUAL_Rev_5-2011.pdf

Pew Forum (2018). *Religion and public life. The United States religious landscape survey*. Retrieved from: http://religions.pewforum.org/.

Pierre-Louis, B., Akoh, V., White, P., & Pharris, M. D. (2011). Patterns in the Lives of African American Women with Diabetes. *Nursing Science Quarterly*, *24*(3), 227- 236. https://doi.org/10.1177/0894318411409423

Pirutinsky, S., Rosmarin, D. H., & Holt, C. L. (2012). Religious coping moderates the relationship between emotional functioning and obesity. *Health Psychology*, *31*(3), 394–397. https://doi.org/10.1037/a0026665

Polit, D. F., & Beck, C. T. (2004). *Nursing research: Principles and Methods* (7th edition.). Philadelphia: Wolters Kluwer Health /Lippincott Williams & Wilkins.

Powell, L., Jesdale, W., & Lemon, S. (2016). On edge: the impact of race-related vigilance on obesity status in African–Americans. Obesity Science & Practice, 2(2), 136–143. https://doi.org/10.1002/osp4.42

Pruchno, R., Wilson-Genderson, M., & Gupta, A. K. (2014). Neighborhood food environment and obesity in community-dwelling older adults: Individual and neighborhood effects. American Journal of Public Health, 104(5), 924–929. http://doi.org/10.2105/AJPH.2013.301788

Qobadi, M., & Payton, M. (2017). Racial disparities in obesity prevalence in Mississippi: Role of socio-demographic characteristics and physical activity. *International Journal of Environmental Research and Public Health, 14*(3) doi: http://dx.doi.org/10.3390/ijerph14030258

Reinert, K. G., & Koenig, H. G. (2013). Re-examining definitions of spirituality in nursing research. *Journal of Advanced Nursing, 69*(12), 2622–2634.

Risica, P. M., Gans, K. M., Kumanyika, S., Kirtania, U., & Lasater, T. M. (2013). SisterTalk: final results of a culturally tailored cable television delivered weight control program for Black women. The International Journal of Behavioral Nutrition and Physical Activity, 10, 141. http://doi.org/10.1186/1479-5868-10-141

Rogers, M., Lemstra, M., Bird, Y., Nwankwo, C., & Moraros, J. (2016). Weight-loss intervention adherence and factors promoting adherence: a meta-analysis. *Patient Preference and Adherence*, *10*, 1547–1559. https://doi.org/10.2147/ppa.s103649

Rosenberg, L., Kipping-Ruane, K, Boggs D. & Palmer, J. (2013). Physical activity and the incidence of obesity in young African-American women. American Journal of

Preventative Medicine, 45, 262-268. doi:10.1016/j.amepre.2013.04.016

Routh, B., Hurt, T., Winham, D., & Lanningham-Foster, L. (2019). Family Legacy of Diabetes-Related Behaviors: An Exploration of the Experiences of African American Parents and Adult Children. *Global Qualitative Nursing Research*, *6*, 233339361985234–. https://doi.org/10.1177/2333393619852343

Rowe, K. (2019). "Nothing Else Mattered After That Wig Came Off": Black Women, Unstyled Hair, and Scenes of Interiority. Journal of American Culture (Malden, Mass.), 42(1), 21–36. https://doi.org/10.1111/jacc.12971

Ryan, R., & Deci, E. (2000). Intrinsic and Extrinsic Motivations: Classic Definitions and New Directions. Contemporary Educational Psychology, 25(1), 54–67. https://doi.org/10.1006/ceps.1999.1020

Salkind, N. J. (2010). *Encyclopedia of research design* Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412961288

Sattin, R., Williams, L., Dias, J., Garvin, J., Marion, L., Joshua, T., Kriska, A., Kramer, M., & Venkat Narayan, K. (2016). Community Trial of a Faith-Based Lifestyle Intervention to Prevent Diabetes Among African-Americans. *Journal of Community Health*, *41*(1), 87–96. https://doi.org/10.1007/s10900-015-0071-8

Scarinci, I.C., Moore, A., Wynn-Wallace, T., Cherrington, A., Fouad, M. & Li, Y. (2014). A

community-based, culturally relevant intervention to promote healthy eating and physical activity among middle-aged African American women in rural Alabama: Findings from a group randomized controlled trial. Preventive Medicine, 69, 13-20.

Schreier, M. (2013). Content Analysis, Qualitative. In P. Atkinson, S. Delamont, M.A. Hardy, & M. Williams (Eds.), *SAGE Research Methods Foundations.* doi: 10.4135/9781526421036753373

Seale, J. P., Fifield, J., Davis-Smith, Y. M., Satterfield, R., Thomas, J. G., Cole, B., Atkinson, M. J., & Boltri, J. M. (2013). Developing culturally congruent weight maintenance programs for African American church members. *Ethnicity & Health*, *18*(2), 152–167. https://doi.org/10.1080/13557858.2012.708914

Sterba, K. R., Burris, J. L., Heiney, S. P., Ruppel, M. B., Ford, M. E., & Zapka, J. (2014). "We both just trusted and leaned on the Lord": a qualitative study of religiousness and spirituality among African American breast cancer survivors and their caregivers. *Quality of Life Research*, *23*(7), 1909–1920. https://doi.org/10.1007/s11136-014-0654-3

Sumlin, L., & Brown, S. (2017). Culture and Food Practices of African American Women With Type 2 Diabetes. *The Diabetes Educator*, *43*(6), 565–575. https://doi.org/10.1177/0145721717730646

Sutherland, M. E. (2013). Overweight and Obesity Among African American Women: An Examination of Predictive and Risk Factors and Weight-Reduction Recommendations.

Journal of Black Studies, *44*(8), 846–869. http://doi.org/10.1177/0021934713511639

Talleyrand, R. M., Gordon, A. D., Daquin, J. V., & Johnson, A. J. (2017). Expanding Our Understanding of Eating Practices, Body Image, and Appearance in African American Women: A Qualitative Study. *Journal of Black Psychology*, *43*(5), 464- 492. https://doi.org/10.1177/0095798416649086

The Department of Health and Human Services. (2010). Evidence-Based Clinical and Public Health: Generating and Applying the Evidence. *Secretary's Advisory Committee on National Health Promotion & Disease Prevention Objectives for 2020*, 32.

The Obesity Society. (2014). Summit on obesity in African American women and girls. Retrieved from https://www.apa.org/pi/women/resources/reports/obesity.pdf

The State of Obesity. (2014). Obesity Prevention in Black Communities. Retrieved from https://www.rwjf.org/en/library/research/2014/09/the-state-of-obesity.html

Toma, J. D. (2011). Approaching rigor in applied qualitative research. In Conrad, C. F., & Serlin, R. C. *The SAGE handbook for research in education: Pursuing ideas as the keystone of exemplary inquiry* (pp. 263-280). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781483351377

Turner-McGrievy, G., Wilcox, S., Frongillo, E., Murphy, A., Hutto, B., Williams, K., Crimarco, A., Wilson, M., & Davey, M. (2020). The Nutritious Eating with Soul (NEW Soul)

Study: Study design and methods of a two-year randomized trial comparing culturally adapted soul food vegan vs. omnivorous diets among African American adults at risk for heart disease. *Contemporary Clinical Trials*, *88*, 105897. https://doi.org/10.1016/j.cct.2019.105897

U.S. Department of Health and Human Services Office of Minority Health. (2011). Obesity and African Americans. Retrieved from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=25

U.S. Department of Health and Human Services. (2014). Physical Activity. Washington, DC. Retrieved from http://www.healthypeople.gov/2020/ topics-objectives/topic/physical-activity

Usher, K. & Jackson, D. (2014). Phenomenology. In Mills, J., & Birks, M. *Qualitative methodology* (pp. 181-198). 55 City Road, London: SAGE Publications, Inc. doi: 10.4135/9781473920163

Venkataramani, A. S., Chatterjee, P., Kawachi, I., & Tsai, A. C. (2016). Economic Opportunity, Health Behaviors, and Mortality in the United States. American Journal of Public Health, 106(3), 478–484. http://doi.org/10.2105/AJPH.2015.302941

Versey, H. S. (2014). Centering perspectives on black women, hair politics, and physical activity. American Journal of Public Health, 104(5), 810–815.

http://doi.org/10.2105/AJPH.2013.301675

Voelker, R. (2012). Escalating Obesity Rates Pose Health, Budget Threats. *Journal of American Medical Association, 308*(15), 1514.

Walker, S. (1996). Psychometric evaluation of the Health-Promoting Lifestyle Profile II. University of Nebraska Medical Center

Wang, Y. C., McPherson, K., Marsh, T., Gortmaker, S. L., & Brown, M. (2011). Health and economic burden of the projected obesity trends in the USA and the UK. *The Lancet*, *378*(9793), 815–825. http://doi.org/10.1016/S0140-6736(11)60814-3

Weaver, K. & Olson, J.K. (2006), Understanding paradigms used for nursing research. Journal of Advanced Nursing, 53: 459-469. doi:10.1111/j.1365-2648.2006.03740.x

Webb, J. R., Toussaint, L., & Dula, C. S. (2013). Ritualistic, Theistic, and Existential Spirituality: Initial Psychometric Qualities of the RiTE Measure of Spirituality. Journal of Religion and Health, 53(4), 972–985. doi:10.1007/s10943-013-9697-y

Wesley, Y. (2009). *Black Women's Health : Challenges and Opportunities*. New York: Nova Science Publishers, Inc. Retrieved from https://search.ebscohost.com/login.aspx?direct=true&AuthType=cookie,ip,url,uid,athens&db=nlebk&AN=315727&site=ehost-live

Woods-Giscombé, C. L. (2010). Superwoman Schema: African American Women's Views on Stress, Strength, and Health. *Qualitative Health Research, 20*(5), 668–683.

https://doi.org/10.1177/1049732310361892

Woods-Giscombe, C., Robinson, M.N., Carthon, D., Devane-Johnson, S., & Corbie-Smith, G. (2016). Superwoman Schema, Stigma, Spirituality, and Culturally Sensitive Providers: Factors Influencing African American Women's Use of Mental Health Services. Journal of Best Practices in Health Professions Diversity, 9(1), 1124–1144.

World Health Organization. (2016). Obesity and Overweight (Fact sheet N°311). Retrieved from http://www.who.int/mediacentre/factsheets/fs311/en/

Zimmer, R., Rubio, V., Kintziger, K. W., & Barroso, C. (2019). Racial/Ethnic Disparities in Dietary Intake of U.S. Children Participating in WIC. Nutrients, 11(11), 2607–. https://doi.org/10.3390/nu11112607

APPENDICES

APPENDIX: A

Recruitment Flyer

APPENDIX: B

Demographic Questionnaire

Instructions: Answer each question to the best of your ability and please be honest. All information is confidential and will be used for research purposes.

ANSWER THE FOLLOWING QUESTIONS:

Section A: Participant Information

1. What is your age: (circle your age range)

18 -25 26- 35 36- 45 46- 55 56- 65

2. What is your marital status?

☐ Single (never married) ☐ Separated

☐ Married ☐ Widowed

☐ Divorced ☐ Living together/not Married

☐ Other: _____

3. Weight without shoes: _____ Pounds

4. Height without shoes: _____

5. What is your work status?

☐ Part-time ☐ Full-time

☐ Self-Employed ☐ Retired

☐ Not Employed ☐ Other: _____

APPENDIX: C

Obesity, Spirituality, and Health Behaviors in African American Women

by

Andrea S. Poynter

Interview Guide

September 7, 2019

Individual Interview Guide

I. INTRODUCTION

Hello, my name is Andrea Poynter and I am a PhD student at ETSU and I will be conducting the interview for today.

The purpose of this interview is to talk about topics that impact the African American woman such as obesity, spirituality and health behaviors. I'll be asking your opinion and your lived experience with these topics. The intent is for you to give your input and be allowed the opportunity to speak your thoughts and views on the questions asked. Questions will be asked and follow-up questions may be asked in order to help expand the conversation and for clarity. Any and everything discussed during this interview is confidential and your name will not be used on any of the information reported. This session will also be recorded in order to accurately transfer the information but the recordings will be erased immediately after the information has been analyzed. Your attendance and participation in this interview is voluntary and if there is any topic that you do not want to discuss just state so.

Complete Informed Consent Form and short demographic survey

II. GROUND RULES

1. This session will last about 1-hour max unless your story and experiences bypass the allotted time.
2. This session is being audio taped and after the first few minutes I won't be taking notes.
3. There are no wrong answers in this interview; I am looking for different points of view. I want to know what your opinions, thoughts, and feelings are.
4. Do you have any questions before we begin?
5. I will not be referring to you by name once the study begins?

III. Questions

1. Can you tell me what a typical day looks like for you?
    a. You mentioned that _____ tell me what that was like?
2. Thinking about your day to day routine, what kinds of things do you enjoy?
    a. Are there any activities that you did previously that you had to stop doing? Any activities that you would like to do that you feel are impacted by your weight?
3. If you had to describe yourself, your health to a doctor or nurse what words would you use and why?
4. What are your thoughts about trying to make changes regarding your weight?
    a. Are you ready to make any changes regarding your weight?

i. If yes, why now? Motivation? What do you think could possibly hinder you?

ii. If no, why don't you think your ready? Barriers? What do you think could motivate you to start?

5. What does spirituality mean to you?
    a. What spiritual values are important to you/ which are not important to you?
    b. Tell me if you think this is a true or false statement: My spirituality impacts my day to day decisions or lifestyle?
        i. Why is that? or Why not?
            1. Does it matter for you?
6. Describe for me your thoughts of what a healthy person is?
    a. Do you consider yourself to be a healthy person?
        i. Tell me more.
7. What concerns, hopes, or thoughts do you have about your health or spirituality that you feel people need to know from your experience with life?

APPENDIX: D

Field Note Outline Guide

Participant ID#

Interview Date: _____

A. What happened during the session: body language, facial expressions, 'native words'?

B. What was the environment/participant like?

C. Insights:
   - During the interview:
   - After the interview:

D. Personal reflection during and after the interview

E. Notes:

VITA

ANDREA SYKES POYNTER

Education:	Ph.D. Nursing Research, East Tennessee State University, Johnson City, Tennessee, 2020
	M.S. Nursing Education, Austin Peay State University, Clarksville, Tennessee, 2010
	B.S. Nursing, Austin Peay State University, Clarksville, Tennessee, 2005
Professional Experience:	Assistant Nursing Professor, Columbia State Community College; Columbia, Tennessee, 2017- Present
	Staff Nurse-PRN, Critical Care Unit, Maury Regional Medical Center; Columbia, Tennessee, 2016- Present
	Assistant Nursing Professor, Tennessee State University, Nashville, Tennessee, 2013- 2017
	Clinical Nurse Educator, Maury Regional Medical Center, Columbia, Tennessee, 2010- 2013
Publications:	Brown, A., Boshers, B., Floyd Chapman, L., Huckaba, K., Pangle, M., Pogue, L. C., Poynter, A. & MacArthur, S. (2015). CE. Do Elderly Patients Use Patient-Controlled Analgesia Medication Delivery Systems Correctly?. Orthopaedic Nursing, 34(4), 203-210 8p. doi:10.1097/NOR.0000000000000159