2021

Exploring Ethnic and New Orleans Cultural Influences on Health Behaviors of African American Women

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Walden University
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Abstract

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

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February 2021

Abstract

In the United States (U.S.), African American women suffer disproportionately due to obesity and chronic diseases. Many studies have examined the culture of African Americans and its influence on their health behaviors in order to gain knowledge to inform obesity and chronic disease prevention interventions. However, a geographical segment of the U.S. African American population shares a unique culture that had yet to be studied. This qualitative study used in-depth interviews to understand the perceptions of overweight and obese African American women living in the Greater New Orleans region about their culture's role in the prevalence of obesity and obesity-related conditions in their communities and how they perceived their culture and lived experiences influenced their beliefs about obesity and obesity prevention. The study's sample consisted of 12 overweight or obese African American women over the age of 18, who self-identified as African American or Black and were native to the New Orleans area. The health belief model guided the study, and the data were collected through semi-structured, in-depth interviews and examined using interpretive phenomenological analysis. Findings demonstrated culture was felt by participants to be a major influence on their health behaviors. This culture influenced their beliefs and attitudes about weight standards, recommendations, and health and body image. Participants desired more culturally relatable and realistic recommendations to address obesity in their communities. This study addresses health behaviors and beliefs of this unique subculture and demonstrates the need for more specific culturally tailored interventions to address disparities in this population.

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Dedication

I dedicate the second biggest accomplishment of my life to my most prized accomplishments, Tyler André and Kameron Kenneth. You two are the loves my life and the reason why I am who I am today. You motivated me to keep pushing through every challenge and every obstacle. Because of you, I never considered giving up. When you look back, you may remember Mommy working all the time, but I pray that I have instilled upon you the value of hard work and determination.

Tyler and Kameron, it is my hope that this dissertation will inspire you to aspire for greatness. I believe in you and know that you will grow up to make this world a better place. Tyler, you inherited Mommy's superpower of ADHD, which means your mind is capable of more than anyone could imagine. There will be challenges, but don't let anyone put limitations on you. Do not follow the path of others for you have the ability to dream up your own path. Kameron, you inherited Mommy's superpower of empathy. It's with this gift that you will change lives. Embrace your sensitivity, feed your intuitiveness, and continue to love others with the love of God. I love you both with everything in me, forever. I dedicate this dissertation and the degree that will follow to you, Tyler and Kameron.

I also dedicate this dissertation to my Nanny, Dorothy Richard and my Uncle Gregory Anderson. Unc, you fueled my passion to educate our people on how to live healthy lives and Nanny, you've been my inspiration to live a life of love and charity and to leave a legacy that will continue long after I have departed this world. May you both rest in peace.

Acknowledgements

First, I would like thank God for giving me the wisdom, knowledge, strength and endurance that I needed to reach this goal. Secondly, I would like to thank all of my family, friends, and coworkers(family) for your love, support, and encouragement. Mommy and Daddy, you were there consistently, supporting me through every step of the way. When things got hard around me, you helped to pick up the pieces so that I could remain on track. I couldn't have done this without you. Juan, thank you for reminding me every day that I was worthy of this and that I had the strength within me to overcome every obstacle put before me. Thank you for providing your unconditional love when I needed it the most. André, you provided many of the challenges and obstacles, but they motivated me to keep pushing. Thank you for that. But more importantly, thank you for the support that you provided that allowed me to finish my dissertation. I couldn't have finished my last chapter without your help. Tyler and Kameron, thank you for providing me all the love, hugs, and kisses that kept me alive over the last 4 years.

Dr. Naa-Solo Tettey, my committee chair, thank you for your support, feedback, and encouragement throughout the dissertation process. I am grateful for your understanding through all of my struggles. Also, thank you to my committee member, Dr. Carla Riemersma, for your time and feedback. Lastly, I would like to thank the participants of this study for your time and your willingness to tell me your stories.

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Chapter 1: Introduction to the Study

Introduction

"How does it feel to be a twin?" Although I've heard this question asked in different ways, the answer seems to always be the same. "I don't know, that's all I've ever been" or something similar is usually the response. When you have only seen life from one perspective, it may be difficult to initially see the uniqueness of your own experience. It would require you to view your experience from a lens other than the one you've always used. Our perspectives shape how we move through life. They shape how we perceive ourselves in the world, our beliefs, our attitudes, and later our behavior and our decisions. An individual living in a rural area without television or access to the outside world may be surprised to learn that others living outside of their town live a different way of life. An individual who has accomplished a goal by following steps A-Z may find it difficult to understand why another individual cannot follow those exact steps to reach the same goal. As a native resident of the Greater New Orleans region (GNO), my experiences growing up were quite different from those of whom I viewed on television or those with whom I visited in other places, especially outside of the state of Louisiana. However, it wasn't until I lived hundreds of miles from where I grew up that I realized how unique my experiences were.

As a health-sciences major, I learned much about health and healthy eating. Although I absorbed the information and regurgitated it regularly, it never occurred to me that the application of these principles were real expectations. That is until I moved to Washington DC and learned that my way of living, although somewhat similar to the

foreign cultures residing in the country's *melting pot*, was very different from how much of the rest of the country lived. It is within this concept one can understand the definition and value of truth from a relativist perspective. Within this ontological perspective, I will guide the reader by exploring the unique realities of a group of individuals who suffer from preventable conditions, yet who seem to continue to partake in the offending behaviors.

African Americans, especially African American women, are suffering and dying at high rates due to chronic preventable conditions. In this study, I examined a specific community of African American women. I describe disproportionate rates of prevalence among African American women and factors that contribute to these rates. In current day public health, it is common practice to look at health from a socioecological perspective, addressing multiple levels of health determinants. For this reason, I described how community and family level determinants such as culture can affect individual behaviors. More specifically, I examine how the culture of a city known for its food, music, partying, and its laid-back style of living, affect the health behaviors of overweight and obese African American women. Understanding how culture influences these behaviors and how these individuals understand their own experiences will help promote positive change by providing information needed to build culturally-informed interventions that educate and encourage culturally-specific health behaviors that are conducive to the realities and experiences of this unique population. In this chapter, I explain the problem and purpose of this study. I provide a brief explanation of the methods and theoretical

framework, as well as the nature, scope, assumptions, limitations, delimitations, and significance of this study.

Background

The phenomenon of the increased risks and prevalence of obesity and chronic disease in African Americans, compared to other ethnicities in the United States (U.S.), has been the driving force for many investigations and interventions (Centers for Disease Control and Prevention, 2017a). Many of these studies have focused on obesity prevention at the individual and community levels by addressing health behaviors as a priority to influence positive change. According to theories, such as the health belief model (HBM) and the Social Cognitive Theory (SCT), an individual's decision to perform preventive behaviors can be influenced by both internal and external factors (Kelder et al., 2015; Skinner et al., 2015). For example, according to the HBM, an individual's participation in behaviors related to disease prevention depends on their beliefs about their susceptibility, knowledge of the disease's severity and perceptions of about the behavior, barriers that make it difficult to participate, and benefits to performing that behavior (Sheeran & Abraham, 1996). Much of the research described in this study involves attitudes, knowledge, and perceptions of African Americans regarding health and obesity and their health behaviors.

The findings among much of the literature demonstrated the depth of the cultural influences of African American culture on how African Americans made sense of their own experiences, body image, and perceptions and knowledge about obesity, chronic disease, behavioral changes, and disease prevention. For instance, African American

women's perceptions about obesity and their susceptibility were shown to be heavily impacted by their perceptions of their body image. Many of them had positive body images, and although most had body weights that classified them as overweight and obese, they considered themselves to be within the normal and healthy weight range (Lynch & Kane, 2014; Ogden et al., 2014; Pickett & Peters, 2017; Williams-York et al., 2013). The findings suggested that much of the reasoning for this is related to their sociocultural experiences, beliefs, and norms (Grant, 2017; Pickett and Peters, 2017; Talleyrand et al., 2017). This reasoning also applies to their attitudes regarding the role of food, where they expressed feelings of obligation to remain faithful to tradition out of respect for their ancestors and elders as well as comfort due to the familiarity and emotional ties associated with following traditional cooking methods and recipes (Bernstein et al., 2014; Swierad et al., 2017). In addition, their perceptions about health and obesity were heavily influenced by cultural norms regarding weight and body shape and size as well as their beliefs about their genetic susceptibility (James et al., 2012, Lopez et al., 2014; Woodruff et al., 2018). And lastly, culture also weighed heavily on their perceptions about barriers to health and weight management. Some viewed culture and traditions as barriers to maintaining their health and weight, while others perceived issues of trustworthiness within the health system and problems with affordability and access to care as barriers, which were beliefs and socioeconomic factors common to the African American community as a whole (Antin & Hunt, 2012; Bernstein et al., 2014; Cameron et al., 2018; Long et al., 2017; Lopez et al., 2014; Sheats et al., 2018; Sumlin & Brown, 2017; Swierad et al., 2017).

Although these concepts have been rigorously studied among general populations of African Americans and some regional segments of this population, little had been found in the literature regarding the unique local culture of New Orleans, LA and how its traditions, cuisine, and way of life interact with African American culture to influence the behavior of African American women who reside there. Though many of the studies provided information on how African American culture affects the health behaviors of African Americans, the lack of specificity does not allow the findings to be realistically contextualized when applied to this particular group of individuals. For example, it would be difficult to contextualize findings from a study about the southern traditions affecting the behaviors of African Americans in Georgia to African American women in the GNO without considering the unique food environment and traditions of the region. This study sought to identify and explore the unique cultural traditions practiced by the African American population in the GNO and examined how overweight and obese African American women in this region make sense of their cultural experiences and its influence on their health behaviors and attitudes, beliefs, and perceptions about health and obesity. This study provides information to help guide future chronic disease and obesity prevention efforts by providing information on how this regional culture influences health behaviors and perceptions of overweight and obese women in the GNO. This information could help create more specific, culturally sensitive, and tailored interventions that could be more effective in promoting positive behavior change than interventions that do not consider New Orleans culture's influences.

Problem Statement

In the U.S., African Americans, especially African American women, have higher risks of morbidity and mortality due to chronic diseases such as stroke, heart disease, and diabetes when compared to whites (Centers for Disease Control and Prevention [CDC], 2017a). They also have higher obesity rates, which have been linked to the development of hyperlipidemia, hypertension (HTN), diabetes, and other chronic diseases (CDC, 2019; Ogden et al., 2014). To address these disparities, the Centers for Disease Control and Prevention (2017c) created Racial and Ethnic Approaches to Community Health (REACH), a chronic disease prevention and health promotion program that has worked with local organizations since 2005. Several studies have demonstrated the link between culture and chronic disease in African Americans. For instance, Swierad et al. (2017) identified both mainstream and ethnic cultural factors that African Americans in New York believed influenced their health behaviors. And Long et al. (2017) found that culture influenced African American men's perceptions in both Georgia and North Carolina as it related to HTN and hyperlipidemia. Other studies have been performed to create and evaluate the effectiveness of community-based and culturally appropriate programs in improving obesity risks and the heart health of African Americans (James et al., 2012; Villablanca et al., 2016).

Although researchers continue to explore the role of culture in the development and prevention of chronic diseases in African Americans, there were no current or recent studies that evaluated the unique cultural influences experienced by those immersed in the gumbo pot of cultures of New Orleans, LA. Accounting for approximately 60% of the

population, African Americans in New Orleans suffer similar disparities as those in the remainder of the U.S., which include higher rates of obesity, increasing the risk for HTN, heart disease, stroke, and diabetes, among others (New Orleans Health Department, 2013). However, unlike African Americans in other cities, in addition to ethnic and mainstream cultures, those in New Orleans experience a very different way of living because of the city's very unique celebratory culture that celebrates food, alcohol, music, and historical traditions. The way of life of many in New Orleans follows the city's mantra, "laissez le bon temps rouler," which translates to "let the good times roll," and one of the city's nicknames, "the city that care forgot," was intended to describe the carefree nature of its residents. For instance, Spring in New Orleans is a season of Mardi Gras, Lent, and food and music festivals. In each of those, the over-indulgence of food and alcohol is the social norm. Cultural traditions include cooking red beans seasoned heavily with pork on Mondays and eating fried seafood on Fridays. It is unclear what specific cultural factors are most influential and how they affect health behaviors. To effectively address obesity as a means to prevent chronic disease within this community, it is necessary to understand how the cultural norms and traditions of New Orleans influence perceptions, attitudes, and behaviors relating to obesity and obesity-related conditions in adult overweight and obese African American women in the GNO.

Purpose of the Study

The purpose of this dissertation was to identify and explore cultural traditions and norms within the GNO that influence overweight and obese African American women's health behaviors and their perceptions and attitudes about obesity and obesity-related

illnesses and gain insight regarding their perceptions of the influence of their culture and health behaviors on obesity-related morbidity and prevention efforts. A qualitative study with a phenomenological approach using in-depth semi-structured interviews was conducted to address gaps in the literature regarding this unique community. Findings were analyzed to better understand how African American and New Orleans cultures influenced African American women's health behaviors.

Research Questions

RQ1: What are the perceptions of overweight and obese African American women in the GNO regarding the role that regional and ethnic culture plays in the prevalence of obesity and obesity-related illnesses in their population?

RQ2: How do the cultural experiences of overweight and obese African American women in the GNO influence their knowledge, attitudes, and perceptions of obesity and obesity-related conditions?

Theoretical Framework

The health belief model (HBM) guided the research for this study. The model was created in the 1950s as a result of public health officials' quest to determine why people were not participating in preventive screenings for communicable diseases (Rosenstock, 1974). The theoretical assumptions of the HBM are explained in Chapter 2. But essentially, the model theorizes that whether an individual participates in certain health behaviors can be predicted by several factors, which include an individual's perception of their susceptibility to a condition and its consequences, perceived benefits of the recommended behavior, and perceived challenges associated with adopting the behavior

(Sheeran & Abraham, 1996). Within the current study, the HBM guided the phenomenological exploration into how culture has influenced the perceptions and subsequently, the health behaviors of overweight and obese African American women.

Nature of the Study

I used qualitative methods with a phenomenological approach to explore the cultural influences on the health behaviors of overweight and obese African American women in the GNO. The purpose of the study was to gain an understanding of how the culture of African Americans in the GNO influenced their perceptions, attitudes, and beliefs regarding obesity, obesity-related conditions, and prevention. The phenomenological approach allowed me to understand and explain how the participants understood the influence of their culture and lived experiences on their health behaviors (Creswell, 2007; Davidson, 2013).

I conducted in-depth interviews with a purposeful sample of adult African American women who had spent most of their lives in the GNO. Also, ethnographic elements, such as participant observation, were planned to observe the participants in their natural environments. I explored each case thoroughly using the idiographic case study approach (Peat et al., 2019). With the help of Dedoose, a qualitative data analysis software program (QDAS), the transcripts and notes were analyzed within 48-72 hours after each case to extract, organize, and group the emergent, overarching, and subthemes. Once I completed the first case, I repeated the process with the next case and ended once I reached data saturation. As I analyzed the cases, I noted the patterns between them.

Once I had individually analyzed each case, I reviewed them again and further explored the emergent themes with the incorporation of theory (Fade, 2004).

Definitions

Body Mass Index (BMI): A screening tool used to estimate body fat and determine whether an individual's weight is within a healthy range (CDC, 2019).

Culture: The way of life, including morals, values, beliefs, attitudes, practices, traditions, social norms, behaviors, music, cuisine, and language of the participants that they share with others due to race or ethnicity and geographic location (Sumlin & Brown, 2017; Swierad et al., 2017).

Greater New Orleans (GNO) region or area: The GNO consists of New Orleans, LA and nine other surrounding parishes that share a unique culture.

Obese: *A* body weight higher than what is considered healthy, which is a calculated BMI of 30 or greater (CDC, 2019).

Overweight: A body weight higher than what is considered a healthy weight, or a calculated BMI of 25 or greater (CDC, 2019).

Assumptions

The study had two assumptions. First, I assumed the study participants understood the unique qualities of their culture. Secondly, I assumed they were aware that their culture influenced their perceptions, attitudes, and behaviors regarding their weight.

Scope and Delimitations

In this study, I explored the link between the culture of African American women in the GNO and obesity. Obesity is a significant risk factor for many chronic conditions

such as heart disease, stroke, hypertension, and type 2 diabetes (CDC, 2019). Compared to Whites, African Americans have higher morbidity and mortality risks due to these conditions (CDC, 2017a). The study focused on how the regional and ethnic cultures influence the participants' behaviors as well as their attitudes and perceptions about health behaviors related to the prevention of obesity and obesity-related conditions. An important issue was how cultural practices, traditions, and beliefs contributed to the increased risk of chronic disease morbidity and mortality in this group. However, the issue was too broad to explore rigorously within the scope of this study. Instead, the study focused on obesity, which is a major risk factor of those chronic diseases.

The study included participants who were African American women at least 18 years of age who were either native to the GNO or had spent most of their lives there and had at least one parent who was a native. With this study, I intended to understand how ethnic culture and the culture of the GNO influenced their attitudes, perceptions, and behaviors, and I included criteria regarding nativity to maintain credibility. Since children's health behaviors are usually determined or influenced by their parents, they were excluded from the study. The idea was to have a sample of adult women who independently make decisions about their own personal health, so the age requirement of at least 18 years was chosen.

In this study, I examined how culture influenced the participants' perceptions about obesity, their self-efficacy related to performing preventative behaviors, and their perceptions about social norms and social support. I considered Bandura's Social Cognitive Theory (SCT) as a theoretical model to investigate social factors such as

perceived social support, perceived barriers, and social norms that interact to promote or discourage positive health behaviors. However, since changing cultural norms is unlikely, the use of the SCT would have been impractical. Instead, the HBM was used to examine participants' knowledge and perceptions about obesity, risks, and benefits of performing healthy behaviors, as well as barriers they may encounter.

Lastly, although there was potential for transferability, it was not likely to be within the major themes of this study. The themes that I expected to emerge were related to the unique cultural experiences of the population. I did not specifically intend for these findings to be transferrable to other communities; however, the magnitude of a culture's influence on behaviors, attitudes, beliefs, and perceptions regarding health conditions and health behaviors may be a theme that future researchers can apply to other individuals belonging to unique cultural groups within the U.S.

Limitations

There were two apparent limitations of this study. First, the findings were not generalizable to African American populations outside of this specific geographic locale. However, certain themes, especially those associated with the influence of culture on health behaviors could be transferrable to studies examining the cultural influences of similarly unique cultural groups. The second research limitation was related to the methodology. Within this phenomenological study, most data were gathered through interviews, leaving the study at risk for bias from both the interviewer and the participants (Roulston & Shelton, 2015). I intended to use triangulation to limit recall and reactive bias on the part of the participants. Other techniques such as reflexivity and

member checking were used to minimize any interpretive or confirmation bias in my role as the researcher.

Significance

Chronic diseases such as heart disease, hypertension, diabetes, and obesity are significant issues affecting African Americans, especially African American women (CDC, 2017a). These racial disparities are also found in New Orleans (New Orleans Health Department, 2013). Many studies have attempted to understand how African American culture influences behaviors, perceptions, and success of chronic disease prevention interventions. However, I was unable to find any recent studies that addressed the unique cultural influences experienced by African Americans in New Orleans, LA and how those influences affected their health and health behaviors. This research addresses this gap.

After studies like Long, Ponder, and Bernard's (2017) examination of the beliefs and perceptions about chronic disease in African American men living in Southeastern United States and Swierad, Vartanian, and King's (2017) exploration of the influence of ethnic and mainstream cultures on the health behaviors of African Americans, the next logical step in developing a preventive plan for the target population of this study was to address the stated problem. This research informs future culturally-specific interventions for African American women in the GNO to ensure the inclusion of cultural factors significant to this particular community. The study can potentially lead to positive social change by providing knowledge and evidence that can be essential in addressing disparities in this marginalized community.

Summary

African American women suffer from obesity and chronic diseases at disproportionate rates both in the GNO and nationally. Many studies have demonstrated a link between culture and the health behaviors of African American women. Although these studies' findings may help create culturally specific interventions among many African American populations, there appeared to be a gap in the literature related to the unique culture of the GNO. Using the HBM, I aimed to understand how African American and regional cultures influenced perceptions of overweight and obese African American women in the GNO. In-depth interviews were used to identify cultural factors that influenced their beliefs, perceptions, and attitudes about obesity, obesity-related conditions, and preventive behaviors. Gaining this understanding provides insight into encouraging positive change by promoting healthy behaviors to improve health outcomes.

This study's foundational basis is described in Chapter 2 and includes an exploration of the theoretical underpinnings that guide this study. I explain and justify the theoretical framework and its application. In addition, I provide an exhaustive review of recent and seminal literature related to the phenomenon. This includes descriptions of how the phenomenon was approached, studied, and applied to practice. Within this analysis, the literature gap regarding the phenomenon is identified and reviewed.

Chapter 2: Literature Review

Introduction

There is an obesity crisis in the U.S., and with each passing year, the obesity rate grows. The prevalence of adult obesity between 2015 and 2016 was 39.8% (Hales et al., 2017). Obesity is defined using the Adult BMI, a screening tool calculated by dividing an individual's weight by the square of their height (CDC, 2019). Individuals are considered overweight if their BMI is greater than 25 and obese if it is greater than 30. Excess fat in overweight and obese individuals has been linked to the development of many chronic diseases, including heart disease and stroke. This link is apparent in other conditions such as type 2 diabetes, which affects about 30 million Americans and can be prevented, in many cases, with weight loss (CDC, 2017b). These obesity-related diseases have been the leading cause of premature and preventable deaths in the U.S. and contribute to billions of dollars annually in medical costs.

Although the epidemic affects a large portion of the U.S. population across gender, race, and ethnicity, there are racial and ethnic disparities, with non-Hispanic African Americans and Hispanics having the highest obesity rates (Hales et al., 2017). Hispanics (47%) and African Americans (46.8%) suffer from obesity at significantly higher rates than non-Hispanic Whites (37.9%) and non-Hispanic Asians (12.7%). Although the rates of Hispanics and African Americans are disproportionately high compared to other ethnic groups, the rates of obesity among African American women are higher. African American women had an obesity rate of 54.8% compared to Hispanic women at 50.6%, non-Hispanic White women at 38%, and 14.8% of non-Hispanic Asian

women. Their rates were also significantly higher than African American and Hispanic men, whose obesity rates were 36.9% and 43.1%, respectively.

Higher obesity rates in African American women coincide with risks of developing chronic diseases and morbidity and mortality due to those chronic diseases. Conditions such as hypertension, type 2 diabetes, and stroke are all diseases found to occur in African American women at higher rates compared to other groups (Blackwell & Villarroel, 2016; CDC, 2017b). For this reason, this population has been the target of many studies and interventions. One step in the direction of prevention has been to address health behaviors in this group. However, to create strategies that influence change, it is crucial to understand the unique factors that influence current behaviors.

Theoretically, individuals' decisions to perform behaviors are determined by their beliefs about obesity and perception regarding risks (Stretcher & Rosenstock, 1997). Studies, such as those performed by Gustat et al. (2017), Lopez et al. (2014), Talleyrand et al. (2017), and Woodruff et al. (2018), examined African Americans' beliefs about weight and their perception of body image, as these factors may motivate or discourage health behaviors related to obesity. This chapter will review much of the current literature in respect to the HBM and key concepts relating to health behaviors of overweight and obese African American women, including perceptions, attitudes, and knowledge about the definition of obesity, associated risks and consequences, and obesity management and prevention methods.

Literature Search Strategy

My search began using CINAHL, Medline, PubMed, EBSCO, Google Scholar, ProQuest Dissertations, and Thesis Global. The search terms used in this study were: African American, Black, women, weight, obesity, obesity-related diseases, illnesses, overweight, chronic health conditions, chronic diseases, women's health, health belief model, culture, New Orleans, Louisiana, Southern, soul food, diet, body image, health behaviors, and lifestyle.

Research regarding my particular topic was somewhat limited. Although my research focused on the influence of culture on African Americans, I found literature about Hispanic and other ethnic cultures' influence on obesity. I also included research that addressed both males and females and other racial groups. I excluded studies about children exclusively but considered the studies that examined families. I also found articles that examined the impact of culture on the behaviors of African Americans with obesity-related chronic conditions useful. There was minimal literature regarding the influence of the culture of New Orleans on obesity or chronic disease. To address this issue, I searched for articles that discussed culture related explicitly to behaviors or beliefs. I also included articles that discussed Southern cultural influences on African Americans' health behaviors. Lastly, seminal studies involving theory were included.

Conceptual Framework

The HBM was used as the conceptual framework for this study. The HBM came about when researchers found a correlation between health behaviors and health beliefs. They theorized that an individual's perceptions about their susceptibility to a particular

condition, the consequences of that condition, the benefits of preventative behavior, and the barriers and costs related to behavior change are factors that determine his or her health behaviors (Sheeran & Abraham, 1996). In this study, I aimed to understand the health beliefs of the target population and tell, in their words, their perceptions of how those beliefs and other external factors influenced their health behaviors.

HBM

In the 1950s, public health officials were faced with determining why people were not participating in preventive and screening measures for communicable diseases, such as tuberculosis, polio, and rheumatic fever (Rosenstock, 1974). As a response to this problem, the model developed theoretically and practically to explain what factors influenced individuals to participate in preventive health behaviors. An early example of reference is the reluctance of many healthy individuals to participate in free tuberculosis (T.B.) screening programs in the early 1950s. In their study of 1200 individuals from 3 cities with recent TB screenings, Stretcher and Rosenstock (1997) found that 82% of the individuals who believed that they were susceptible to T.B. and thought that early detection was beneficial voluntarily participated in at least one preventive X-ray screening before the study. By contrast, of those who had neither of those beliefs, only 21% had participated in voluntary screening X-rays prior to the study. This study demonstrated that an individual's decision to participate in a T.B. screening voluntarily was associated with their perceived susceptibility to T.B. and perceived benefits of the early detection (Stretcher & Rosenstock, 1997).

The HBM model later expanded to suggest that participation in preventive behaviors for screening, prevention, and maintenance of illnesses depends on individuals' perceived susceptibility to the condition, perceived severity of the condition, and their perception of whether the benefits of their preventive actions outweigh the cost or barriers (Stretcher & Rosenstock, 1997). A more present-day example would be that for a woman to have a mammogram voluntarily, she would have to believe that she is susceptible to breast cancer, understand the consequences and severity of breast cancer, believe in the benefits of early detection, and believe that the benefits outweigh the time lost and inconvenience associated with the test. These constructs have since become widely used to predict health behaviors and to guide the development of public health interventions (Skinner et al., 2015).

Application

By evaluating individuals' perceptions, the HBM helps gain insight into their adoption of preventive behaviors (Skinner et al., 2015). In the current study, I used the model to examine the perceptions of obesity and obesity risk and explore the influence of culture on the perceptions and the health behaviors of a sample of overweight and obese African American women in the Greater New Orleans area. Many studies have taken a similar approach, using the model to inform future interventions. In their study of African American men living in the southeastern U.S., Long et al. (2017) used the constructs of the HBM to create semi-structured focus group questions, which they designed to assess the men's attitudes, knowledge, and health beliefs regarding the self-management of hypertension and hyperlipidemia. They hoped that their study would later

inform future heart prevention interventions for their target population. The application of the model allowed the researchers to explore the perceptions of health and illness held by African American men, which led to the discovery of pertinent issues that could be addressed by future health prevention interventions.

James et al. (2012) and Agne et al. (2012) both applied the constructs of the HBM to examine the health beliefs of overweight and obese women about obesity from a cultural perspective. The researchers aimed to use the model to provide culturally relevant data that would aid in the development of culturally appropriate community interventions for Latina immigrants and African American women. In their study, James et al. (2012) conducted focus groups consisting of overweight or obese African American women. The women were guided in a discussion about obesity using HBM constructs, such as perceptions about the condition, perceived threat related to obesity, and perceived barriers to losing weight. Agne et al. (2012) similarly conducted focus groups of overweight and obese Latina immigrants to examine their perceptions regarding obesity. Both studies provided implications for practice modifications and cultural competency when addressing obesity among women of these particular cultural groups and in the development of culturally appropriate obesity prevention programs.

Rationale

In the current study, I examined the relationship between culture and behaviors. The intent was to evaluate how culture influenced health behaviors among overweight and obese African American women and how they perceived this relationship. The study investigated how culture has affected the participants' perceptions about obesity and

preventive health behaviors, their confidence in their ability to perform healthy behaviors, and their perceptions about social norms and social support regarding obesity and obesity prevention. Although I could have used Bandura's Social Cognitive theory to evaluate the norms, perceived barriers, perceived social support, and the reciprocal interaction among them that drive or discourage the performance of health behaviors, it would not have been practical to attempt to change the social norms of an entire metropolitan area, but rather educate utilizing the HBM (Kelder et al., 2015). The study followed the model to examine knowledge about obesity and obesity prevention and perceptions regarding risk, benefits and barriers of changing behaviors, and the expectations of those changes.

Similarly to how Mattei et al. (2016) assessed Puerto Ricans' knowledge of cardiovascular disease and their motivations and perceived barriers to performing preventive behaviors, this study used the HBM to guide the assessment of the knowledge and perceptions of overweight and obese African American women regarding obesity and obesity prevention. The study aimed to gain insight into the participants' perceptions of how their cultural experiences had influenced their knowledge, perceptions, and beliefs about obesity. Also, it looked at the role of the individuals' social-cultural experiences and observations in their health decisions. The HBM and its constructs aligned with this intent and provided an outline to proceed in acquiring the information. With this theoretical framework, this study demonstrated how these women made meaning of how their culture affected their behavior. The research also provides a foundation for the creation of culturally appropriate obesity prevention interventions to address the

prevalence of obesity-related diseases and health disparities facing the African American population of the Greater New Orleans area.

Literature Review

Perceptions of Body Image

According to some of the literature, African American women's perceptions of body image may contribute to the population's issues with obesity. Many found that African American women have more body satisfaction despite having higher rates of overweight and obesity than women of other racial groups (Allan et al., 1993; Ogden et al., 2014). In fact, many African American women whose BMI placed them outside of the healthy weight range described their weight as normal or healthy (Lynch & Kane, 2014; Pickett & Peters, 2017; Williams et al., 2013). The research has shown that social and cultural experiences have influenced African American women's perceptions of their body image. Some African American women suggested that there should be different standards for weight based on ethnicity or other bone structures. Many expressed their belief that African American women are naturally curvier and heavier (Grant, 2017; Talleyrand et al., 2017). Pickett and Peters (2017) found that the preference and satisfaction of an individual's significant other also influenced body image perception in their study of 150 African American women, ages 18-40. Talleyrand et al. (2017) also found peer influences and social norms positively and negatively impacted body image perception.

Media influences and a sort of rebellion against unattainable standards have also contributed to greater body image acceptance in African American women (Cameron et

al., 2018; Talleyrand et al. 2017). Cameron et al. (2018) found that women were uncomfortable with weight standards projected at them. They felt those standards were considered normal for Whites, and therefore oppressive since they were expected to conform. Women interviewed by Talleyrand et al. (2017) and Moyer (2018) pointed to media influences like the singer, Beyonce, who they believed promoted having a curvier figure and model, Ashley Graham, who they felt demonstrated confidence despite negative peer messages about her weight. However, others in the study by Talleyrand et al. (2017) described positive influences to be more fit, such as former First Lady Michelle Obama and some not-so-positive influences as those seemingly perfect bodies flaunted on plastic surgery television shows.

Knowledge, Perceived Susceptibility, and Perceived Severity

According to the HBM, individuals are more likely to participate in healthy behaviors if they believe that they are susceptible to a condition and believe that the condition's consequences are severe enough (Rimer & Brewer, 2015). The literature shows a conflict between African American women's perception of their weight and the weight classes as defined by health care providers. Pickett and Peters (2017) found that over 50% of overweight and obese women in their study described their weight as normal. Similarly, in Lynch and Kane (2014), 56% of the overweight and 40% of the obese women did not self-report their weight as overweight or obese, and 39% of men and women studied by Gustat et al. (2017) also underestimated their body size. These studies aligned with earlier findings, such as those found by Williams-York (2013), in their examination of the perceptions of college-aged African American women

concerning their body composition and health status. They found that 42% of overweight participants perceived their weight as normal, 40% of their total sample underestimated their weight, and 26% did not consider weight a health status indicator.

There are several possible explanations for the disconnect between their perception and the medically defined weight classifications. One possibility which suggests a cultural component may be African American women's attitudes towards "unrealistic standards" or as the participants in Cameron et al. (2018) study described as "White norms." Perception of body image may also factor in, as many of the women in the studies evaluated their weight based on how they saw themselves and how they felt in their clothes. For example, in assessing their participants' feelings about their weight, Woodruff et al. (2018) noted that many participants were comfortable with their weight. However, they felt like they should lose weight. They found that the women placed more value in how they felt physically and how it affected their day-to-day activities than in the numeric value of their weight. This emphasis on body image versus actual weight was also demonstrated among educated African American women who lost and maintained their weight loss (Barnes & Kimbro, 2012). For both women who regained their weight and those who maintained their weight, Barnes and Kimbro (2012) found that some reported purposefully regaining weight because they felt they had lost too much or looked too thin.

Perceptions and Attitudes about Behavioral Changes for Obesity and Chronic Disease Prevention

Obesity has been linked to chronic diseases such as heart disease, cancer, stroke, and type 2 diabetes (National Heart, Lung, and Blood Institute, 2013). These diseases are the leading causes of death in African Americans (Heron, 2018). Sheats et al. (2018) examined perceptions about healthy eating among African Americans in New Orleans, LA, and was the only recent study that had evaluated the construct in this specific population. They found that many of the participants believed that eating healthier led to better health outcomes; however, many found it difficult due to cost, time, and "cultural elements unique to African Americans and being a Louisiana or New Orleans native" (Sheats et al., 2018, p. S18). Similarly, the African American men from Georgia and South Carolina studied by Long et al. (2017) demonstrated an awareness of the benefits of behavioral changes, such as longer life expectancy. They discussed how Southern and African American cultures are barriers to following healthy eating recommendations. The researchers noted that the culture also influenced food traditions, habits, and how participants felt about illnesses. In another study, Sumlin and Brown (2017) found that African American women with type 2 diabetes struggled with their desire to eat culturally familiar foods and the need to make healthier food choices.

Many of the studies examining participants' perceptions regarding dietary and lifestyle changes demonstrated that participants had an awareness of the benefits of eating healthy. Still, many also believed that the barriers presented a significant challenge to performing healthy behaviors. Common barriers included cost and accessibility, but

many expressed that culture and tradition were also barriers to eating a more nutritious diet (Horowitz et al., 2004; Johnson et al., 2014; Long et al., 2017; Sheats et al., 2018; Sumlin & Brown, 2017). Some of the participants felt that adhering to a healthier diet would mean giving up their culture. For example, Sumlin and Brown (2017) documented the emotional connection that the women in their study had, not only to the traditional foods, but also the act of preparing the foods. Some of these women believed that it was in some way turning their backs on their history if they were to abandon their cultural cooking traditions. Some also felt that changing their dietary habits was difficult due to food's social position in their culture. The participants discussed events such as Sunday dinners and social events where many meet to gather around cultural foods that often go against healthier lifestyle recommendations (Horowitz et al., 2004; Sheats et al., 2018; Sumlin & Brown, 2017). The literature shows that African Americans understand the benefits of changing their behaviors but may refuse because of their emotional ties to the traditions around their cultural diets, including attending social gatherings and preparing the food.

Evaluating the Influence of Culture Using Qualitative Methodology

I chose to use qualitative methodology to evaluate the influence of culture from African American women's perspectives. Doing so would provide rich data on this complex topic and allow me to tell the participants' stories in their own words. A review of the literature demonstrated several approaches to gathering qualitative data. For instance, Cameron et al. (2018), Swierad et al. (2017), Talleyrand et al. (2016), and Woodruff et al. (2018) used semi-structured interview protocols to gather information on

the perceptions and experiences of their participants. Semi-structured interviews allow interviewers to guide the interview, address specific topics, and ask follow-up questions, while also providing the participants the ability to tell their stories (Cameron et al., 2018). Lopez et al. (2014) also performed individual semi-structured interviews. They were described as in-depth interviews and were chosen because of the more natural conversational style and ease in developing a rapport between the participant and interviewer.

Focus groups are another way to obtain rich data about the participants' experiences. The interviewers or facilitators in the following studies used semi-structured protocols to guide the discussion among group members in multiple sessions. For example, using focus groups, Long et al. (2017) gathered information to describe the attitudes, knowledge, and behaviors of African American men regarding their health. Sachs et al. (2017) used focused groups, which allowed them to examine African Americans' perceptions of health and the factors they believed influenced their health and Mattei et al. (2016) used focus groups to evaluate the perceptions and motivations of Puerto Ricans to perform preventive health behaviors. Lastly, Sheats et al. (2018) conducted focus groups of African Americans in New Orleans to determine the acceptability of a mobile intervention and describe healthy eating perceptions.

Although individual interviews and focus groups are common, there are many other approaches to qualitative research. For example, Sumlin and Brown (2017) sought to highlight the traditions and perceptions that influenced their participants' food practices using an ethnographic study design. Using this approach, the authors immersed

themselves into the participants' lives, observed their behavior, and conducted semi-structured, in-depth interviews. This method provided an additional source of data for their study. Another way to use multiple sources of data would be to utilize a multi-method design similar to the approach used by Antin and Hunt (2012). Their study considered the complexity of food choice and chose to evaluate the decision-making process from a multidimensional perspective using three different qualitative methods. In addition to conducting semi-structured interviews, the participants also participated in a listing and card sorting activity and a photo-elicitation activity (Antin & Hunt, 2012).

Quantitative methods have also been used when studying obesity and health behaviors in African Americans. Mastin et al. (2012) used both a survey and semi-structured interview protocol guided by the Social Cognitive Theory in their attempt to understand the perceived weight loss obstacles of African American women. Quantitative studies such as those performed by Lynch and Kane (2014), Pickett and Peters (2017), and Williams-York et al. (2013), all examined African American women's perceptions about weight and body image using cross-sectional surveys or questionnaires.

Analysis of Previous Approaches to Addressing the Health Behaviors of African Americans

In this study, I examined the influence of culture on health behaviors and attitudes. Although I could have investigated health behaviors with a quantitative study, a qualitative approach provides richer data. It allows for the attainment of a deeper understanding of the people performing the behaviors. For example, Pickett and Peters (2017) applied a cross-sectional design to examine African American women's beliefs

about their weight and its relationship to BMI. The authors were able to demonstrate what many of the women believed contributed to their excess weight and their perception of their body image. Still, they failed to give insight into how the women came to these beliefs or understand why and how other factors influenced those perceptions. For this reason, I used qualitative inquiry in this study to explain the participants' experiences from their perspectives.

Qualitative studies can be approached from many different philosophical and theoretical perspectives (Patton, 2015). Talleyrand et al. (2017) used a phenomenological approach to investigate the factors influencing eating behaviors, body norms, and perceptions of overall appearance in African American women. They sought to explore how the women's experiences influenced their behaviors and perceptions. The researchers conducted semi-structured interviews on a small sample of 11 African American women aged 25-59 years. They utilized consensual qualitative research methodology to collect and analyze the data, which allowed for a very reflective and trustworthy analysis. The researchers tested and modified their data collection tool with focus groups, addressed their personal biases throughout the study, and identified domain codes and core ideas after thorough discussion and consensus. Although the sample was diverse in economic status and age, the size could be perceived as a weakness. Despite this weakness, the authors conducted an in-depth study with an insightful view of the perceptions of their sample of African American women from the Washington metropolitan area.

Cameron et al. (2018) took a different approach and applied grounded theory in their research. In their qualitative study, the authors explored African American women's

lived experiences and how those experiences influenced their perceptions of attractiveness, body image, and health. The theory used, the Social Construction of Reality Theory, was appropriate as it aligned with the problem and the purpose of the study. They collected the data using semi-structured individual interviews of 11 African American women, ages 18-65, with varying backgrounds and careers. The researchers used principles of grounded theory with an iterative thematic analysis of the data. This approach was a strength, as it allowed for several themes to emerge about the women's experiences, attitudes, and perceptions about their health, body image, and barriers. However, the sampling method led to a very homogenous sample of mostly educated individuals, therefore excluding the ability to apply the findings to the general population of African American women.

Although a limiting factor of the previous study, homogenous samples are beneficial when conducting focus groups (Patton, 2015). In their study evaluating the perceptions of African American men and women in New Orleans about healthy eating and mobile health support, Sheats et al. (2018) used focus groups for their data collection. They recruited overweight and obese African Americans over the age of 30 from various places in the community. Four focus groups with 31 individuals were conducted with questions guided by the Theory of Planned Behavior and the Social Cognitive Theory. Patton (2015) stated that focus groups are usually made up of small groups of individuals with similar experiences and backgrounds. The make-up of the focus groups in this study, however, may have led to biased results. First, the groups consisted of both men and women, which may have influenced the individual responses. Also, according to the

authors, the participants were at varying stages in their health journey. There were very few male participants, and the participants' contributions were uneven across all focus groups. The study could have been more trustworthy if researchers used semi-structured individual interviews or formed more homogenous groups.

Sumlin and Brown (2017) used an ethnographic study to evaluate the day-to-day practices, behaviors, food choices, attitudes, and influences of African American women with type 2 diabetes. The authors conducted interviews and observations during grocery shopping trips, food preparation, and a church fellowship dinner. This approach allowed the authors to get a first-hand view of the participants' behaviors in their natural environments and obtain their personal stories about their own experiences. The authors took both a descriptive and ethnographic approach that provided data from the perspective of the participants. The sample included 20 African American women, ages 35-70, from local African American churches. Data collection included observation, informal and formal individual interviews, and data analysis began after the first session. The benefit of this approach was that the researchers were able to obtain rich cultural data and observations. However, as with qualitative studies, those observations are subject to individual biases of the interviewers and observers. In addition, ethnographic studies require a significant amount of time.

Justification of Concepts

In the current study, I used the constructs of the HBM to gain an n understanding of the health behaviors of the target population and evaluate how they made meaning of the relationship between their cultural influences, their beliefs, and their health behaviors.

Review of the literature provided evidence that perceptions of personal body image, weight, and health are connected to the assumed ambivalence in some overweight and obese African American women (Lynch & Kane, 2014; Pickett & Peters, 2017; & Williams-York et al., 2013). In addition, the diet and traditions attributed to African American culture consist of the consumption of large meals, especially in connection with social gatherings, of unhealthy foods which many times are fried, high in fat, heavily seasoned, overly sweet, and may also contain heavy starches, potatoes, pasta, and high-fat meats (Antin & Hunt, 2012; Bernstein et al., 2014; Sumlin & Brown, 2017; Swierad et al., 2017; Talleyrand et al., 2017). Several studies reported internal conflicts among African American women with health conditions to eat healthy because many still desired these traditional foods (Lopez et al., 2014). In the attempt to understand the influence of culture in the health behaviors of African American women in New Orleans, the factors such as the women's beliefs about health, obesity, and their behaviors, which have influenced the outcomes of similar populations, were justifiable and relevant concepts to be evaluated in the current study.

Review and Synthesis

In past investigations of obesity in African American men and women, several factors influenced the attitudes, beliefs, knowledge, and perceptions of their health behaviors. African American culture appeared to be an overarching theme that encompassed traditions, social norms, economic hardships, lack of adequate access to healthy food options, health care, education, and perceptions about body image, personal

health, and obesity. These constructs all seemed to connect in some way to the health behaviors that are associated with obesity.

Role of Traditional Food

Food appeared to play a significant role in the cultural traditions and daily lives of many of the African Americans in the studies reviewed. The type of food associated with the culture maintains symbolism in its historical roots of slavery and oppression but has become more representative of family connectedness, expressions of love, and respect for elders and ancestors (Sumlin & Brown, 2017; Swierad et al., 2017; Talleyrand et al., 2017). Many women expressed difficulty moving away from preparing and eating certain foods as they described a sense of obligation to pass on the traditions of their past to their children, the pride associated with others' enjoyment of their food, the pressure from family members to prepare traditional foods, and their connections to the familiarity of traditional foods (Bernstein et al., 2014; Swierad et al., 2017). Another common theme found was the emotional role that food played in the lives of many individuals. They described the food as comfort that provides enjoyment, as well as an antidote to anger, sadness, and stress (Antin & Hunt, 2012 & Talleyrand et al., 2017). This community's emotional and traditional ties to cultural foods demonstrate that the role of food in this population is one of significance and must be acknowledged in any attempt to encourage behavior change.

Perceptions of Body Image and Obesity

A common finding among the research was that obesity rates in African American women were related to their personal definitions of health and obesity. Many studies

demonstrated discrepancies between the medical definitions of "overweight" and "obese" and how overweight and obese African American women defined the terms (Lynch & Kane, 2014; Lopez et al., 2014; and Pickett & Peters, 2017). Also significant is African American women's increased likelihood to be more accepting of larger body sizes and having positive body images, despite being considered medically overweight or obese. Several studies demonstrated this acceptance, where most women who had BMIs that were deemed to be overweight or obese self-reported their weight as normal or healthy (Lynch & Kane, 2014; Pickett & Peters, 2017; and Williams-York et al., 2013).

The differences between medical weight standards and African American women's perception of weight could also result from cultural influences. According to African American women in several studies, African American cultural norms regarding body size are higher than mainstream standards (Cameron et al., 2018; James et al., 2012). Many women believed that African American women should not be measured by the same measure as White women. They suggested that the differences lied in each race's genetic predisposition. Some even felt that BMI was a tool for oppression and discrimination and referred to the weight standards as "white" or "European" standards.

Many women rejected what they described as "white" standards for a healthy weight and instead judged their weight based on physical attributes and comfort (Pickett & Peters, 2017; Woodruff et al., 2018). As for physical appearance, external factors such as cultural norms, male acceptance, and the media all influenced the women's perceptions of their body size. The women used terms such as "thick" to describe what they felt was slightly overweight and described the word "obese" as an offensive term and defined it as

someone who was "way out of control" or someone who "600lbs" (James et al., 2012; Lopez et al., 2014). For others, their level of comfort and physical ability were their measures of whether they were a healthy weight (Talleyrand et al., 2017; Woodruff et al., 2018).

Perceptions of Health and the Causes and Consequences of Obesity

In some studies, African Americans viewed health as a holistic entity, encompassing the mind, body, and spirituality (Cameron et al., 2018; Sachs et al., 2017). Some described health as their ability to perform daily tasks and admitted that daily stress due to poverty, crime, and violence negatively affected how they viewed their health. In some situations, perceptions of health and weight did not align. For example, some women self-reported their body weight as overweight, but also expressed their beliefs that their weight was both healthy and acceptable (Lopez et al., 2014; Woodruff et al., 2018). In one study, individuals believed that their race made them more susceptible to chronic disease and obesity (James et al., 2012). However, as in the study by Long et al. (2017), although the African American men participants believed that African Americans were more susceptible to hypertension and hyperlipidemia, they demonstrated low perceived susceptibility before their diagnosis.

Generally, many women had a fair understanding of the causes of their weight issues. Many cited unhealthy eating habits, such as eating foods high in fat and sugar and overeating, and lack of physical exercise as causes of their weight gain (Lopez et al., 2014; Pickett & Peters, 2017; Woodruff et al. 2018). However, one of the most common responses, and according to the women in one study, the primary contributor to their

weight struggle, was stress, worry, and disruption of their emotional well-being. Many attributed their poor eating habits to stress and their emotional state. Other causes believed to contribute to weight gain were pregnancy, family history, and the belief that African Americans are genetically susceptible to obesity.

The studies showed that African American women were generally aware of some of the health consequences of excess weight. Still, they mostly associated these consequences with what they viewed as extreme or morbid obesity. They demonstrated knowledge of the relationship between obesity and chronic conditions such as heart disease, high blood pressure, and diabetes. However, most cited physical concerns such as not fitting their clothes or the inability to stand for long periods due to excessive weight (Lopez et al., 2014; Pickett & Peters, 2017; Woodruff et al. 2018). Other consequences mentioned were lack of energy and inability to perform certain physical activities.

Perceptions of Barriers to Health and Weight Management

Across much of the literature, the most common barrier to health and maintaining a healthy weight perceived by African Americans was food. Many aspects of food as a barrier were addressed, but food from the African American cultural perspective was a significant issue among most of the samples studied. Many described their affinity for traditional cultural foods as a weakness or a struggle, as they understood the consequences of eating such foods, but had difficulty choosing healthier options over their favorite familiar dishes (Antin & Hunt, 2012; Bernstein et al., 2014; Cameron et al., 2018; Long et al., 2017; Lopez et al., 2014; Sheats et al., 2018; Sumlin & Brown, 2017;

Swierad et al., 2017). Also, some described pressure and influence from friends and family to eat or prepare unhealthy traditional dishes. Other barriers regarding food were affordability and access to healthy food options, lack of self-efficacy in shopping for and preparing healthy dishes, and overeating due to emotional stress (Antin & Hunt, 2012; Cameron et al., 2018; James et al., 2012; Kennedy et al., 2016; Mincey et al., 2017). Besides food as a barrier, other perceived barriers included income, access to affordable and quality care limitations, minimal access to credible health information, and lack of a trustworthy health system.

What Remains to Be Studied

In an attempt to create culturally appropriate interventions, numerous studies evaluated the health behaviors of African Americans and the external factors that influence those behaviors. The individuals studied ranged from children to the elderly, men and women, and those of average weight to those suffering from obesity. Behaviors as influenced by religion, segregation, social environments, income and education, and regional culture had all been explored. However, there was very little in the literature about the specific local culture of New Orleans, LA, and its influence on African Americans' health behaviors. Out of the recent literature evaluating the cultural influences on health behaviors, none of them specifically examined the sociocultural environment of New Orleans, LA, and its impact on its African American residents' attitudes, perceptions, and behaviors. The studies examining the behaviors and perceptions of African Americans living in New Orleans did not specifically explore the influence of their cultural environment. Studies like those conducted by Talleyrand et al. (2017) and

Antin and Hunt (2012) demonstrated the cultural relevance in African American women's perception of body image and food choice. However, the relevancy of New Orleans culture and African American culture concerning health behaviors was an area that had yet to be explored.

Summary and Conclusions

In examining obesity in the adult population of African Americans, culture appeared to have a significant influence on their perceptions and behaviors. Several themes were repeated throughout the literature, including perceptions of body size and body image, knowledge about obesity, prevention, and consequences, and barriers to behavioral changes. Among the themes and factors related to obesity in this population, culture was influential among most.

Earlier literature suggested that body satisfaction may contribute to the obesity rates in African Americans. There was a consensus among the literature that many overweight and obese African Americans underestimated their body sizes and perceived their weight as normal or slightly overweight. Many of the women studied had positive body image perceptions despite mainstream views of normal or acceptable. Their perceptions could be attributed to sociocultural factors such as social norms, peer acceptance, and rejection of mainstream ideals.

For many African Americans studied, personal and social normative beliefs often skewed the knowledge of obesity. According to medical standards, many misidentified what is considered overweight and obese, and some believed the standards are biased. However, although their personal weight definitions differed from the standard

definitions, many understood the health consequences of excess weight. And though they knew that behavioral changes needed to occur, they admitted that barriers often prohibited or hindered them from making those changes. Common barriers included lack of education, access, and affordability; their attachment to cultural traditions and food; the impact of depression, anxiety, and stress; and peer influences and lack of social support.

The literature demonstrated how African American culture influences the perceptions, beliefs, and behaviors regarding obesity in African American men and women of different ages, socioeconomic statuses, and other geographic areas. The city of New Orleans, LA, and its surrounding parishes share a unique culture that differs significantly from the rest of the country. In addition to the influence of African American culture on the health behaviors of African Americans in the GNO, these unique cultural traditions and beliefs practiced and celebrated must also be considered when exploring the problem of obesity in this specific population. There had been studies examining perceptions regarding obesity among this population. However, there have been no studies that specifically addressed the influence of the area's unique culture and African American culture on the problem of obesity in its African American residents. The current study identified some of the cultural traditions celebrated by African Americans in the GNO and examined African American women's perceptions of how their culture influenced their health behaviors and their knowledge and perceptions about obesity. This study also describes how they viewed mainstream obesity definitions and

recommendations for weight management and obesity prevention in relation to their own lived experiences and cultural beliefs.

I used a qualitative methodology to explain the GNO culture and its influence. The approach allowed me to explore culture and obesity from the perspectives of the group with the highest national obesity prevalence (Hales et al., 2017). This methodology provided rich data that will inform the development of culturally appropriate obesity prevention interventions for this population. Doing so will help address the health disparities suffered by those in the GNO and provide a template for examining other sub-cultures of the United States.

Chapter 3: Research Method

Introduction

This study aimed to understand how culture influences health behaviors of overweight and obese African American women living in the GNO. In this chapter, I describe the research design and explain the rationale for the design. I also define my role and explain the different layers of that role within this study. I also describe methods used to complete this study. This is followed by an explanation of my plan to address issues of trustworthiness, and the chapter ends with the ethical procedures used within the study.

Research Design and Rationale

Research Questions

RQ1: What are the perceptions of overweight and obese African American women in the GNO regarding the role that regional and ethnic culture plays in the prevalence of obesity and obesity-related illnesses in their population?

RQ2: How do the cultural experiences of overweight and obese African American women in the GNO influence their knowledge, attitudes, and perceptions of obesity and obesity-related conditions?

Phenomenon

This study's central phenomenon is the health beliefs of overweight and obese African American women in the GNO regarding obesity and the cultural experiences that inform them. According to Matsumoto (1996), culture is a collection of shared attitudes, beliefs, behaviors, and values of a group of people that pass from one generation to the next. Although shared, these aspects of culture are unique to each individual and can

impact individual health behaviors. Cultural experiences in this study included upbringing and family life, traditions, social norms, social interactions, and exposure to other external factors. Prior studies have explored the influences of ethnic culture of African Americans on health behaviors, and although the two may overlap, this study also examined the local culture of New Orleans, LA and how it informs the attitudes, perceptions, beliefs, and ultimately behaviors of overweight and obese African American women.

Qualitative Research Tradition and Rationale

I chose to apply qualitative research methods to gain insight into the lived experiences and perceptions of overweight and obese African American women living in the GNO. I aimed to understand how ethnic culture and the culture of New Orleans influenced attitudes, beliefs, and behaviors that contributed to health behaviors of these women. Unlike quantitative research, qualitative studies allow the collection of rich data, including real stories of real experiences, to explore the unique perspectives of the study participants (Ravitch & Carl, 2016). Numerical data, which could help demonstrate the problem and justify its examination, cannot describe the phenomenon or the people experiencing it.

Among the recent literature addressing the public health problems of obesity and chronic disease in the African American population, several studies have explored culture as a factor in the behaviors that contribute to these health problems. According to the HBM, an individual's beliefs and perceptions involving health matters can explain and predict their health behaviors (Glanz et al., 2015). Culture, which can include shared

ideals, values, and traditions, can influence individuals' beliefs and perceptions, as it provides a lens through which the individuals view the world around them (Spencer-Oatey, 2012). In this study, I explored the study participants' culture and examined how it influenced their beliefs and perceptions. Also, I gained insight into how they understood the relationship between their culture and their health behaviors. Conducting a qualitative study with a phenomenological approach allowed me to describe the participants' lived experiences and perceptions from their unique perspectives (Davidsen, 2013). An ethnographic approach could have been used to understand and explain this culture. However, approaching this from a phenomenological perspective allowed me to explain the participants' experiences within their culture and describe how they understood, viewed, and found meaning in how their culture influenced their beliefs and perceptions about health matters (Creswell, 2007).

Role of the Researcher

My role in this study was as an observer-participant. With an ontological assumption, in my role as a researcher, I reported the subjective realities of the participants through the lens of social constructivism (Creswell, 2007). I collected data through in-depth interviews in the participants' natural environments. I also planned to observe their behavior within their natural environment and any changes in behavior that may have occurred due to social interactions.

The researcher's role when using a phenomenological approach is first to identify his or her own personal experiences and beliefs, then differentiate, understand, and provide an accurate description and interpretation of the participants' experience

involving the phenomenon (Creswell, 2007). My biases, beliefs, and experiences were addressed and noted before data collection began, throughout the data collection process, and during data analysis. There were no projected ethical issues relating to my role as a researcher in this study.

Methodology

Participation Selection

I used a purposeful sampling strategy to gain a sample of participants who had experience and knowledge regarding the phenomenon. With this type of sampling, I had the opportunity to gain rich data from participants who were capable and willing to share information and insight on the phenomenon (Moser & Korstiens, 2018). Although this type of sampling may not be preferred in broad populations due to the possibility of drawing unjustifiable generalizations, researchers can justify its use in target populations defined by location, gender, and ethnicity, such as the current study (Robinson, 2014). A random sample does not provide the homogeneity necessary for a phenomenological study. Instead, purposive sampling was used to ensure the findings remain in the context of the defined population.

This study utilized criterion sampling, which ensured the participants had experienced the phenomenon and could provide rich and insightful data (Moser & Korstiens, 2018). Criterion sampling is used in phenomenological studies because it allows researchers to choose participants who know the phenomenon and have their own individual lived experiences within the context of their shared experiences. The study's sample was taken from a population that includes overweight and obese African

American women who were at least 18 years of age and living in the GNO. Participants' weight and height were self-reported, and overweight and obese individuals were identified based on BMI standards, excluding those with a BMI of less than 25 (CDC, 2018). Women who self-identified as African American, Black, or Creole Black were included. Age criteria eligibility was determined using self-reported age. And to maintain the richness of the cultural component of the study, I limited inclusion to individuals who were native to and currently living in the GNO. I defined native as an individual born in the GNO to native parents and had spent over half of their childhood years in the GNO or were born elsewhere to native parents but spent over half of their childhood in the area.

I sourced the sample through a combination of advertising and snowball sampling. To advertise, I posted flyers digitally on Facebook. Promoting through churches and other organizations would have required communication with a gatekeeper, such as a pastor or a member of leadership (Robinson, 2014). If a trustful relationship had been established, the gatekeeper could have assisted in the recruiting efforts by identifying potential participants and encouraging participation. Due to the weight criteria's sensitive nature, which limited the response to advertisements, I also used snowball sampling. Robinson (2014) suggested that this method could be used in place of advertising when there is a fear of stigmatization among potential participants. However, in this study, the strategy was used as needed throughout the sampling process.

Since qualitative studies aim to explain or illuminate specific information rather than generalize, samples are generally small in size (Creswell, 2007). Robinson (2014) recommended that sample sizes be small enough to ensure each participant has a voice

and that a thorough analysis can be performed on each case. For qualitative studies, the sample size is determined by data saturation, which is the point where no new information about the phenomenon can be gathered (Moser & Korstiens, 2018). The appropriate size will vary depending on the research question, the phenomenon, the data collection method, the heterogeneity of the participants, and the richness of data collected and can range from 3 to 16 participants. However, according to Moser & Korstiens (2018), phenomenological studies should not require samples larger than 10 participants. Before data collection, I estimated the sample size to fall in the range of 8 to 10 participants. However, I reached data saturation at 12 participants.

Instrumentation

For the current study, I conducted semi-structured interviews to gain further insight into the participants' individual experiences related to the phenomenon. In-depth semi-structured interviews are the most common data collection method used in qualitative research (Smith, 2017). This type of interview is conversational, with the interviewer asking questions and following up the participants' responses with questions that gain clarification or further insight (Morris, 2015). Although very natural and free-flowing, the interviewer directs the conversation while still allowing them to speak freely and tell their own story. Conducting in-person, face to face interviews are ideal; however, if necessary, interviewing by telephone, videophone, or email can also be done. Unfortunately, those methods can limit the amount of non-verbal communication to be observed and interpreted (Oltmann, 2016).

The instruments used for data collection in the current study included a demographic questionnaire (see Appendix B), an interview guide (see Appendix C), a digital recorder, a laptop with a camera or mobile phone, a video-conferencing application, and a journal. I performed interpretive phenomenological analysis (IPA) on the data collected. IPA focuses on the meaning of the participants' experiences. The instruments allowed me to capture those experiences in a descriptive format, which helped me understand how they understood their experiences. The participants completed the demographic questionnaire before the individual interviews. The data collected from the questionnaire provided details on both the similarities and differences among the sample regarding age, body composition, and socioeconomic status, which helped contextualize the remainder of the data.

The interview guide included a list of open-ended questions designed to elicit responses that would provide the rich data needed to answer the research questions. I conducted the interviews by telephone and video conferencing with a semi-structured approach. Questions were guided by the HBM and focused on the participants' knowledge and perceptions of their personal experience of the phenomenon. The first half of the interview guide focused on the participants' knowledge and perception of obesity and obesity-related conditions and their perception of their personal risk and susceptibility to experiencing obesity-related consequences. The second half of the interview included questions that elicited responses that provided insight into their cultural experience and how they believed it influenced how they understood the phenomenon.

The other instruments were used to facilitate and record the interviews. Due to circumstances limiting social contact, I conducted the interviews by telephone or using a video-conferencing application that could be utilized with a smartphone or computer. I used a digital recorder to record the interviews for the creation of interview transcripts. Lastly, I recorded observations, notes, and personal reflective notes in a journal.

Researcher-Developed Instrument

The demographic questionnaire (see Appendix B) and interview guide (see Appendix C) were designed to elicit responses to sufficiently answer the research questions. The demographic questionnaire included closed-ended questions that provided necessary demographic information about the participants' age, body composition, and socioeconomic status. However, the interview guide had a list of open-ended questions designed to encourage the participants to tell their stories of their personal experiences. I divided the interview questions into two sections. The HBM guided the first section, which assessed the participants' knowledge and beliefs about the problem. Those questions linked together to answer the third research question, which inquired about their perceptions regarding the clinical definition of obesity in relation to their own personal beliefs. The second group of questions helped identify the cultural traditions and beliefs that played a role in the participants' lifestyle choices and understand the participants' perception of this relationship and how they made meaning of it in their lives. This section answered the first and second research questions by examining the participants' experiences within their culture and providing the data to interpret how they made sense of those experiences. The questions were guided by and aligned with the

study's purpose, the research questions, the theoretical framework, and the phenomenological approach of the study. I grouped the interview questions so that my examination of the phenomenon would emphasize the participants' cultural experiences and their understanding of those experiences.

I tested the validity of the interview questions in two ways. First, they were reviewed by my dissertation committee, which included a content expert and a methodology expert, for alignment with the study's purpose, theoretical framework, and design and the ability of the instrument to elicit rich and meaningful data. I also pretested the interview questions. Pretesting involves administering the interview protocol to a small group of individuals similar to the sample population (Hurst, 2015). This process supports the iterative process of qualitative research in that it allows the researcher to identify and correct issues during the design phase. Ruel et al. (2015) encouraged pretesting on family, friends, and colleagues and suggested that the individuals pretested fit the sample population's cultural and demographic profile. I pretested the guide on my friends, coworkers, and family members who matched the inclusion criteria, which required that potential participants be an overweight or obese woman, African American, and a native resident of the GNO. Pretesting allowed me to evaluate the guide for content validity and the language, wording, and arrangement of the interview questions.

Procedures for Recruitment, Participation, and Data Collection

Participants were recruited using the snowball technique and through advertisement on social media (see Appendix D). During recruitment, I asked that individuals interested in participating in the study contact me by phone or email. The

information from the interest form (see Appendix A), including their age, ethnicity, height, weight, place of residence, length of time they have lived in the GNO, and contact information, was collected by telephone or email correspondence. Once I identified volunteers who met the study's criteria, I explained the data collection plan to them. The plan included the completion of a demographic questionnaire and at least one in-depth semi-structured interview. After I attained verbal informed consent from a volunteer, I scheduled their interview. I then sent them an email containing the informed consent and demographic forms (see Appendix B), which were to be completed and returned by email before the interview.

When scheduling the interviews, I provided the participants with information and instructions for their participation in the data collection process. I informed them that the session's estimated duration would be approximately 1-2 hours and asked that they find a quiet place for their interview to avoid interruptions. At the start of each interview, I reviewed the data collection process again and provided an opportunity for the participant to ask questions. I also obtained consent to audio record and take notes during the interview. Each participant was debriefed after the interview and was again given the opportunity to ask questions. Debriefing included asking the participants if they experienced any negative feelings due to the topics discussed or the interview process itself. I informed them that if needed, mental health resources were available. I provided each participant with my contact information and encouraged them to contact me if they had any questions or concerns later. I confirmed their contact information, including their email addresses, to send their interview transcripts to them for review. I also informed

them that I may contact them for a follow-up interview if I should need clarification and that they may also request a follow-up if they felt the need to clarify something after reviewing the transcript. Lastly, I asked the participants if they would be available to review the findings and interpretation of the data for accuracy.

Data Analysis Plan

This qualitative study aimed to provide meaning to the quantitative data concerning obesity in the GNO. Unlike quantitative research, which uses objective methods to produce numerical data, qualitative research is subjective, using the researcher as an instrument (Pathak et al., 2013). In this study, I collected the data and interpreted the findings utilizing IPA. IPA varies from the traditional phenomenological approach or descriptive phenomenology, as it goes beyond only describing lived experiences. My role in IPA is one of an interpreter who seeks to make sense of how the participants find meaning in their experiences.

IPA is influenced by the hermeneutic phenomenology of Martin Heidegger, which differs from the ontological and epistemological perspectives of traditional phenomenology (Laverty, 2003). Heidegger believed that reality is determined by our understanding of the world, which is based on the knowledge provided by our background and culture. Where phenomenology acknowledges the researcher's perceptions, beliefs, and biases but requires that researcher bracket them to view others' experiences without influence, IPA follows Heidegger's school of thought that it is impossible for the researcher to step in and out of their own understanding. In IPA, the researcher's preconceptions, beliefs, and biases are not to be put aside, but instead, it is

valued as providing an insider point of view that enriches the interpretation (Fade, 2004; Peat et al., 2019).

The data analysis followed the idiographic case study approach, as described by Fade (2004) and Peat, Rodriguez, and Smith (2019), which began with an in-depth exploration of the first case. Within 48 to 72 hours of data collection, I transcribed the interviews verbatim. I inserted the non-verbal communication that was observed and documented during the interviews into the transcription. I then uploaded the transcripts to Dedoose, a qualitative data analysis software (QDAS) program. I utilized the QDAS to store and organize the data and to assist in data analysis.

Once the transcript was completed and uploaded, the analysis of the data began. The transcript was read to completion several times until I felt that I had connected with the data. I noted any thoughts or observations along the document's margins and highlighted and coded statements, similar ideas, or patterns. I then analyzed the coded data for emergent themes. As I found connections among the themes, I grouped them into meaningful clusters and established overarching themes and sub-themes (Peat et al., 2019). Once I completed my analysis, I set the themes aside and repeated the process for the next case.

As I analyzed each case, I began to look for patterns across them. Once I reached the point of data saturation and analysis of all the cases, as suggested by Fade (2004), I reviewed the previous cases to see if I had missed, in my first analysis, any themes had that emerged in later cases. From there, I organized the themes into super-ordinate themes and sub-themes. I then began to incorporate theory in the exploration of the data

and further analysis of the themes. Lastly, using the original research questions, theoretical constructs, and the analyzed data, I formulated a narrative summary and interpretation of the findings that included the participants' stories and pertinent quotes.

Issues of Trustworthiness

Until the 1980s, the rigor of qualitative studies was measured using the same methods in which quantitative studies were evaluated: internal validity, external validity, reliability, and objectivity. This scientific approach led to increased flexibility in the standards by which rigor was measured in naturalistic studies, thereby threatening qualitative research's trustworthiness. Lincoln and Guba introduced criteria that qualitative researchers use today, which parallel the quantitative measures and provide a method to maintain rigorous standards within qualitative research.

Credibility

Credibility, which is the qualitative measure of internal validity, measures the value of truth in the findings of qualitative research (Krefting, 1991). In the current study, I planned to utilize several strategies to establish credibility. First, I planned to collect the data using several methods, including in-person, semi-structured in-depth interviews, participant observation, and unstructured interviews. This method, which is called triangulation, allows for different versions of the truth to emerge, providing a more comprehensive picture of the participants' reality (Patton, 1999). However, due to circumstances discussed in Chapter 4, I was unable to perform in-person interviews, observation, and unstructured interviews. In my attempt to maintain credibility under the

circumstances, I cross-checked data collected during remote in-depth interviews with online sources to confirm specific events and traditions discussed.

The second strategy used was performing member checks. I provided each participant the opportunity to review their interview transcript to ensure accuracy and to verify that I conveyed their story as intended. In addition, I asked some participants to examine the interpretation of the data. Kortsjens & Moser (2018) provided an example of a qualitative study performed by primary care researchers that used member checking. In their study, the researchers provided participants with transcripts. They also held a meeting to allow the participants to review the interpretations and provide feedback regarding accuracy and validity. Not only can this method be used in the data collection and analysis stages, Lincoln and Guba (1986) suggested that the final report also be formally tested by a sample of the participants.

Lastly, the final strategies planned to ensure the research's credibility were prolonged engagement and persistent observation. Although this is a phenomenological study, I planned to use an ethnographic approach in the data collection to better understand the participants' culture and how it influenced their perceptions and behaviors. Prolonged engagement in the field would have allotted more time to gain the participants' trust, which, along with persistent observation, would have aided in gathering rich, thick data (Maggs-Rapport, 2000; Morse, 2015). However, as stated previously, social distancing restrictions prohibited prolonged engagement and persistent observation.

Transferability

In quantitative studies, researchers evaluate the findings for external validity or generalizability, which is the ability of the study's findings and conclusions to be applied to another population or setting other than the one studied (Lincoln & Guba, 1986; Morse, 2005). Because the current research examined a unique community, generalizability was not part of the expected outcome. Instead, transferability, which is the qualitative measure of external validity, is obtained when researchers can apply the emerging concepts from the current study to other unique populations (Morse, 2005). To obtain transferability, I collected thick data and provided rich descriptions of the context surrounding the data, which will allow judgments and comparisons to be made by those who seek its application (Lincoln & Guba, 1986).

Dependability

A quantitative study is reliable if it meets the standards for stability and consistency (Krefting, 1991). Reliability demonstrates the study's ability to be replicated with the same results. However, the criterion of reliability relies on assuming that there is only one truth, which is not applicable in qualitative studies, which assumes there are multiple realities. Since there is expected variability in truth, consistency is instead viewed using the concept of dependability. The current study utilized an audit trail to maintain dependability. Shenton (2004) recommends that the researcher documents, in great detail, to allow future researchers to repeat the study.

Confirmability

Confirmability demonstrates that a study's findings truly reflect the participants' experiences (Shenton, 2004). To ensure that the findings and conclusions are credible, the researcher must confirm them. I achieved confirmation by using multiple data collection methods, completing member checks, and by maintaining reflexivity.

Ethical Procedures

In the current study, I addressed ethical concerns by following the guidelines set forth by Walden University's Institutional Review Board (IRB). Due to the innately personal nature of qualitative studies, it was vital that I maintained high ethical standards from the design stage to the reporting stage (Sanjara et al., 2014). The procedures followed during the data collection and reporting processes considered ethical concerns, such as informed consent and confidentiality. Also, following data analysis, procedures were followed, ensuring both credibility and informed consent.

I approached recruitment and data collection within this marginalized community of African Americans with careful consideration of its past regarding ethical failures in previous research studies. I ensured that while recruiting, collecting data, and reporting findings, informed consent remained a priority. This process included ensuring that potential and current participants were informed of the study's purpose, the procedures, the possible risks and benefits of participating, and their rights involving their participation (Nijhawan et al., 2013). They were also informed of the procedures to maintain confidentiality, including safe storing of data and removing personally identifiable information from all data. To ensure that all participants understood the

guidelines regarding their voluntary participation in the study, I asked them to sign a document verifying their informed consent.

Once data were collected and transcribed, I provided the participants with the opportunity to review interview transcripts and suggest changes as needed. Also, some participants agreed to review the final report for accuracy. I reminded the participants that their participation was voluntary and they could withdraw consent at any time.

Summary

I used a qualitative phenomenological design to gain an understanding of how both ethnic culture and the culture of the GNO influenced attitudes, perceptions, and behaviors of overweight and obese African American women who had spent the majority of their lives in the area. I interviewed the participants individually using a semi-structured in-depth interview guide. I then transcribed the data and analyzed it with the assistance of qualitative data analysis software. I used IPA to analyze data, which allowed me to interpret how the participants made sense of their cultural experiences as well as how they perceived those experiences influenced their attitudes, perceptions, and behaviors.

Chapter 4: Results

Introduction

The purpose of this study was to gain an understanding of how African American and New Orleans cultures influenced knowledge, perceptions, and health behaviors of overweight and obese African American women. Through IPA, the lived experiences of 12 participants and how they made sense of those experiences were explained in order to determine what their perceptions were about the role their culture played in the prevalence of obesity and obesity-related illnesses in their population, as well as how those experiences influenced their knowledge, attitudes, and perceptions about obesity and obesity-related conditions. In this chapter, data collection, data analysis, and the steps followed to ensure trustworthiness are explained, followed by a report of the results. The findings which are organized by theoretical themes, include narrative accounts of the unique lived experiences of the participants in relation to the phenomena of interest. These accounts are then summarized further to respond to the research questions.

Setting

The setting of this study was the city of New Orleans and its surrounding 10 parishes, which is known as the GNO. Near the start of my data collection, the city, country, and most of the world were affected by the COVID-19 pandemic. New Orleans became one of the nation's hotspots for the virus (Yang & Nalty, 2020). The city and a few of its surrounding parishes led the state in the number of cases and deaths.

Due to rising numbers of COVID-19 cases, social distancing recommendations were made by state and national governments. The city of New Orleans began cancelling

all public gatherings, including concerts, festivals, and conferences, as well as closing public entertainment venues, parks, schools, and many other businesses. This influenced the participants' experiences around the time of data collection. Prior to starting my data collection, my methods were modified in order to comply with the social distancing recommendations. Instead of performing face-to-face interviews and conducting observations, interviews were conducted via telephone or video conferencing. In addition, during interviews, when asked about cultural activities, the participants were asked to answer in terms of pre-COVID-19 conditions.

Demographics

The population in this study were African American women native to and living in the GNO. The inclusion criteria for the study required the participants be at least 18 years old, identify as Black or African American, and be overweight or obese. The final sample contained 12 participants between the ages of 30-50 years old. Weight classification was made by calculating the participants' BMI, using their self-reported weight and height. BMI is used to categorize a person's weight to determine if they are underweight, normal weight, overweight, or obese (CDC, 2020). The participants' BMIs were calculated using the CDC's Adult BMI Calculator. Based on their BMI, all participants were classified as obese and had a BMI of 30 or greater, and half were considered severely obese, with a BMI of 40 or greater. The lowest BMI calculated was 31.8, and the highest was 54.7.

The participants were of varying socioeconomic statuses. Most participants self-identified as middle class, two identified as upper middle class, one as lower middle

class, and two as below middle class. They also had diverse educational backgrounds. All participants admitted to education or training beyond high school. The highest level of education attained ranged from trade school to the doctorate level. They had occupations in various fields including hospitality, sales, administration, community development, and healthcare. Five were married, four were divorced, and three were single. Participant demographics appear in Table 1.

Table 1

Participant Demographics

Name	*Age*	*BMI*	*Weight Classification*	*Income*	*Education*	*Occupation*	*Marital status*
Denise	40's	31.8	Obese	UMC	Doctorate	Medical	Divorced
Alicia	30's	40.5	Severely Obese	MC	Bachelor's	Self-employed	Married
Trenice	30's	45.3	Severely Obese	BMC	Associate	Sales	Single
Michelle	30's	45.5	Severely Obese	LMC	Bachelor's	Community	Divorced
Stacy	40's	35.6	Obese	BMC	Bachelor's	Administration	Divorced
Donna	50's	39.9	Obese	UMC	Associate	Self-employed	Married
Keisha	30's	37.8	Obese	MC	Associate	Self-employed	Married
Alana	40's	42.7	Severely Obese	MC	Master's	Medical	Single
Latanya	40's	39.1	Obese	MC	Associate	Administration	Married
Jackie	40's	54.7	Severely Obese	MC	Master's	Administration	Divorced
Temika	30's	36.8	Obese	MC	Bachelor's	Hospitality	Single
Melissa	40's	48.1	Severely Obese	MC	Trade school	Hospitality	Married

Note. Income classifications are abbreviated as follows: below middle class (BMC), lower middle class (LMC), middle class (MC), and upper middle class (UMC).

Data Collection

Data in this study were collected from the participants using demographic forms (see Appendix B) and semi-structured interviews. The interview guide (see Appendix C) was structured to follow the aim of interpretive phenomenological analysis (IPA), which is to elicit the participants' perspectives and personal accounts of their lived experiences (Peat et al., 2019). I tested the guide by interviewing friends, family, and coworkers who fit the description of the population of interest. The test participants provided feedback

regarding the wording of questions, and questions were then modified and reevaluated with the same as well as new test participants. Demographic forms were emailed to sample participants to be completed prior to interviews and were submitted via email. The forms included participants' age, self-reported weight and height, race, occupation, highest level of education attained, income class, and marital status (see Table 1).

The initial data collection plan had to be modified due to the COVID-19 pandemic, which led to social distancing mandates and recommendations. Modifications were made to recruitment, which was completed by advertising on social media (see Appendix D) and using the snowball technique. Instead of in-person interviews, interviews were conducted via telephone and videoconferencing. In addition, observations that were planned were replaced with questions that were added to the interview guide. The additional questions were intended to elicit information that could have been gathered during observation.

Data in this study were collected from 12 participants. Prior to the interviews, the data collection process was explained to each participant by telephone and an informed consent form, demographic form, and interview instructions (see Appendix E) were sent via email at the end of the call. Each participant returned the consent and demographic forms via email prior to their interviews. Informed consent was addressed again at the start of each interview, which included reiterating the data collection procedures, informing the participants of their ability to opt out of the interview at any time, and providing them with the opportunity to ask questions. Ten participants were interviewed using Zoom, a video teleconferencing tool, and the remaining participants were

interviewed via phone. Interviews were conducted over 10 weeks, with most occurring every 5 to 7 days, with the exception of a 19-day gap between the ninth and 10th interviews. The average time of the interviews was 46 minutes. Each interview was audio-recorded using a digital recorder, and the audio files were uploaded to my personal computer. These audio files were then uploaded to NVivo Transcription, an online service that provides automated transcription assistance, where they were stored in a cloud-based storage and transcribed. The files were all transcribed within 48 hours of each interview for analysis. Due to the accents and dialects of the participants, NVivo was unable to correctly transcribe most of the interviews, but was useful in providing formatting for the transcripts.

Each participant was debriefed at the end of their interview. I provided them with my contact information and instructed them to contact me if they had any questions or concerns. I also asked their permission to contact them if I had any questions or to request feedback on my findings and each of the participants agreed. I informed each participant that I would be transcribing their interviews and asked if they would like a transcript of the interview. After the transcripts were completed, they were sent to the participants who were interested in having a copy of their interview transcript.

Data Analysis

In this study, I used Interpretive IPA to analyze the data. I was constantly aware of my own attitudes, beliefs and experiences in order to enrich my interpretation of how the participants made sense of their experiences. I documented my own reflective thoughts throughout the data collection and analysis process, which was used as I

interpreted the findings. I began by following the idiographic case study approach, but with each case I took note of the patterns and similarities between the cases while also building a code list.

Data were analyzed with the assistance of a qualitative data analysis application. First, the transcripts were transcribed with the assistance of NVivo. The notes that were taken during the interview, which included pertinent observations and reflexive thoughts, were added to the appropriate places on each transcript. The transcripts were printed and saved to a folder on my computer with new pseudo names for each participant. Once the hard copies of the transcripts were read over and any needed corrections were made, they were uploaded to Dedoose.

Case Study Approach

After transcribing each interview, I printed the transcript and began the coding process. I read it in its entirety while also listening to the audio recording of the interview. During the first read, as I read through the participants' responses, I wrote observations and reflexive notes in the margins. I then uploaded the transcript to Dedoose and attached it to the participants' demographic information. During the second and third times reading through the transcript, I highlighted important phrases, added codes and made notes about the significance of phrases. Some phrases were coded with multiple codes. For instance, a participant discussing how she felt about her weight and her disagreement with medical weight standards, was coded with "attitude about weight" and "disagrees with weight standards." As themes emerged, some of the codes were grouped and some subgroups were created. As seen in Table 2, "attitude about weight," "desired

weight or size," "perceived severity," and "perception of smaller sizes" were all grouped together under "attitudes and beliefs about weight." At the completion of each case, a short narrative was written describing the participant and a summary of how they experienced the phenomenon. With each case, I followed the same procedures for reading and coding the data. Each time, there were new perspectives and new codes added, however, many of the themes began to repeat themselves and patterns began to emerge among the cases. As patterns emerged, I began to rename, regroup and recategorize codes and themes as each case brought new or similar perspectives with different circumstances or ideas.

Table 2

Examples of Themes, Codes, and Excerpts

Themes and Codes	***Excerpt Examples***
Attitudes and beliefs about weight	
• *Attitude about personal weight*	*"On record, on paper, I would be considered obese. Me, I consider myself to be overweight but not obese. I think an obese person is someone who may have problems walking at a normal pace."*
• *Desired weight or size*	*"Honestly, I don't have a desired weight. I just look good in my clothes and be comfortable."*
• *Perceived severity*	*"I would definitely define my weight as obese and definitely not a safe weight."*
• *Perception of smaller sizes*	*"Ain't nobody worried about looking like a stick. I know I'm not. I don't want to look like no stick."*
Barriers to behavior change	
• *Bad food makes us feel good*	*"It makes us it makes us happy. Louisiana in general is known for their food. And I see food as, culturally, for me is like a gathering*

(table continues)

	mechanism, like cookouts and people come. And you see good times, happiness, parties. It just makes people happy."
• *Lack of organization/planning*	*"I'm not very organized. So even planning meals ahead of time or meal planning things like that, it just it just doesn't work to me."*
• *Healthy food is expensive*	*"Yeah! Of course! Healthier food is more expensive. And the bad foods is more readily available for us. Like we can get it like nothing. Like a burger costs a dollar but a salad cost six. So, you do the math. If you don't have enough money, you have six kids that's hungry. We don't have X amount dollars X, Y, Z, but we can afford six dollar-burgers. You know what I'm saying? So, yeah, the cost is a problem.*

Identifying Patterns and Data Exploration

With each new case, patterns in the data began to emerge. By the 12th case, I noted that no new data had emerged from the interview and that I had reached data saturation. I then began to read over the cases again, exploring the similarities and differences, and identifying the patterns. I then renamed, regrouped, and recategorized many of the codes, sub-codes, and themes, which included a total of 738 excerpts. The themes elicited aligned with the interview questions and began to create the meaningful data needed to answer the research questions, so I grouped them as such (Table 2). I then began to explore the data excerpts from the perspective of theory and the purpose of the study. Although the last grouping included some theoretical concepts, after exploring the data further, I regrouped the data again categorizing the themes under overarching themes that were based on the research questions and the constructs of the study's theoretical framework (see Table 3). Lastly, an additional theme was added, which included excerpts

about the participants' perception about the influence of their cultural experiences on their current behaviors.

Table 3

Final Grouping of Themes and Subthemes Using Theoretical Framework

HBM Constructs/Themes	Sub-Themes	Codes
Background – Modifying Factors • Sociopsychological Variables		
	• Food Culture: It's just this is what we do	• Food is everywhere • Cultural dishes • Highly seasoned/flavored • Unhealthy preparations • The Holy Trinity • Pickled meat • Starch on top of Starch
	• Food Culture: Day to day food traditions	• Red bean Monday • Seafood Fridays • Spaghetti/Lasagna
	• Food Culture: Holidays and Seasonal food	• Lent – Seafood on Fridays • Crawfish season • Mardi Gras – King Cake • Christmas and Thanksgiving
	• Food Culture: Gatherings	• Always includes food • Impromptu gatherings • "Boil" • Potluck: Who bought the potato salad?
	• Food Culture: There's a festival for everything	• Festivals are year-round • Food Vendors • Jazz Fest • Crawfish Monica
	• Cultural Attitudes About Food	• Let's go feast • I love to eat • Food brings families together • Cooking is an expression of love • Food is a priority • An obligation to eat • Clean your plate • We take food seriously

(table continues)

	• Cultural Attitudes About Health	• Lack of concern • Lack of knowledge • Lack of trust • Denial • Not taking it seriously • Health isn't important until it is • COVID-19

	• Cultural Attitudes About Weight	• Overlooked or accepted
		• Cultural weight standards
		  • Body proportion
		  • Attractive/desirable
		• Skinny is undesirable
		• Weight is celebrated
		• Criticized/discrimination

Perceptions		
Perceived Susceptibility		
	• Perception of overweight	• Based on feelings or comfort • Based on physical ability Based on health issues
	• Perception of obese	• Extreme definitions • Visual definitions • Obesity is a bad word
	• Attitude about personal weight	• Misclassification of body weight • Dissatisfaction • Positive body image • Disagree with weight standards • Body proportions
	• Desired weight versus healthy weight	• A comfortable weight • Memory of positive body image • Comfortable in clothes • Healthy weight recommendations are laughable
	• Cultural view of weight	• Standards derived from white supremacy • African Americans are thicker • No one wants to be thin • Cultural weight standards • Fat shaming

Perceived Severity		• It's scary
		• Health issues associated with weight
		• Physical effects of weight
		  • Back and joint pain
		  • Physical limitations
		  • Wardrobe limitations

(table continues

		• Social limitations • Social stigma/criticism
Perceived Threat (perception of risk of developing chronic illnesses)		• Risk due to weight • Risk due to behaviors • Risk due to pre-existing illnesses • Risk due to family history • Risk due to race • Risk due to stress • Low perception of risk
Perceived Barriers to Change		
	• Lack of access	• Insurance • Lack of options • Lack of affordable options
	• Timing/Scheduling	• Lack of time to prepare • Lack of organization
	• Lack of knowledge	• Preparing meals • Menu/recipe ideas • Deciphering information
	• Environment	• Abundance of unhealthy foods • Festivals and events
	• Psychological	• Anxiety, stress, and depression • Give up because discouraged • Hormonal cravings • Taste – picky eater • Stubborn or stuck on tradition • Lack of support • Peer pressure
Perceived Benefits of Change		• Better health • Look and feel better • Be comfortable in clothes
Action		
Motivation or Cues to Action		
	• More food options	• More palatable options or substitutes • More menu or recipe ideas • Cultural modifications
	• Support	• Nutritionist or coach • Support system or social support
	• Body image	
	• Health issues	

(table continues)

	• Results	
Self-efficacy	• Knowledge	• Relationship between food and health • The effects of certain foods on health issues
	• Past attempts	• Food restrictive diets • Success with attempt • Tried and gave up
	• Healthy behaviors	• Low carb diet • Lifestyle change • Exercise • Discontinuing bad foods

Evidence of Trustworthiness

In order to demonstrate the value of truth within this study, it is necessary to provide evidence of trustworthiness. In qualitative studies, validity is often measured by standards which were created by Lincoln and Guba (1986) in the 1980's to mirror the methods used in quantitative studies. In order to measure the value of truth, consistency, applicability, and neutrality, Lincoln and Guba paralleled the quantitative criteria with credibility, transferability, dependability, and confirmability. With each, there are strategies that can be used demonstrate the extent in which the criteria have been met.

Credibility

Due to changes in the data collection methods as a result of social distance restrictions, some of the strategies that were planned to establish credibility were disrupted. It was intended to utilize three methods of data collection, which included semi-structured in person interviews, observation, and unstructured interviews, for triangulation. However, the only data collection methods that were able to be utilized to obtain data from the participants were semi-structured interviews by telephone or

teleconference and demographic forms which were completed by the participants and returned by email. Also, due to social distancing guidelines, prolonged engagement, which was also planned, could not occur. However, some of the data was cross-checked with online sources. For instance, traditions that were common across cases, were cross-checked and the information was presented along with the findings.

In addition, member checking was conducted. The participants were emailed a copy of their transcripts and advised to contact me if any changes needed to be made. However, none of the participants responded by email. I made follow up calls to each of the participants to inquire if they had any concerns after reading the transcripts. Only five of the participants, Temika, Donna, Jackie, Denise, and Michelle had read their transcripts and all of them confirmed accuracy. In addition, once the data had been analyzed and the report of the findings was complete, I emailed the full report to the three participants who agreed to provide feedback, which were Jackie, Michelle, and Denise. Jackie responded by text message, stating, “I agree with everything. Great work! I found it funny that everyone talked about red bean Mondays.” After one week, I followed up with the other two participants by phone. Both follow up calls provided the opportunity to discuss the findings in detail. They each discussed certain aspects of the data that they found interesting and both confirmed the validity of the findings.

Transferability

Since the purpose of this study explored a unique culture and population, generalizability was not an expected outcome. However, in order to demonstrate external validity, steps needed to be taken to ensure the study provided enough data to make

judgements about the applicability of the findings to other unique populations. In order to meet this criterion, thick and descriptive data was collected and a narrative with rich descriptions along with direct quotes within context were provided to allow others to draw their own conclusions about the data.

Dependability

The steps taken to achieve dependability included maintaining documentation of the steps taken during the research process. This audit trail includes the documentation of any abnormal circumstances affecting the recruitment, data collection, and data analysis. The recruitment procedures, times and dates of interviews, data collection procedures, reflective notes, interview notes, and documentation of member checking and participant feedback were all maintained. In addition, all participant data, including completed demographic forms and transcripts have been saved as recommended.

Confirmability

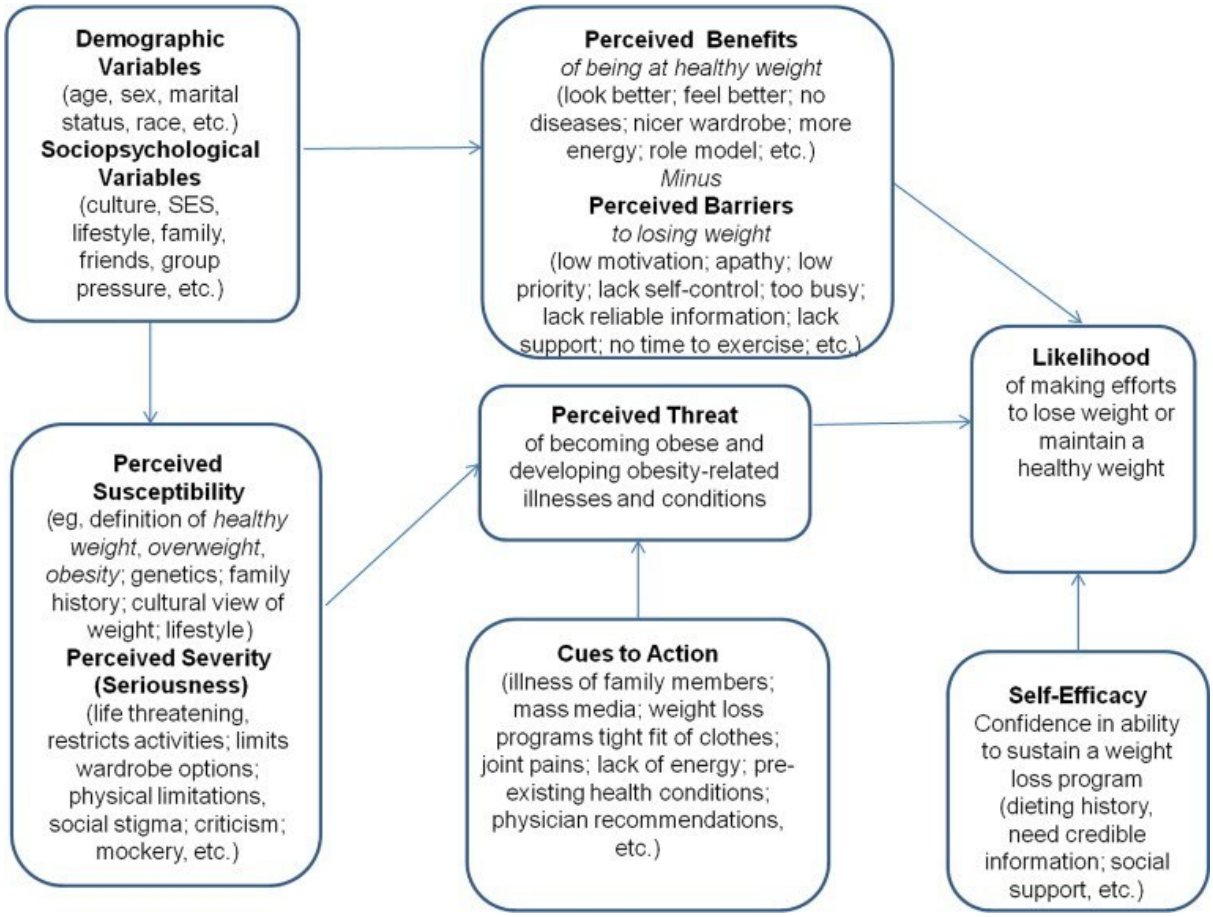
In order to ensure that the findings truly represented the participants experiences, I utilized multiple data collection methods, member checking and reflexivity. Although there were adjustments made to the data collection methods, member checking and reflexivity were maintained. In addition, a peer review was performed. All participants were provided with their transcripts and three were asked to review the report of the findings. All participant feedback acknowledged that the findings reflected their experiences. In addition, a psychologist, who is a native of the GNO with an interest in the mental health of African American women, completed a peer review and confirmed the alignment of the raw data, the findings, and the interpretation.

Results

The data collection in this study explored the attitudes, behaviors, and beliefs of overweight and obese African American women living in the GNO in order to gain a better understanding of how their cultural experiences have influenced their knowledge, attitudes, and perceptions about obesity and what role they perceived their culture played in the prevalence of obesity and obesity related conditions. The data is organized based on the constructs of the HBM, which include modifying factors, perceived severity and susceptibility, perceived barriers and benefits to change, cues to change, and self-efficacy. The overarching themes include these constructs, as well those addressing the participants' perceptions about the influences of their culture and cultural experiences on their health behaviors. Figure 1 demonstrates the organization of the theoretical constructs as relates to obesity. This figure was available for public sharing.

Figure 1

The Health Belief Model



Note. From James, D. C. S., Phoebe, J. W., Oxidine, D., Brown, L., & Joshi, G. 2012, *Journal of the Academy of Nutrition and Dietetics,112,* p. 665 (https://doi: 10.1016/j.jand.2012.02.003)

Sociopsychological Factors

When asked about the role of food in their culture, all of the participants expressed their belief that food is the mainstay of New Orleans culture. The women described food within their culture as a priority and one participant even expressed her

belief that there is too much emphasis put on food. According to the participants, food is everywhere and is incorporated in many aspects of their lives, from home, to work, to church, and socializing. “Food is everywhere. Everything, pretty much that’s unhealthy. It’s pretty much everywhere,” expressed Trenice. The types of food and the manner in which food is cooked, served, and enjoyed were very similar among all of the participants.

The food of New Orleans, according to the participants, is highly seasoned and most would be considered unhealthy. Trenice stated that “everything is heavily salted and heavily seasoned” and Denise described the flavors of the food as “potent.” When asked about the difference in the food in New Orleans compared to everyone else, they all commented on the lack of flavor or seasoning used in other places. Alicia stated, “they don’t have all the highly seasoned and rich foods like we have here in New Orleans.” They also discussed food preparation of New Orleans culture such as starting most recipes with the “Holy Trinity,” which in Creole and Cajun cooking includes onions, bell-peppers, and celery, and the use of “pickle meat” which was said to be put “in everything.” According to Donna, pickled meat is “meat from a hog” that “is pickled and sold in the stores or in a meat market.” All of the participants mentioned pickled meat when discussing foods such as greens and red beans. “Pickle meat,” as called by most New Orleanians, is, as Donna described, pork that has been pickled. More specifically, prior to refrigeration, pork was pickled or preserved in vinegar or a salty brine (Hemard, 2013). Pickled meat is a staple to Cajun and Creole cooking and is used as “seasoning” for beans and smothered vegetables, such as greens and cabbage. The cultural foods of

the area were also described as high in carbohydrates and sugars. Jackie stated, “sugar is on the forefront of everything” and Temika stated “we eat starch on top of starches.” She gave the example of a dish she called “smothered potatoes.” She stated that many times it is served over rice. She also stated that most of the dishes in New Orleans are “some type of starch” and are either served with rice or pasta.

Another common theme noted among the participants were the traditions of eating certain foods on certain days. In the New Orleans area, it is a tradition of many people to eat red beans on Monday. Alana explained the tradition stating that Mondays were traditionally the “wash day” and the women would soak their beans and slow cook them, allowing them to be ready for dinner. According to multiple sources, as Alana stated, the tradition does stem from wash day in New Orleans. Prior to electric washing machines, women washed all of their clothes by hand, which left little time to prepare dinner (Gerdes, 2012). Red beans was a dish that could be simmered all day while the women completed their laundry, leading it to become the area’s traditional Monday meal. All of the participants admitted to eating red beans on Monday. One participant, Alicia, said that she even continued the tradition when she lived outside of the state of Louisiana.

The other common factor is that all the participants, except three, admitted to adding “pickle meat” or pork to their beans. The other three admitted to eating it that way growing up but made changes later. When asked about the ingredients in their red beans, Latanya responded, “Everything bad. Smoked turkey necks, pig tails, pork sausage. That’s about it. Neckbones sometimes. Everything bad.” Jackie said that she added “pickle meat, ham hocks, and smoked sausage” and Melissa explained why she no longer

used those ingredients, stating she only added "smoke sausage because my husband don't eat pickle meat and all that other stuff. I would put pig tail, pickle meat, I would put all that in there, but he does not eat that at all." Some of the participants also described other weekly traditions, such as eating spaghetti and meatballs or lasagna on Wednesday or Thursday and seafood on Fridays. Two participants added that with those meals, although they contain meat, there will still be another meat served. For example, Temika said, "when you got your red beans and rice and you can have all the meat you want in there but you still gotta get it with pork chops or fried chicken."

Table 4

Food Traditions That Influenced Participants' Daily Lives

	EXCERPTS
ALICIA	"Okay. So Red Bean Monday. And that's crazy because it is really something that has been like and I'm sure all of New Orleans families forever like, you know, I can remember when I was a little girl, that they would classify that as Red Bean Monday. And fish on Fridays, it's like no matter if you were Catholic or not that was just like in my household; I know my grandmother always wanted fish on a Friday for whatever reason and she wasn't Catholic. And it's crazy that that tradition really sticks with me because I lived in Houston for a few years and it would feel like every Monday I needed to cook red beans for whatever reason."
STACY	"My father, he does fried fish every Friday." "Monday is his red beans day and he's gonna put chopped ham in there. He's gonna put his pickle meat. And he's gonna put the pig feet and pig tails in there as well"
KEISHA	"So, like the red beans on Monday or seafood on Fridays. Wednesday, we do spaghetti and meatballs. And it's been tradition for so long. My mom used to do it. My grandmother used to do it before her. And now I do it for my family and my kids. So, yeah, that's what we all know."
LATANYA	"Well, for me and my family, we eat beans on Monday."
JACKIE	"Well, day to day, you know, we have our Red bean Monday. So, that's pretty much every week."
TEMIKA	"Mondays would be read beans and rice."
MELISSA	"There was red beans on Mondays. We have seafood on Friday. I think on Thursdays we had Italian food. We had like spaghetti and meatballs."
DONNA	"So, the tradition that I still follow is Monday is red beans, Tuesday is usually leftovers and add fried chicken to it or pork chops. Wednesday, I forgot what Wednesday are. Thursdays are some kind of spaghetti and meatballs. Friday is your fried fish. You know, your seafood Friday. And then Saturday is another day that we have poboys or something like that. So, I could say growing up, we had routine meals.

Holidays and seasons. When discussing holiday traditions, Michelle described how specific foods are cooked at specific times. She said, “New Orleans is broken up into seasons and those seasons just call for certain things.” As stated previously, the participants admitted to traditions such as seafood on Fridays. In the city of New Orleans, which has over forty Catholic churches and along with the state of Louisiana, has deep roots in Catholicism, Lent is celebrated by many of its residents (Crowe, 2013). During Lent, although many of the participants denied being Catholic, most of them said that they eat seafood on Fridays during Lent and some throughout the year. Stacy said that “not just during lent,” her father “fried fish every Friday” and served it with “potato salad, macaroni, and peas on the side.” Michelle talked about how she looks forward to “churches that have those fish plates on Fridays” and said that it comes with “your potato salad, your green peas, and macaroni and cheese.”

Other holidays that were discussed were Mardi Gras, Easter, Christmas and Thanksgiving. A few of the participants talked about their lifestyle behaviors during Mardi Gras, such as eating sugary foods and drinking alcohol. Melissa said, “You know, Mardi Gras, most people are going to drink more alcohol than they typically would because it’s Mardi Gras. Every time you go out to a parade, you’re drinking.” And Stacy talked about the abundance of sweets stating, “Oh, during Mardi Gras, oh the King Cake. They have all sorts of King Cake, stuffed ones, the strawberry, the cream cheese. You have the regular one, the pecan.” King Cake is a sweet pastry that has historical roots in Catholicism and is very popular among locals during its available season, which begins in

January and ends on Mardi Gras, the day before Lent season starts on Ash Wednesday (Hatic, 2018). Other foods that they associated with that time of year included Crawfish and Snowballs. All of the participants discussed crawfish season and a few mentioned foods such as crawfish bisque being a food that they traditionally ate on Easter Sunday. During the Thanksgiving and Christmas holidays, the participants named foods that are traditional in their family. Many of the items listed were considered Cajun or creole and were unique to the region.

Table 5

Seasonal and Holiday Food Traditions

	EXCERPTS
ALICIA	"For Thanksgiving, we kinda do the traditional, stuff bell peppers, macaroni and cheese, turkey, ham, stuffed mirliton."
TRENICE	"During the holidays there's gumbo with a lot of meat, a lot of pork in it. Dirty rice with more meat."
	"Definitely eat a lot of crawfish like when they're in season."
MICHELLE	"Just living in New Orleans, like they have certain things, they have certain times of the year when you're going to eat this no matter what."
	"If its crawfish season, so I'm going to get five pounds every Friday."
	"During like around Easter, crawfish bisque is like a number one. During the holidays, stuffed bell peppers. You can't have a holiday unless somebody made some stuffed bell peppers."
	"Because it can also be towards the colder months where you're gonna have somebody that's gonna make a big ole pot of gumbo and your gumbo is gonna have smoked sausage, hot sausage. It's gonna have chicken in it. It's gonna have gizzards in it. It's gonna have crab, shrimp. So it just depends on what season it is."
STACY	"Seasonal, I would say like the boiling of crawfish and shrimp."
	"Wintertime, definitely the gumbo. Gumbo, definitely. I would say summertime is the crabs, the crawfish, the shrimp, the smoked sausage, the corn, potatoes."
	"During Mardi Gras, oh the King Cake."
	"You go by your mother house for Christmas and you might have shrimp creole. You gonna have my favorite, which is okra, the seafood okra. You have the seafood okra gumbo."
TEMIKA	"So, like during crawfish season. You gotta get your crawfish. You can't just get crawfish. You gotta get your potatoes, you gotta get your corn, you gotta get the sausage."

Family gatherings. Also common among the participants was the idea of family gatherings and the some of the traditions that were followed during these gatherings. According to many of them, family gatherings can occur for any reason and at any time. There are the planned and traditional holiday gatherings, but many also referenced impromptu gatherings, which they said, "always includes food." Gatherings discussed including those held on Easter, Thanksgiving, and Christmas, but also included birthdays and those held for no reason at all. The women spoke about many different food traditions, some which are common to the African American community and others that were more common regionally.

All of the participants shared their love for what they called, "crawfish season" and talked about their need to have their share of boiled crawfish before the season ended. Crawfish season is typically from late winter to early summer, but peaks in the spring. One of things that frequently occurs during spring and summer gatherings and can also be classified as a type of gathering is a boil. Denise described the event as:

> A crawfish or seafood boil is where you get together with friends or family and they actually boil seafood, be it shrimp, crab, crawfish typically. And they boil it in like a spicy seasoning and they add all kind of fixings that go in there with it besides the seafood.

The most common fixings among the participants that are added in a boil were, sausage, corn, potatoes, and turkey necks. A couple of participants named items like boiled eggs and neck bones. Both Trenice and Latanya pointed out that although they love eating the food served at these events, they also know that the seasonings used can

be unhealthy. Latanya said that the food is always “high in salt” and Trenice said she knew it was something she is “not supposed to have. It is also to be noted that the participants admitted to eating these foods outside of family gatherings where they admitted to individually eating up to 5lbs.

These gatherings, many times, will also include alcohol and other types of foods such as barbecue and sweets. Some of the participants provided descriptions of their typical family gatherings. Keisha said:

> You would see a lot of crawfish, beans, barbeque. Different types of barbecue from chicken to ribs, hot dogs, and hamburgers. It’s like a whole spread of foods. You would see a lot of sodas, coolers everywhere, one for water, one for drinks, one for beer and wine coolers, and then one for juices for the kids. You’ll see everybody mingling, socializing, probably playing cards, dominoes, music, people dancing, bus stop (New Orleans name for the Electric Slide), second line (traditional New Orleans dance). You see kids playing around.

Stacy said that her family usually has several types of food, including a dessert table inside and boiled and barbecue foods. She said:

> So, you’re gonna have your regular foods, maybe the baked macaroni, yams, barbecue ribs, barbecue chicken, fried chicken, fried chicken wings, potato salad, jambalaya, definitely your gumbo, etouffee. I would say that would be one of our tables. The next table will be a candy table depending on if it’s a party. You gonna go outside and we gonna have the crawfish. You’re going to have the crab,

the smoke sausage, the corn, the potatoes. It's just about eating and listening to music and having fun."

As mentioned, prior, these gatherings can happen at any time and can happen frequently. During the spring and summer months, the participants stated that they can occur up to "at least twice a month." Many times, the gatherings follow a "potluck" theme with individuals asking the host, "what you want me to bring?" According to many of the participants, this sometimes leads to a problem, especially when it comes to "who made the potato salad?" Alana said if the wrong person made the potato salad, either the person who asked is not coming or there will be two potato salads. Michelle echoed this when she said there are only "like two people that make potato salad in my family. Anybody else is not trusted." Not all gatherings follow the potluck theme, especially if it was planned at the last minute. Sometimes the more impromptu gatherings may just include family-sized takeout orders of fried chicken and daiquiris. But no matter what, there will always be food involved.

In the New Orleans region, festival season is typically in the beginning of the year, but festivals occur year-round with the city hosting about 120 festivals a year. The participants named some of the more common and well-known festivals that occur in the area, such as Jazz Fest, which is the New Orleans Jazz & Heritage Festival, and the French Quarter Festival. But they also pointed out that in their area, they are surrounded by festivals. At the height of festival season, New Orleans has festivals almost every weekend.

The Jazz Fest was the most mentioned festival among the participants. They described an environment that encouraged eating. Trenice said of the food at the festivals, "you're encouraged to try *every* food." Jazz Fest was described as an event with many food vendors, music and alcohol. The participants stated that upon entering the festival, they have a plan of which foods they will eat first. A few of the participants described very similar experiences when they attend, starting with finding their resting spot for their time there, making a plan among their friends and family as to who will go to which food vendor, listening to music, drinking daiquiris, and later eating more food. Most of the participants expressed their excitement about this event, specifically for the foods that are only available during festival season (see Table 6).

Table 6

Participants' Favorite Jazz Fest Foods

	EXCERPTS
DONNA	"There's so much, so many food items. Oh, my God! Crawfish Monica!
ALICIA	"We would go get us some crawfish bread or Crawfish Monica."
TEMIKA	"I might be in a line for the Crawfish Monica and my friend might be in line for the crawfish bread."
MICHELLE	"And when I go to Jazz Fest, straight up, I have to have Crawfish Monica."
DENISE	"Crawfish Monica was always something I always got if I went to Jazz Fest."

The participants named their favorite food items for each of their favorite festivals and most of them also made it known that they primarily attended the festivals to experience the food offerings (see Table 7). They also stressed the significance of festivals within their culture. Donna stressed "I live in New Orleans and we have more festival than probably anyone." Denise, who said her favorite festival to attend is the

Strawberry Festival also stated that she tries to go "to every festival that's in New Orleans. Gumbo fest, crawfish fest, oyster fest, crab fest, seafood fest, chicken fest. They have a fest for just about every food we have down here and I'm at all of them." Stacy expressed her belief that any visitor to New Orleans is likely "coming for the food and entertainment." She also stressed the number of festivals in the area, saying, "We have a lot of festivals. We have the alligator fest. We have the crawfish, the shrimp, the gumbo, the jambalaya, the strawberry fest." And Alana said, "Most of our festivals in New Orleans are centered around food, whether it be a tomato, a strawberry, a crawfish or a crab. It's something you gonna put in your mouth."

Table 7

Festival Food Experiences

Participant	Festival Food Experiences
Keisha	"Like around Jazz Fest time, a lot of people have their lil jambalaya booths where you come downtown to make sure you get the jambalaya or like the little mini poboy sandwiches. We look forward to praline candy, that's a must. So many things. Fried chicken! They have a festival just for fried chicken."
Trenice	"Jazz Fest is the last festival I went to and it's definitely, hey, you're encouraged to try every food. You must try all the food. You gotta check out all the vendors. Food is definitely the number one reason to be out there. Then, listen to the music. But you must have some food."
Jackie	"All of the festivals that we have, you go to the festivals to eat. There's nothing else to do other than listen to some music. And you listen to the music and you eat at the same time."
Denise	"We're surrounded by festivals. So, you're always trying, especially if you've got restaurants that you like in the area that you've never been to. And maybe they'll give you a little sample size for five dollars. And so you're eating everything and tasting and sampling everything at these festivals."
Melissa	"Me and my husband, we go to French Quarter Fest every year. Soon as we walk in we already know the first booth we're gonna hit is Baucresson Hot Sausage. We're gonna get a hot sausage poboy. First thing, off the rift. Then we're gonna get a daiquiri."
Michelle	"I'm going out there with money. I'm not going to buy nothing from any of the artists out there. I'm not there for that. I'm there for the food and the music. So, Jazz Fest is a must for me. French Quarter Fest is a must for me."

In fact, the food culture within the festivals are so significant, that even a pandemic could not deter the locals' desire for festival food. Donna stated that this year because of the COVID-19 pandemic, she did "Jazz Fest in place." She said:

> Although we could not go to Jazz Fest, we actually still celebrated Jazz Fest as if Jazz Fest was going on. So, we still went and purchased food items. And we social distanced and we drink and listen to music as if we were still at Jazz Fest. So that goes to show you even when the pandemic is going on, we are still celebrating. Like we did drive-bys, ordered our food from the different vendors and we met in the park or we met at somebodies open back yard and we put on WBOK to listen to the Jazz Fest music of the different bands that would have been performing.

Donna was the only participant that participated in this modified festival, but she was not the only participant that expressed regret that the pandemic was affecting the festival season.

Cultural Behaviors and Attitudes About Food

For all of the participants, food was associated with comfort and family. They found food to be the center of their culture, as it brought families together, connected them to their history, and had been used to show love and gratitude. They described food as comfort during times of bereavement and discussed the tradition of bringing food to family members of the deceased. They also described the role of food in celebrations and

in everyday life. Denise discussed summer with her grandmother and explained how cooking was "an expression of love" for her grandmother. She said:

> My grandmother had a way that she knew that each of her grandkids didn't like this or didn't like that. And so, when she cooked, she always cooked something that we all, that there was something on the table that we would all eat. So, if I didn't eat gumbo, which I did, and she made a pot of gumbo, but she knew I liked red beans, she would have cooked a pot of red beans for me. It's an expression of love.

Michelle also talked about cooking as both an expression of love and one of appreciation. She and Jackie expressed how they enjoyed watching everyone eat the foods that they prepared. Michelle said that growing up, she experienced cooking for someone as a form of gratitude and stated that, "I may not be able to give you no money and actually pay you, but I could feed you."

She also described growing up in a small family-oriented church where they would often cook or bake for visiting preachers. She said, "I can remember having revivals and the preachers wouldn't get paid. But I would be at home baking cakes and we would pay the preachers with a cake and they would absolutely love it."

Food is also viewed as a priority. When asked about the role that food played in the culture, the participants either stated a very large or significant role or they stated that the culture *is* food. Denise said about the role of food, "I don't think people in my culture actually look at food as just sustenance or nutrition. Food is built around celebration. It's not always about being hungry. It's just this is what we do." Most of the participants

expressed their love of eating the cultural foods and some suggested that the love of the food was a driving force in how much food they cooked and how much they ate. Stacy said about the culture, “I believe that New Orleans is all about food. I think that’s just our culture. It’s just the food, I would say that’s our attitude. Our attitude is let’s go feast.” Alicia echoed this saying, “I guess there’s something in it you can’t be without. The better the food is, I think the more you eat.” Denise said:

> Because it tastes so good. It doesn’t become no more that I’m eating to live. I’m living to eat. Like I love food. I’m a foodie. If it tastes good, I’m going to eat it. And even if I’m full, I’m going to go back for a second plate.

Two of the participants also expressed how it could be looked at as disrespectful if one did not eat the food that was offered to you by your family. Michelle said, “First of all, you don’t go to nobody house and don’t eat they food, because if you do, you gonna be considered disrespectful.” Alana expressed how eating is sometimes an obligation, saying, “You know each meal is centered around your mama, your grandmama, your auntee and ‘nem. So, you don’t have a choice. You gotta go over there and eat whatever they fixing.”

The amount a food an individual ate was also relayed back to the principles that were instilled at a young age. A few of the participants spoke about the idea of cleaning their plate as the reason why they feel the need to continue eating after they feel full. Trenice recalled her mother telling her “to clean her plate” because there were people starving in Africa and Denise said that she was raised “not to waste” her food, which drives her to finish her food and not be wasteful by throwing uneaten food away.

The richness and flavor of the food was also a very important consideration for all of the participants. They expressed their dissatisfaction with food that is advertised as authentic New Orleans or Louisiana in other states. Temika summed up the thoughts of most of the participants when she said, “We take food seriously. Like it’s not a joke to us. It’s gotta be done right. It’s gotta be, you know, made correctly. We’re hard critics. But food is serious. Food is life in our culture.” Most of the participants believed that food plays a major role in their culture, whether it’s to bring family together, to show love, or to bring comfort. They all agreed that food was at the center of many of their lives and traditions and they were clear in their feelings about the traditional foods of their culture.

Cultural Attitudes About Health

When asked what they believed was the overall attitude about health within their culture, the participants provided several different, but similar responses. Most of the participants believed that there was a lack of concern about health within their culture. Some of the participants believed that people in their culture prioritized happiness and traditions over their own health. One participant expressed her concern that their cultural traditions were causing them to die prematurely. So, instead of choosing or attempting healthier behaviors, the participants believed that the people of their community chose to continue their current behaviors with the thought that they were going to die at some point anyway. Donna said that she heard all her life from family members that “we gonna die from something, so eat and be happy.” And when asked about the overall attitude about health, Stacy responded,

> I believe there is none. I don't think anyone in New Orleans worry about health as much. I mean, we have maybe, I would say 40% worry about health. Everyone else just want to live. I mean, they just want to live to eat, not eat to live.

Temika said:

> I think people be like "I gotta die one day, so I might as well." I literally hear this. "I gotta die one day. So, I might as well do what I want. Eat what I want. Be happy and live for the moment.

And when asked the same question, Alicia expressed her belief that "it goes back to our culture, where we come from" when it comes to the attitude about health and not making "the right decisions." She also believed that this lack of concern and poor decision making has made her community more vulnerable to COVID-19.

Two of the participants believed that a lack of knowledge influenced the attitude of those within their culture about health. Trenice expressed her belief about the ignorance associated with the unhealthy foods that are common in her community. She admitted that she didn't believe that everyone understood the connection between the foods they ate and their health issues. And Michelle discussed the instances where people may think they are eating healthy, but because of their lack of knowledge, they may still struggle. She gave an example of someone eating a piece of fish, but having it covered in sauce. She said, "the thought and concern is there, it's just not all the way there."

Another issue brought up by some of the participants was a lack of trust. They believed that many in their community did not trust those in the medical community and this affected their attitude about health. Trenice believed that people in her community

are “afraid of doctors due to the past experiences with the medical field.” Donna believed that the best healthcare is not available in New Orleans and believed that is why “people have fear and don’t trust doctors.” Michelle, who had a similar perspective, stated, “certain hospitals in New Orleans was not to be trusted. It was like, ‘don’t trust those white people cause…’ And that’s just what I would hear my family members say a lot.” They believed the lack of trust affected the amount of knowledge that they had about their own health and the measures that they took to maintain their health.

For others, one participant who works in the health care field, believed that people in her culture are in denial. She said, “you could show them that their numbers and sugars are running high and they still will deny the fact that they have diabetes and don’t feel like they need to lose weight.” She said for many in her culture, they associate their health with how they feel. She stated she heard people say things like “I don’t feel like my blood pressure is high” or “I don’t feel like my sugars are running high.” Others felt like many aren’t taking their health seriously enough, whether it’s not prioritizing their health because of costs or failing to be more proactive. Latanya believed many young people are dying too soon because they are afraid of change and because they don’t get regular check-ups. Many of the participants spoke on the reactive nature relating to health in their community. Some spoke on some people’s non-compliance with prescribed medications and some spoke on other’s reliance on medication and failure to change their lifestyle behaviors. Jackie added that there is also a spiritual component where people in her community fail to take accountability for their behaviors because she believes they “lean towards spirituality” and said “if we’re sick, we’re going to pray.” She believed that

spirituality somewhat "takes away from the ownership of what we could do personally instead of just relying upon other interventions."

The second most common theme was the idea that health isn't important until it is. Many spoke on how people are finally taking their health more seriously since the pandemic. But, for many, most of the participants believed that health doesn't become important in their community until it's too late. Most of the participants denied that proactive health measures are stressed in their culture and said that many don't go to their doctor until their sick. Keisha said, "my family members, I know a lot of them, they don't go to the hospital or clinics unless they're sick, really sick." Alicia believed for many in her family, it has to be life or death before they make changes and Temika said that she noticed that people "wait until things go wrong" before they start caring about their health. Melissa said,

> I'm guessing that if they ain't dying, they good. They don't have any health issues, they good. Now, the crazy part is being proactive, you know, that ain't even an issue. You cross that bridge when you get there, basically.

Cultural Attitudes About Weight

The participants were asked about what they believed was the overall attitude about weight within their culture. All, except one, believed that being overweight is accepted or overlooked in their culture. Because many of their peers are also overweight, some believed that having a positive body image has become more important, while others felt as it has just become a way of life and is sometimes embraced. When asked why she thought there was acceptance, Keisha replied, "Because you see a lot of people

that are like that. You see a lot of people that are overweight. And a lot of people embrace it." Alicia said that she believes the culture has adopted a "no judgment zone" and that "people are just accepted." For a few of the participants, they believed that an individual's body proportion made excess weight more likely to be overlooked or even celebrated. Alicia said that African Americans are "more hippy," have "more butt," and are "shapely" which leads many to overlook the fact that they are considered overweight. Stacy said a woman could be obese, but if her body was proportioned, "they're not worrying about their weight." Some of the participants mentioned that many women who are considered overweight or obese don't want to lose weight because culturally, their body appearance is considered desirable. Alana said that in the culture of New Orleans, a "big, fine, healthy woman is attractive." Because of these cultural ideals, many of the women also believed that within their culture, being thin is looked at as different and not desirable.

One participant had a different perspective from the rest of the participants. She believed that the culture looked down upon obesity but was becoming more accepting. Her experiences with her weight differed significantly from some of the other participants. She admitted to instances of fat shaming and discrimination and believed that within her culture, they still had "a lot of work to do as it relates to body acceptance."

Perceptions

Perceived Susceptibility

According to Skinner et al. (2015), in order for a woman to consider getting a mammogram, she would first have to believe that there is a chance of her getting breast

cancer. The belief in the likelihood that an individual could be affected by a condition is the individual's perceived susceptibility. In this study, the participant's perceived susceptibility was measured using questions to determine how they defined overweight and obese, how they described their own weight, their feelings about their own weight, and their cultural views on weight, body types, body image, and medical weight standards.

Personal Definitions of Overweight and Obese

When asked what their personal definition was of being overweight, the participants' responses varied from technical definitions to those based on feelings or comfort. A few of the participants defined overweight as either having a BMI over what's recommended or weighing more than the weight recommended for their height. The remainder of the participants defined the term based on other factors. Several of them believed that an individual is overweight when they began to experience health issues. One participant defined the term as, "when you start to get health issues that's related to weight, like hypertension and diabetes." This was echoed by another participant who defined being overweight as, "so, like if you have diabetes or high blood pressure. Like when your weight is affecting your health."

A few of the participants also defined being overweight by physical limitations and pain experienced because of one's weight. One participant expressed that a person would know that they are overweight when they began experiencing difficulty performing physical tasks. Her response to the question was, "not active. Not being able to walk a flight of stairs without being out of breath." Other definitions were based on

physical and mental comfort, such as an individual "just being uncomfortable" or not satisfied with their body size, visual attributes, such as "having a fupa," and lastly based on clothing size and fit. The participants described feeling uncomfortable in their clothes or having to buy larger sizes and shop in specific stores.

When asked about the term obesity, the responses again varied, but this time from technical definitions to more extreme definitions. Two of the participants who work in the health care field, both described obese as being significantly over the recommended BMI and possibly having health problems due to weight. Some definitions were based on physical limitations, such as "problems walking at a normal pace and getting short of breath." But others had more extreme perceptions of what obesity looks like and shown in Table 8.

Table 8

Participant Definitions of Overweight and Obese

	Definitions
Overweight	"I think overweight means just a few pounds over your normal body weight"
	"My personal definition of being overweight is when you start to get, I guess health issues that's related to weight, like hypertension and diabetes."
	"My definition of overweight would be probably about 50 pounds over whatever the height-weight ratio chart would say.
	"Just being uncomfortable. Over your BMI. Having health problems that goes with it."
	"My personal definition would be, I guess, heavy weight. Not very active. I guess not being able to walk a flight of stairs without being out of breath."
	"My definition of being overweight would be when it affects your health. So, like if you have diabetes, high blood pressure, like when your weight is affecting your health."
	"I basically think overweight is someone who is just not satisfied with their weight. They just think that they're not, they're not comfortable with their weight. It's up to each individual."
	"Me defining overweight would be, it's more of a visual thing. So, knowing I'm overweight, I can look at myself and see I have a fupa or my arms are fat. Then I have to wear clothing in a certain size."

(table continues)

Obese	"My personal definition of being obese would be basically five times over the weight limit. Having health issues and really about to be close to death"
	"Obesity means being way over the weight for you frame and unhealthy."
	"Not being able to carry weight, your load to me is obese."
	"I would say when you are unable to care for yourself fully. When you need assistance to do the daily activities of life."
	"Unhealthy. Not active. Overeating. Just fat."
	"I think obese is a someone who may have problems walking at a normal pace, getting short of breath."
	"My personal definition of obese is someone who is very uncomfortable with their weight, who has difficulty breathing, walking, just everyday activities. They're just uncomfortable."
	"When I think about obesity, I think about the people who are on those shows where if for some reason you had to be taken out of the house via ambulance, you would have to be lifted. Or people who are obese, they are really limited in the way they can move in certain things like that. And it's also visual. If I see them and they're a certain size, I'm like, wow, this might be really big."

For many, the term obesity was viewed as a bad word. They described the negative feelings they experienced when hearing the term. For some, the term affected their body image and for others it motivated them to make changes in order to get to a healthier weight. One participant said, "Anytime you hear the word obesity or obese, it makes you, it's like a cringing type thing. Like Oh my God!" Another participant expressed how the word made her feel about herself, stating, "it's kind of offensive. Society says, 'oh, you're obese.' Obese is such a harsh word to me. So, when I hear that, it makes me feel insecure about myself." Overall, the participants' personal definitions of the terms demonstrated, in part, a look into their perceptions of what is considered normal versus what would be considered unhealthy.

Personal Weight and Body Image

Within this sample of participants, most of the participants self-identified into the correct weight classification. Those seven participants were all classified as obese based

on their self-reported weight and height. One participant self-identified as overweight, but her height and weight classified her as very obese. The remaining four participants understood that medical guidelines would classify them as obese, but they personally classified themselves as overweight.

Many of the participants disagreed with the current weight standards and classifications. Four of them particularly disagreed specifically about their own classification. Two of the participants who both admitted to being physically active and eating mostly healthy diets, classified themselves as overweight. Latanya stated that although society would say that she is obese, she believes she is overweight. She said, "I'm overweight. I don't think I'm obese because I'm very active and I eat healthy. I put in healthy vitamins." The other two participants both understood that based on their height and weight, that they would be considered obese, but felt that the classification was incorrect. Alana, who works in the health care field, stated, "on paper, I would be considered obese. I consider myself to be overweight but not obese." Michelle also felt this way. She stated, "I know I'm overweight, but I also know I'm obese because of what the definitions are. But I look at myself and I know I'm overweight."

Alana, however, believed the way her weight was distributed distinguished whether she should be classified as overweight or obese. She said, "I'm a solid African-American woman. I'm bottom heavy, I'm not top heavy. If I was top heavy at 265lbs, then yes, I would consider myself obese."

When it came to body image, most of the women expressed dissatisfaction with their current weight. When asked how they felt about their weight, most responded

stating they weren't happy with their weights and some described their weights as "depressing." Melissa had mixed feelings about her weight. She was aware that she classified as obese and stated she wasn't happy with her weight, but also expressed positive feelings toward her body image, stating, "I know when I put on my clothes, I look good." A few others also had positive body images despite their body weight classifications and expressed comfort in their physical appearance. They all, however, admitted that they believed that they needed to lose weight, but expressed that it didn't affect how they saw themselves. Donna said, "I'm comfortable with my body image. I know it can be better, but I'm comfortable with what I have now." And Alana proclaimed, "If I feel good and I know I look good, then screw the rest. It's all about me. My weight does not contribute to my overall feeling or mental status." And lastly, Michelle explained her positive body image, stating,

> I carry myself well. I'm not a sloppy person. I'm proud of my body image. I know I can stand some work and I won't deny that at all, but I don't let the part that I'm overweight stop me from seeing my image as something that's really good.

Desired Weight Versus Healthy Weight

In order to get an idea of what the participants believed would be a healthy weight for them, I asked them to tell me their desired weight. Most of the women stated a weight that would still be considered either overweight or obese. For most, their desired weight was based on where they believed they would feel "comfortable." For some, their desired weight was a weight that they once were, and they associated it with a positive body

image of themselves. For others, their desired weight was above a weight they remember being when they were younger, but now feel that the weight is too small. Jackie, who had been obese for most of her life and at the time of the interview was greater than 300lbs, stated that her desired weight was 185 and she stated it was because she didn't "remember being one-anything." The last two participants were not able to provide a desired weight. Melissa stated, "I don't have a desired weight. I just want to look good in my clothes and be comfortable." And Michelle stated that she didn't know what an ideal weight for her would be, but she had an ideal size. She expressed, "my ideal size as far as clothing would be like maybe a size 12 or 14."

Since the participants' desired weights fell outside of the normal healthy weight range, I decided to find out what they thought about the recommended weight range for their height. When told their recommended weight range, their reactions were mostly the same. For many, I was unable to read the entire weight range before I was interrupted by their laughter and/ or disagreement. Most felt the weight ranges were unrealistic and stated that they would never want to be that size. The reactions to the recommended weights can be seen in Table 9.

Table 9

Participants' Reactions to Recommended Weight Change

PARTICIPANT	RECOMMENDED WEIGHT	PARTICIPANT RESPONSE
JACKIE	122-164	(Laughter) "I think my leg probably weighs that. Oh no!
TEMIKA	118-159	"Yeah that's crazy! No. Never!"
MELISSA	115-154	"I don't ever remember being 115, ever! At 115, I would seriously look like I was on drugs."
LATANYA	95-128	Child, please! I could never be that skinny."
ALANA	115-154	"No. I weighed 115 when I was 10 years old."

(table continues)

DONNA	111-150	"That's not reality to me. I will look like somebody sick."

The participants' attitudes towards these smaller sizes seemed to stem from cultural influences and norms. Some of them expressed that the smaller sizes seemed too small and suggested that they would appear sick or appear to be on drugs. Latanya said, "I believe if you go to a certain weight, you kind of look kind of sickly, too skinny, you know." Another perspective included age as a factor. A few of the participants associated smaller sizes with younger age and expressed that it was asinine to even consider that someone their age would be within that weight range. As a health care professional, Denise believed that medical guidelines would suggest that she be around 120 to 125 lbs. But she stated, "That was high school weight. And I don't see myself as a 45-year-old woman weighing 120, 125." Two of the participants echoed this sentiment but suggested that it was even crazier when they consider their daughters. Latanya exclaimed, "That's like my daughter's weight. She is 19. I'm a 40-year-old woman. Come on now!" And Melissa explained why she would never desire to be the recommended weight, stating, "because I have a 12-year-old daughter who weighs 140. I can't see it." Most of the participants agreed that they would not be comfortable at a weight within the recommended weight range. They didn't believe they would be happy with the way they looked or felt if they were to lose the amount of weight to be considered a normal weight. Although all of the participants desired to lose weight, none intended to ever aim to reach the recommended weight range.

Personal and Cultural View of Weight

The participants had a clear understanding of why they felt the way they did about their own desired weight as well as the medical weight guidelines and recommended weight ranges. They all pointed to culture and race as factors in how they viewed weight. For many, to start, they believed that the medical guidelines were not created for them. One participant stated that the culture that created the guidelines was "derived from white supremacy." Many of the participants felt this way, as they believed the medical recommendations did not take ethnic and racial differences into consideration.

The participants' reluctance to follow the medical recommendations as noted in the previous section may result from their opposition to the lack of inclusion of ethnic and racial considerations. Many of the participants expressed their belief that Black women are built differently and should not be measured by the same scale used to measure Caucasian women.

Ideas such as differing body structures, genetic predisposition, and White or Caucasian standards were repeated among most of the women. Jackie explained,

> As African American women, we tend to be thicker in nature. We tend to carry a little more weight. Whereas that height-weight chart might have us looking too thin, but they are supposed to be ideal weight. I just find that our genetic makeup probably already puts us out of that range. So, I don't feel medically that that height-weight ratio is accurate for all ethnic groups.

Melissa expressed a similar opinion, stating, "black people are built totally different from Caucasian people. So, I believe that every number that is given is based on

their weight and not ours. They should have a totally different scale from us." And Michelle, provided her perception as it related to evolution of ethnic features, such as those developed by people of African ancestry, stating,

> I just wish they would incorporate those things because I am an African American woman. So, of course, I have that arch in my back. I have that high butt. So, I'm quite sure if we were to start to factor in things like bone density and whatnot, it would be different from someone who maybe came from another region of the world."

In addition to their disagreement with the medical guidelines and weight standards due the lack of inclusion, many also pointed to regional and racial culture for their views on weight. Many of the women openly expressed their desire to not be "skinny." Their responses pointed to cultural norms and beliefs as influencers of their perception of what is considered a normal weight. When discussing her desired weight, Alana stated,

> And it could be the culture of New Orleans. I mean, we know that a big, fine, healthy woman is attractive. So, that could be a reason why you don't find a lot of black women starving themselves to be thin.

She conveyed that she had no desire to emulate the "Caucasian standards" of beauty and what "they" considered normal. Although her weight would have her classified as severely obese, Alana, expressed confidence in herself and her weight and comfort in her place among the cultural norms of her city. Donna somewhat summed it up when she said, "But, in New Orleans, it's like we fat! We here! We pretty! Keep

eating! Keep it moving!" Melissa had similar views as expressed that she had no desire to be thin. She said, "ain't nobody worried about looking like a stick. I know I'm not. I don't want to look like no stick." And when asked if she believed that being overweight or obese was more accepted by those in her culture, she responded, "yeah. Because everybody fat. I don't have no skinny friends. It's not celebrated, but it's like, 'yeah, she fat. So?' Everybody fat. That's how I look at it. Everybody fat." Alicia, described the culture in the city stating, "It's kind of like it's a no judgement zone. I mean people are just accepted, you know."

The participants also discussed cultural weight categories and terms such as thick. The term "thick" was used to describe one that is heavier or one whose body shape is curvier. Denise used the term in both ways by first listing cultural body types, saying "in the African-American community, you can be slim-thick, thick-fine, or thin" and when describing her own weight gain, she stated "I am thicker than I've ever been." When Latanya explained that she just could not imagine herself "being skinny," she went on to say that she would desire to have a "little thickness," but "not too thick." The participants also described the curvy nature of Black women stating that they have more hips and butt and expressed how being "thicker" in those areas are both accepted and desirable. Gaining weight can also be looked at as a positive. For instance, Temika described how gaining weight is sometimes celebrated in her culture. She said if a woman gained weight and was in a relationship, it is automatically assumed that she is happy. She said you would hear things like, "Oh, you're eating good. Such and Such is feeding you good!"

Being thin within their culture was not conveyed as a desirable goal by the participants. Stacy even suggested that thinner women are now wanting to be "thicker" and would take drastic measures to obtain a thicker frame. She said, "Everything is being thick now. We have the ones that used to be slim, they're now going get their body done to be thicker." And when asked how did their culture, as a whole, view and perceived those who are thin, many of the women described more negative perceptions. Some expressed that assumptions are made that thin people are not eating enough or that they are sick or on drugs. One participant talked about her friend that is thin and how she appeared to monitor the nutrition facts of her food too closely. Another participant described her reaction to really thin people, stating that when she sees someone that is "skinny" she thinks to herself, "She don't eat no food. She needs a pork chop or a hamburger or some French fries. She don't eat. She eating like a bird. She eating bird food." Alana went on to say about the cultural view that,

> It's like a taboo for you to be skinny in the black culture. You're not supposed to be skinny. "You're supposed to eat some meat. Put some meat on your bones." You know, "go eat some mash potatoes so something can stick to your ribs." That's what I grew up hearing all the time.

There was one different cultural perspective, however. One participant had a significantly different perspective in regard to cultural acceptance. Jackie, who admitted to being overweight as a child and obese for all of her adult life, had a very different story from the other participants. She did not believe the culture was accepting of obesity but stated that since the celebrity of the singer Lizzo, she has noticed that people are

becoming more accepting. But she believed for the regular non-famous person, there was still a struggle with judgement and "fat shaming." Still, Jackie's view on weight is similar to those of the other participants. Although she wants to lose weight, she does not desire to be thin, nor does she agree with the recommended weight range for her height.

Perceived Severity

The participants had varying perceptions of severity related to their weight. Only three of them expressed fears specifically about the serious affects that their weight could possibly have on their life. When asked how she felt about her weight, Latanya said, "I don't like it. It's scary. I already have underlying health conditions." Stacy demonstrated her knowledge about her risk when she stated that she knew that "hypertension can really kill you and it's a silent killer." And Trenice spoke candidly about her fears when asked how she would describe her weight. She answered, "I definitely would define my weight as being obese and definitely not a safe weight." When asked how she felt about it, she responded, "It's alarming. It's also kind of discouraging and also scary at the same time." I then asked her why it was scary for her and she responded by saying,

> Because, you know, my health is being affected by my weight. And I want to live long. That's what makes it scary that my weight could take away my life. Make my life shorter than what it's supposed to be.

Although they didn't explicitly speak about the seriousness of possible life-threatening consequences, the other participants did express their perception of the severity when it related to how their weight may be related to their health conditions, as

well as the limitations that they believed they experienced as a result of their current weight.

Most of the participants admitted to health problems that they associated with their weight. Latanya, in particular, has a congenital heart condition. She expressed her concern for developing other conditions such as hypertension because of her weight and her condition. Donna has an inflammatory condition and stated that she believed that her flare ups were related to her diet and her weight. Trenice talked about her blood pressure and sleep apnea and she demonstrated her awareness of the relationship with her weight and those conditions. Stacy also admitted to having high blood pressure, as well as asthma. She stated,

> I have hypertension and also asthma. I feel as though I have hypertension because I'm obese. Actually, since I've been losing, I haven't been having problems with my hypertension. I also feel as though my asthma has evened up a little bit; I haven't been having as many attacks as I usually have. So, I think that my weight does play a big part with my health conditions.

Some of the other participants also talked about joint and back pain related to their weight. Denise believed that her health conditions and pain were a result of her weight gain. She said,"I have joint pain. That's my biggest thing which I attribute to my being overweight. I have a herniated disc which can flare up and I do attribute that to carrying more weight than I should."

There were similar admissions among the other participants, including knee and ankle pain, as well one participant admitted to varicose veins which she attributed to both her weight and standing for long periods on her job.

In addition to pain being attributed to their weight, some of the participants also discussed physical limitations. Alicia stated, “I feel bad trying to go upstairs or just doing different things. It’s a struggle sometimes to do some of those everyday things.” Michelle, Latanya, Jackie and Donna also admitted that they sometimes were uncomfortable and felt out of breath when performing tasks like getting dressed or walking.

Another issue related to the severity of being overweight or obese, which was discussed by all of the participants, was the limitations when it came to their wardrobe. Many described feeling uncomfortable because of how their clothes fit and having to shop at certain stores. Melissa and Michelle both spoke about the issues of having to shop at stores known for plus-sized clothes due to their weight. Michelle said, “I have to wear clothing in a certain size, or I have to shop at certain stores versus shopping at this store, I have to shop here to accommodate my size.” Jackie also spoke about limitations related to her clothes, but she expressed issues more related to comfort and physical limitations. Jackie explained the many limitations that she experienced as a result of her weight. She discussed the limited options in her wardrobe, but unlike the other participants, she expressed issues that were related more to comfort and physical ability. For instance, Jackie demonstrated how her weight limited her physically when getting dressed saying, “All shoes are slip on. There are no buckles, there are no ties with the

exception of tennis shoes. Just because bending over to try to buckle them or tying them is the issue."

She also talked about wearing certain types of clothes to ensure comfort. She said, "Pants, I don't like dresses. I don't like skirts. I carry most of my weight in my midsection, so I find that pants with a tunic length top is pretty much my uniform."

Jackie also discussed activity restrictions and social stigmas, which were experiences not expressed by the other participants. She explained that she had stopped participating in activities that many people enjoy, such as going to the movies because she was uncomfortable in the chairs or going to buffets because of the fear of judgment. She said, "I try to avoid buffets simply because I could feel the judgment when I go to a buffet." Jackie even expressed how her weight had affected her career. She recalled when she was in college and was discouraged from following her chosen career path by the chair of the department,

> She said, "sweetheart, I'm gonna save you a lot of time. And this might sound harsh." She said, "but you're too dark, you're not pretty enough, and you weigh too much to go into public relations."

Jackie went on to also express her belief that her weight had also caused her not to get hired or receive promotions that she believed she deserved. She stated that even when she had a position and was responsible for the success of the department, she believed she was still treated differently by her superiors or coworkers because of her weight.

Perceived Threat

After exploring the participants perceptions about weight classifications, their own personal weight, and the medical recommendations for healthy weight ranges based on their height, I attempted to gain insight on their perceived threat of developing chronic conditions, especially those that are related to obesity. I asked the participants to describe their risk of developing conditions such as hypertension, diabetes, and heart disease. The participants perceived threat of these diseases were related to their perception of risks based on several factors.

Weight and Lifestyle Behaviors

About half of the participants believed that their weight and/ or lifestyle were risk factors for developing one or all of the chronic conditions named. Five of the participants believed that they were at an increased risk because of their weight. Trenice, who already suffered with hypertension, stated that she "definitely" had a higher risk of developing diabetes. She said, "I was a point something away from being a diabetic. So, it's closely related. My weight is closely related to me getting other health issues." She also believed that some of the high-sodium foods in her diet increased her morbidity. Stacy also suffered with hypertension already but believed that her weight increased her risk for developing diabetes. At the time of the interview, she had lost a significant amount of weight but stated, "I believe if I would continue to be obese and get bigger, there's definitely a chance that I can get diabetes." Jackie also believed her risk was high because of her weight and both Alicia and Latanya expressed that they needed to make lifestyle changes because they understood that their diets and weight increased their risk. And

lastly, Alana believed that her highly stressful work environment and her inability to eat healthy due to lack of time both contributed to her risk.

Risk Due to Other Health Conditions

Jackie and Latanya both believed that their pre-existing health issues increased their risk for developing other chronic conditions. Jackie suffers with an autoimmune disease, which she believed was the reason that she had experienced hypertension in the past. She also believed it increased her risk for developing other conditions. She stated, "because of the lupus, I am at an increased risk for developing other conditions." Latanya suffers with a congenital heart abnormality that required a valve replacement. She expressed her belief that "most people that do have heart conditions" also suffer with "hypertension issues," so she believed that her condition increased her risk.

Risk Due to Family History

A few of the participants believed that their family history increased their risk for the obesity-related conditions named. For two of the individuals, family history was the only reason they stated for their increased risk. Keisha believed she was an increased risk because due to heredity, stating, "my grandparents, they have it and my mom, she's borderline for having it." Denise stated,

> I believe that my risk is high because it does run in my family. Diabetes runs in my family. People who have heart disease, in my family. Hypertension. My great grandparents on both sides died from massive heart attacks. So, my risks are high.

Alicia also stated, “Very likely, because I come from a family that has all those things that’s associated with being overweight, high blood pressure, diabetes, and heart problems.”

Latanya and Alana also believed that family history added to their risks. Alana stated that her grandfather had two strokes and that she had diabetes on both sides of her family.

Some of the participants, despite their weight classifications, had lower risk perceptions than the other participants. For instance, Michelle believed that race increased her risk. She said, “I’m at high risk because I’m black.” When asked about health conditions, Michelle denied having any health problems. She stated that her doctor recommended she lose 80lbs but since she does not have any health problems, she did not feel it was necessary. She explained,

> My response to him was when you do my blood work and when my blood work comes back and we need to start focusing on certain things because I’m pre-diabetic or I have high blood pressure or I have high cholesterol, then we can talk about getting those things under control. If getting those things under control calls for me to have to lose weight, then I’ll do it. But if you’re telling me to lose weight just because the culture we live in, which is definitely derived from white supremacy, says I have to lose weight, then no, I decline.

Melissa also demonstrated low risk perception of developing obesity related chronic diseases. She, like Michelle, does not have any known health conditions. She said that recently her dad took her blood pressure and told her it was high. But she stated since she always has had “perfect pressure,” she contributed it to stress as a result of the

pandemic. When asked if her she thought her diet or her weight increased her risk for developing high blood pressure, she responded saying,

> I always use that as a cushion. I don't have any problems with my pressure so I can eat anything I want. That is my attitude, knowing I'm getting older and the fact that they told me I lost weight. I'm like, I'm good.

And lastly, Temika, even when taking her weight into consideration, also believed she had little to no risk of developing obesity-related conditions. When asked to describe her risk, she responded,

> I mean, I don't think I would develop it on my weight because I don't have a bad diet, per say. I think a lot of my weight is coming from stress. So high blood pressure and diabetes, not so much because I don't have bad eating habits.

The full spectrum of the participant's perception of risk failed to be captured in their responses to being asked directly about those conditions. However, as we delve into the aspects of their culture, the participants began to share their perceptions of the influence of culture on their diets, as well as the divulge on cultural foods, which many labeled as unhealthy.

Barriers

The participants were asked about what they believed were barriers to them making lifestyle changes and performing healthier behaviors. The responses varied among the participants but many of them believed their environment was a barrier to change. The culture of New Orleans is very food-driven and many of the participants believed the abundance and constant display of unhealthy foods was a barrier to them

choosing a healthier lifestyle. In her attempt to provide understanding of how much unhealthy food is available, Keisha explained,

> Because it's so many different foods everywhere you look. It could be a corner store. They're going to have like a food section in a corner where you can go in and get hot plates and things like that. And a lot of gas stations nowadays have turned into like semi-food stops. So, it's everywhere. It's everywhere you go.

Other barriers named were the excess of unhealthy foods that are offered at the numerous food festivals, the availability of unique foods and seasonal foods indigenous to the area, and some even believed that their work environment was a barrier due to the abundance of unhealthy food options available. Keisha expressed that "it's hard for someone from New Orleans not to eat the foods that you grew up on that you're known for having in your city." Stacy agreed, stating, "our culture is so rich when it comes down to our food." She said "it's hard to fight the temptation." Other barriers included those related to finances, timing, and mental health.

Lack of Access

Lack of access to health care and affordable healthy food options were frequently named among the participants as barriers. Being uninsured or underinsured was an issue discussed by Latanya, Jackie and Alicia. Jackie stated that she "didn't have health insurance for a while" and was unable to see a doctor and Alicia believed that many people in her community are unable to see their doctor because of the lack of insurance or the inability to pay co-pays. Latanya added to that stating that "and a lot of us don't have health insurance" because it's "impossible to afford." The lack of affordable food options

was also a barrier for many of the participants as they believed that living a healthy lifestyle is too expensive. Alicia and Latanya both discussed the price differences between healthy and unhealthy options. Alicia said, “it is so much more expensive to eat healthy than it is to eat regular” and Latanya provided a similar sentiment stating, “Healthier food is more expensive and the bad foods are more readily available for us.” Some of the participants expressed that healthier foods like lean meats and vegetables are not affordable to everyone and that many of the foods recommended are not available in the stores where they shop.

Timing and Scheduling

Timing and scheduling were barriers for some of the participants. They believed lack of time due to their work schedules presented a barrier to them eating healthier. Denise believed that her “hectic” work schedule made it difficult to eat an appropriate time. She also believed that her options are minimal, stating “the later it gets, the healthy food options decrease.” She also admitted to not being very organized, making it more difficult to plan healthy meals during the time frame that she has available. Alana also expressed that after working long hours, she is too tired to prepare a healthy meal.

Lack of Knowledge

About half of the participants believed that their lack of knowledge was a barrier to their behavioral change. Some of them admitted that they have difficulty preparing healthier meals. Michelle expressed that she knows how to cook the food that she had growing up and doesn’t know how to cook some of the foods that are recommended for her diet. The other issue related to cooking was the lack of ideas. Trenice, Jackie, and

Alicia felt that they needed more menu recommendations and recipes. Alicia said she felt like she was eating the same meals over and over and Jackie said she had difficulty coming up with meals that didn't cause digestive issues. Deciphering the information available was also stated as a knowledge barrier. Latanya, who attempts to eat healthy, when discussing the issue of olive oil versus avocado oil, stated, "It's just all kind of different things like little tedious things they want you to look into and research. And it's hard. Especially when you're doing it on your own." And Alicia talked about hearing mixed messages about what foods were considered healthy and what food items are okay to eat.

Psychological Barriers

The participants provided several examples of psychological barriers, such as depression and lack of motivation. Keisha said that she often gives up when she doesn't see "results right away" because she becomes discouraged and Latanya admitted that sometimes it's just her being "stubborn" and "not wanting" to follow healthy guidelines and recommendations. Others believed stress, anxiety, and depression have been barriers for them. Trenice said that she self-sabotages when she is stressed and Temika said she believed anxiety and stress both contributed to her weight and were barriers in her changing her behaviors.

Other Barriers

There were several other barriers that were also discussed in the interviews. For instance, taste was an issue for some of the participants. Keisha, Temika, and Melissa all admitted to being "picky' eaters and believed that this presented a challenge for them

when eating certain foods. Keisha said, “I’m a very picky eater, so certain things that may be recommended, I may not eat at all.” Donna, on the other hand, admitted to learning how to prepare food in healthier ways, but also admitted that the problem for her was that “it just doesn’t taste the same” because she was “accustomed to tasting the food one way” which she described as “the bad way.” Latanya agreed with those sentiments stating that “it doesn’t taste that good if you follow their recommendations to the ‘T’” and admitted that she adds her “own little spice” and her “own little twist,” even though she believed that the practice was “not right.” And Michelle, believed it was hard to make dietary changes because her palate was not accustomed to the foods that were recommended.

Social norms and lack of social support were also factors that contributed to the challenges the participants perceived as barriers in their behavior change. Trenice, Alicia, and Latanya all agreed that they sometimes feel pressured to eat a certain way by family members, especially during holiday and family gatherings. Trenice said “people will get offended because you don’t want to try their food.” She also admitted to being discouraged from eating healthier, saying “if you try to eat healthy, you get mocked for it.” Others echoed that statement when discussing the reactions they get from family members when they have tried to cook healthier meal options or bring healthy vegetables to family gatherings.

Benefits to Change

The participants perceived benefits to changing their behavior fell into two categories, health and comfort. They either believed that their health would improve or they would be less likely to develop the health conditions that are common in their

families if they achieved a healthier weight. Most of the participants with current health problems believed that losing weight would improve their health. For example, Trenice knew that her blood pressure and sleeping issues would improve with weight loss and Stacy knew that her recent weight loss had contributed to the improvement in her blood pressure and asthma symptoms. Others, like Alicia, who did not have any current health issues, knew that losing weight would decrease the likelihood that she would "develop those problems" that plagued many of her family members. But for Latanya, when it came to health and losing weight, she stated,

> As far as body image, I don't have body image issues, but in my mind, I have a health issue. I need to know that I'm going to be healthy with or without the weight. I don't care about the weight. I just want to be healthy overall.

Comfort was the most common term stated among most of the participants as it related to losing weight. "I just want to be comfortable" was a common response to the question about their desired weight. Melissa had a hard time providing a desired weight and stated that she just wanted to look good in her "clothes and be comfortable." She also said she would "love not to shop in Lane Bryant." Alana similarly responded that she just wanted to be "comfortable" and "look nice" in her clothes. And when expressing her feelings about reaching her goal weight, Temika stated, "I'll be comfortable in my skin. I'll be comfortable in my clothes." And Latanya, Alana, and Jackie all stated that they sometimes feel uncomfortable and suggested that their weight was the cause of the discomfort.

Motivation or Cues for Change

The participants were asked what were the factors that would motivate them and make them more likely to make healthy lifestyle changes. Many of the participants expressed readiness to make changes and believed if they had more resources, they would be more likely to start and maintain healthier lifestyles. For instance, Alana, Trenice and Alicia believed if they had more menu ideas and recipes, they would have more success with eating healthier. Trenice said that if she was given a calendar with menu suggestions, she would be more encouraged, and Alicia believed that if she had more recipe ideas it would be easier to maintain a healthy diet. Alana suggested a recipe exchange as a solution. She believed the different recipe options would help to prevent boredom from cooking the same items "over and over," as well as making poor food choices due to lack of ideas.

The participants also believed if health recommendations included foods that were more palatable, they would be more likely to follow them. Keisha, who admitted that she was a "picky eater" wished that she could be provided with substitution ideas for the foods that she doesn't eat. Other participants believed they would more likely participate in behavior change if the health recommendations were tailored to their culture. Many of them believed the ability to make cultural modifications to both food and exercise would be a motivating factor. For instance, Jackie believed that if there was a way to make modifications to "foods that's indigenous to New Orleans and change them in a way to make them healthy but still authentic," more people would probably eat healthier. She also suggested that music and cultural traditions be incorporated into fitness programs.

Donna and Melissa also believed if they were allowed to eat the foods they loved in moderation, they would be more likely to make dietary changes.

Support and guidance were also factors that the participants believed would motivate change. Jackie stated that she tended to do better when she had "to be accountable to someone else," so an accountability partner would help to motivate her to remain consistent. Alana, who admitted to working long hours, said that "having a support system" among her coworkers would be beneficial. And Temika said she would be more willing to follow recommendations if they were provided by a nutritionist and "catered specifically" for her and her body.

Other motivating factors were body image, measurable results, and health. Keisha works in the beauty industry and stated that she is motivated to make changes because,

> I am the face of my brand. That right there is motivating me to really get my body back right. That's why I've been afraid to do a photo shoot and things like that because I'm not comfortable with my body. But I know that I need to get to that space. So, my business right now will be my motivation for getting myself back together.

Denise said:

> I'm more keen to stay on a diet and do the things I'm supposed to do when I actually start seeing results. So when I see that the weight is coming off and I start feeling better and I'm not having the joint pain or my skin is clearing up, then I'm more apt to try to stay on the right path.

For a few of the participants, the idea of improving their health or preventing health issues, were motivations to follow healthy lifestyle recommendations.

Self-Efficacy

In an attempt to gain insight on the participants' ability to maintain a healthy lifestyle, they were asked questions related to self-efficacy. The participants' dietary and health knowledge and their experiences relating to healthy lifestyle behaviors were discussed. They talked about their knowledge of unhealthy food choices and how these choices can impact their health. We also discussed their current behaviors and their past attempts at making healthy lifestyle changes.

Knowledge

When discussing their diets, many of them expressed their beliefs about the relationship between food and health. For instance, sodium was a topic that was brought up often. Trenice expressed that many of the cultural foods that she is accustomed to eating are foods that can increase her blood pressure. She understood that these foods should be limited but stated that many of the cultural dishes exceed the recommended "daily sodium intake." Michelle, Stacy, and Latanya also demonstrated their knowledge about sodium and hypertension, with Latanya even stating that she maintains a mostly low-sodium diet.

Some of the other participants also talked about their knowledge of the types of food that affect their current health issues. Denise mentioned the effects of sugar on her skin and Donna acknowledged that her poor dietary choices caused flare ups in her skin condition. Alana and Latanya also were both aware of the affect that certain foods have

on their heart conditions. Alana stated, “From doing a little research, I find that a lot of caffeine and a lot of foods with MSG will trigger my SVT.” And Latanya admitted that because of her heart condition, she has to be “cholesterol conscious,” making sure she avoids foods with “high cholesterol, high salt content,” and “high fat content.”

Lifestyle Behaviors

All of the participants admitted to attempting to perform healthy lifestyle behaviors at some point in their adult life. Some of them tried very specific diets that they didn’t continue. For instance, Jackie said she was vegan for a year. She said that she experienced better sleep, clearer skin, and more energy and although she “absolutely loved it” and “felt great,” she gained weight. She believed it was due to eating too many carbs and felt like a low-carb vegan diet was “too restrictive.” She is currently following a low carb diet as she feels counting carbs is easier than counting calories. Another participant who admitted to trying a specific and restrictive diet was Michelle, who said she decided she wanted “to try the pescatarian diet.” She said she “was doing so well,” avoiding red meat and chicken and only eating vegetables and fish. She even brought her own food to family gatherings. Unfortunately, her diet was disrupted during Mardi Gras when she admits that during the celebration, she ate chicken wings.

A few of the other participants chose the route of changing their lifestyle instead of following a diet. Melissa desired the ability to eat the food that she loved, so she follows the Weight Watcher’s model. She said she has lost about 20lbs. Alana admitted to making small, but significant changes in her lifestyle, which included avoiding fast foods and processed foods and not eating after 7 pm. She also admitted to smaller

portions and drinking more water. She said she was able to lose 30lbs and believed she was successful because, “it’s a change in lifestyle” and she didn’t feel restricted. Stacy, Temika, Trenice and Latanya also admitted to following a healthy lifestyle where they’re eating healthier. Michelle states that she has made changes in how she cooks by no longer using pickled meat and now substitutes with healthier ingredients such as smoked turkey. Jackie also admitted to making modifications to her meals, stating, “I did a cauliflower rice jambalaya and it was pretty good. And I did a dirty rice that substituted mushrooms for the meat and that turned out pretty good too.”

Only two of the participants admitted to currently having an exercise routine. Stacy stated that she recently began exercising but Temika was the only participant who admitted to a consistent daily exercise regimen. Jackie admitted to recently training for a half marathon. She said she not only was able to go further than she did in training, but more importantly, she was able to complete the course. Alicia admitted to once being more active, “walking three times a week” but states lately “I haven’t been doing anything.”

Perceptions of Social, Regional, and Ethnic Cultural Influences

Culture and Lifestyle

All of the participants believed their culture had a significant influence on their lifestyle behaviors. In order to assess their perception of the level of influence, the participants were asked several questions about their cultural behaviors and more specifically, they were asked what role they believed their culture played in their diet. The answers given demonstrated the extent in which the participants believed they had

been influenced by their culture. Most of participants replied describing their culture's role as "the biggest" or "huge," while others believed that their culture was "the main role." One participant, Alana, stated, "It doesn't play a role. That's my culture. I mean, I don't know anything other than the way we do things in New Orleans. That's just my lifestyle." The participants elaborated and provided context to this statement with most of their statements aligning with the others.

Many of the participants blamed their culture for their current struggles. They believed the environment contributed to their weight and their health behaviors. Many of them spoke about the abundance of unhealthy food that is available and how it is difficult for them to resist. Trenice said about the food, "Everything, pretty much that's unhealthy, it's pretty much everywhere." And Donna said, "There's bad food everywhere. And it's like the food that's put out and advertised for you is the cultural foods. And it's just unhealthy food." But she went onto to say about her love for the cultural foods, "I know for me, the food in New Orleans is amazing. There's nothing like it." Some even went on to say that their culture makes it difficult for them to change their lifestyle behaviors. Speaking on the difficulty of eating healthy and losing weight, Jackie said, "New Orleans is not the easiest place to try to lose weight or have a healthy lifestyle" and Alicia said, "We do things as far as like trying to diet or cut out carbs and all that is just so hard with where we live."

They added that the cultural traditions that they are accustomed to following can make it even more difficult to resist the cultural foods. One of the common influencing factors among most of the participants were the many festivals that occur throughout the

year. When asked the role of culture in her diet, Donna stated that her culture played 100% of the role in her diet, further stating, “I live in New Orleans and we have more festivals, more tastings, more events than probably anyone in the country.” Stacy echoed this, stating that with the many festivals, she finds it hard to “fight the temptation” and feels that “New Orleans culture has had a bad influence” on her health “because of the food.” She said in New Orleans, “everything’s just fattening, but it’s delicious.” She and several other participants spoke about how a festival could derail any plans for eating healthy. Alicia said, “as soon as you start it’s like there’s always something that’s going on in New Orleans, like you go from one festival to another.” Other cultural factors such as crawfish season and holidays also were described as contributors to their poor behaviors. Most of the participants admitted to knowing how unhealthy boiled crawfish could be due to the sodium in the seasoning, but stated that during crawfish season, they still take part in its consumption.

Another issue that was brought up about the food culture in New Orleans was the lack of healthy options. Temika spoke on the many events within her cultural environment and stated that “they don’t always have healthy options and Alana stated that “New Orleans doesn’t promote a lot of healthy food.” This was also a very common issue among the participants, as many stated, the lack of healthy options had been a factor in their lifestyle. Stacy mentioned that if she goes out for entertainment, it isn’t likely that she will eat healthy because “there’s no salad bar” in the entertainment venues.

Lastly, a couple of the participants spoke of the strength of the influence that their culture has had on their behaviors. Temika stated that she began cooking while she was at

an out of state college so that she "could eat the way we ate in New Orleans." She said this led her to "started cooking for a living." Alicia also admitted to bringing her traditions with her out of the state. She said while living outside of Louisiana, she continued to follow many of same customs that she had been accustomed to in New Orleans, admitting that every Monday, she "needed to cook red beans." Many of the others also admitted to seeking out New Orleans cuisine and ingredients when traveling or living outside of the state.

Family and Sociocultural Influences on Health Behaviors

According to the participants, their culture significantly influenced their current lifestyle behaviors. But in order to gain further insight on their perception of how socio-cultural exposures influenced their health behaviors, they were asked about their health-related childhood experiences. Since many of the participants admitted during their interviews that healthy behaviors were learned or attempted later in life, I asked them what type of healthy influences they experienced growing up. Most of the participants admitted to having limited exposure to healthy influences related to healthy eating and regular exercise.

Healthy eating. According to the majority of the participants, healthy eating was not stressed or even encouraged during their childhood years. Most of them admitted that healthy eating was not a priority. Michelle, like many of the other participants, denied hearing about the importance of eating healthy fruits and vegetables or a balanced meal. She said, "When it came to food, I never heard the terms or the ideas that you should do this because this is healthy." She then admitted that she was more likely to hear, "you

better eat all your food because you better thank God you got food." Alicia, as well as other participants, had similar experiences. Alicia stressed that as a child she was expected to eat whatever her mother cooked, stating she would be told "you better eat this because this is what we're having. And if you don't eat it, you ain't eating nothing." Not only was healthy eating not encouraged, some participants stated that unhealthy eating behaviors were not discouraged. Temika told a story of how she was a "chubby kid" and how her parents allowed her to eat large portions of unhealthy food. While in elementary school, she said her parents would let her order a double cheeseburger meal, which came with two cheeseburgers, fries, and a drink. But it wasn't until she started middle school that she, on her own, decided that she no longer wanted to eat as much, which led her to lose a significant amount of weight.

A few of the participants admitted to exposure to healthy eating behaviors. Jackie, who admitted to being overweight as a child, stated that she was "put on diets" and was given "diet food" while everyone else in the house ate the traditional foods. She also said that her grandmother brought her to doctor frequently for help with her weight. Latanya, who also spent a lot of time in doctor's offices, but because of her congenital heart condition, stated that she was encouraged by her mother to eat healthier foods, but admits that still much of the food cooked by her family would be considered unhealthy. Alana and Denise both admitted to eating healthy fruits and vegetables as children. Alana stated that although healthy eating wasn't stressed, it was "cost effective" because her meals included "fresh fruits and vegetables" out of her family's garden.

Exercise. All except one of the participants stated there was very little exposure to regular physical activity outside of their school physical education classes and their parents encouraging them to play outside. Those participants also denied seeing adults in their family or around their neighborhood participating in regular physical activity. They all stated, however, that as children that they were encouraged to play outside, which included activities such as riding their bikes, playing tag, or jumping rope. But for many, that was the extent of their exposure. Stacy was the only participant that admitted that she received encouragement to participate in regular exercise. Her mother would teach her and her siblings the importance of being active. She said, "My mom, she is very athletic. So, she would ride bikes. She would bring us to play baseball. So, we were always active. She also had days where she would exercise with us."

Reactive health behaviors. The participants all mostly agreed on the reactive nature of those in their family and social environments as it related to healthy behaviors. Some of them admitted that the knowledge that they had about healthy and unhealthy food was attained because someone in their family suffered with a chronic health condition, such as diabetes or high blood pressure. Stacy said she learned as a child that "eating a lot of sweets or eating a lot of starch could possibly give you diabetes." Michelle similarly stated, "I always knew you shouldn't eat a whole lot of sugar because you gonna have 'sugar'." She said both of her grandmothers had diabetes and she "would hear people say things about blood pressure." Many of the participants agreed that the only time they heard anything about eating healthier foods or noticed that family members were making dietary changes was when someone was diagnosed with a health

condition. And according to some of the participants, the behavior changes in the family members who were not diagnosed would be temporary.

Perceptions of Other Influences

There were other factors that some of the participants believed influenced their behaviors. A few of them perceived that their race and ethnicity influenced the behaviors. Trenice, Donna, and Michelle all believed their diet was also influenced by their race. Trenice believed that her race played a "huge part" in the types of food that she was accustomed to eating, especially those high in fats and sodium and Michelle believed that black people tended to eat foods that aren't right for them. Donna talked about the types of food that are common in her racial and ethnic community and how it affects their health. She said, "African Americans, we probably eat more dirty food or unhealthy food than any other ethnic group. We love, I know I love smothered this, smothered that. We eat!" And she went on to say, "Because if you look at the African Americans, we have the highest statistics of diabetes, heart conditions. I guess because we eat all the pickled meat and the pig tales." Some of them also believed that race and ethnicity influenced their attitudes about weight. They believed that black women have different body structures and are more likely to be curvier and not be considered within their social environment as overweight. They admittedly rejected thin ideals because they believed mainstream and medical weight recommendations were not "accurate for all ethnic groups."

Religion was another factor that was discussed among several of the participants. Throughout the interviews, a few participants discussed the Catholic influence on their

diets during lent season. Many of them admitted to eating fried seafood during the season and sometimes throughout the entire year and they all contributed this to the Catholic traditions followed by most people in the GNO. The participants described the traditional "fish plates" with sides such as potato salad, peas, and macaroni and cheese that are sold by the Catholic churches and similar menus cooked and served in homes throughout the area during Lent. The other two factors were opposing perspectives as it relates to religion. Trenice believed that her beliefs have helped her make positive changes in her diet. She said, "My faith has been helping. Listening to sermons about healthy eating and making it a personal journey, especially with religion." But Jackie believed that religion can have a negative influence on health behaviors. First, she discussed how "the church will sell suppers when they're trying to raise money" and how food is usually provided after special church services. She explained that the food, which is usually cooked by the women of the church, is similar to meals that are prepared in the parishioners' homes. She then went on to talk about how spirituality in her community tends to take away individuals' personal responsibility for their behaviors. She said,

> I think we tend to lean towards spirituality a lot in our culture. If we're sick, we're going to pray. And we're going to pray before everything. Before we do anything, we're going to pray about it. So not saying that spirituality is in the way, but it kind of takes away from ownership of what we could do personally instead of just relying on other interventions.

Another issue that was also noted was the internal battle that some of the participants admitted to when making decisions about their diet. Many of them

understood the health benefits of eating healthier foods and the risks associated with eating poorly but still also struggled to choose healthier options. When discussing her recent behavior changes, Trenice stated, “It’s like a battle.” She admitted to gaining more knowledge but felt that her diet was not as “good” as she would have liked it to be. She also felt guilty at times for avoiding traditional foods because according to her, “it makes me lose touch with my ancestors because I know this is what they used to eat.” Denise also expressed that she struggled with the battle between what she knows and what she desires. When she found herself in a situation where there were desirable unhealthy dishes available, she said, “I may feel guilty afterwards but I’m gonna enjoy it while I’m eating it.”

Some of the participants acknowledged that even if they were equipped with knowledge from a healthcare perspective, they still sometimes would make the wrong decisions. Donna explained how her “bad habits overcome the good habits” after attempting to eat healthy. When asked how she felt about the recommendations from her doctor about healthy eating, she said,

> I don’t feel like it, but I understand their logic. But I do also feel sometimes I don’t want to follow the doctor’s rules, because it is hard to go to an event where there are delicious food items like coconut shrimp, which is one of my favorites, wrapped in bacon. Who can say no to that? It’s just hard. I’ve tried it, but I feel like I’m cheating myself because I really want it and I’m trying to convince my body not to do it.

Stacy echoed this saying that she has difficulty avoiding foods that she knows will negatively affect her, stating, “I might eat something and hope that my pressure won’t go up. But it be so good and that’s something you want so you’re willing to take that risk.” This internal battle was also an issue for those who worked in the healthcare field. Alana described the polarity in what she teaches and some of her own health behaviors. She said that working in the health care field requires her to teach her patients about diet, but said she knows after discharging them home, she is going to “eat French fries in the cafeteria.” With knowledge available, some of the participants are as Latanya described, at a “crossroad with eating healthy and not eating healthy” and they will often take the unhealthy road.

Summary

The participants demonstrated an understanding of the relationship between their behaviors and their weight status. They perceived their culture to play a significant role in their health behaviors, attitudes, and health statuses, as well as those of their population. They demonstrated some distinctions between the ethnic cultural influences and the influences related to living in the GNO. Their descriptions of the beliefs, social norms, attitudes, and traditions of their combined culture revealed that their unique experiences have influenced the way they view weight, weight standards, health, and healthy behaviors. They acknowledged this influence and most of them understood the impact that it has had on their weight and their risk for developing obesity related conditions.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this study, a phenomenological approach was used to gain an understanding of the lived experiences of overweight and obese adult African American women living in the GNO. The objective of this study was to gain insights regarding how cultural experiences influenced their knowledge, perceptions, and attitudes about obesity and obesity-related conditions, as well as understand how they made sense of those experiences and determine what they perceived about the role of those experiences in determining their health behaviors. There have been numerous studies that have explored the roles of African American culture on the health behaviors of African Americans. There have also been studies investigating the cultural influences experienced by African Americans living in the southern region of the United States. However, there have been no studies that addressed the unique cultural experiences of overweight or obese adult African American women in the GNO and the role of those experiences in their health behaviors. This study provided information regarding cultural factors that influence the health behaviors of this group, which may be used to create culturally-appropriate interventions to address the public health issues of obesity and obesity-related conditions in this community.

Key Findings

In this study, using IPA, I immersed myself, and my own experiences into the interpretation of the participants' lived experiences to reveal how they interpret their own experiences. As an individual who would have qualified for participation in this study, I

was able to see many commonalities and shared experiences, as well as learn about the unique attitudes and perceptions of the participants that resulted from those experiences. The reported data demonstrated the uniqueness of their lived experiences, but it also tells a story of how they have come to understand and make sense of them. In addition, the data demonstrates crucial factors in their decision-making about regarding healthy behaviors and prevention and management of obesity and obesity-related conditions.

Although I used an idiographic approach during analysis, the interview questions allowed the participants' responses to align with the constructs of the HBM. The HBM posits that an individual's perceptions about a condition, including the severity of the condition, their susceptibility, and the benefits and barriers to performing preventive behaviors predict the likelihood that the individual will participate in the recommended behaviors (Stretcher & Rosenstock, 1997). The participants' perceptions about obesity and obesity-related conditions, as well as their perceptions about the influence of their cultural experiences provide insight regarding factors that are essential to understanding how to motivate change in this community. This study found that the participants' perceptions of obesity differed widely from the medical definitions and were influenced by cultural norms. These differences have led to negative perceptions about BMI weight standards and what is considered normal according to those standards. Most, however, had an understanding of their risks and the consequences associated with obesity and agreed that they needed to make changes to reduce their weight, but their desired weights were still considered unhealthy according to BMI weight standards. The participants also described their past attempts at behavior changes and the barriers they perceived to

inhibit them from making lifestyle changes. For most, their environment was the most significant barrier, followed by a lack of time, knowledge, and access. According to the participants, benefits included better health, looking and feeling better, and being comfortable in their clothes. There were few motivating factors, especially considering their perceptions about obesity. Most admitted that they would be motivated to eat healthier if healthy food resembled the food they enjoyed.

The participants' backgrounds and sociocultural environment was the phenomenon I sought to understand. The participants perceived that their culture, including their environment, social norms, beliefs, and traditions as well as their cultural experiences were the main influencers of their health behaviors. They described food as a priority in their culture. They expressed that they experienced few healthy influences such as instruction, demonstration, or encouragement of healthy eating and physical fitness practices during their day-to-day life. The findings revealed that participants believed they lacked sufficient information and options that were realistic within their cultural environment.

Interpretation of the Findings

The study's findings confirmed and extended what is known about overweight and obese African American women's perceptions of obesity. The main themes noted in the literature review included perceptions of body image and weight, knowledge about obesity, obesity-related conditions, and obesity prevention, and barriers to change. The findings of this study demonstrated the influence of culture on these themes. To further

understand the implications of these findings, they have been explored and interpreted using the HBM.

Perceived Threat

According to the HBM, individuals are more likely to participate in healthy lifestyle behaviors if they believe they are susceptible to obesity and believe obesity-related consequences are severe enough (Rimer & Brewer, 2015). The constructs of perceived susceptibility and perceived severity combine to create the construct of perceived threat, which, in this study, is the perceived threat of developing obesity-related conditions. Most participants' definitions of overweight and obesity differed from the medical descriptions. Instead of weight-based definitions, they defined this term using physical characteristics, physical abilities, or associated health conditions. The findings confirmed those of prior studies that found that participants judged weight based on physical attributes, level of comfort, and physical ability (Agne et al., 2012; Cameron et al., 2018; Lopez et al., 2014; Talleyrand et al., 2017). Their perception of obesity also confirmed previous research findings. Some of the participants had extreme perceptions about what is considered obese, and many of them described the term as harsh, or offensive. Women in the study performed by Lopez et al. (2014) had similar perceptions of the term, such as believing obesity described an individual weighing 600lbs and describing the term as offensive. It is important to understand the participants' perceptions of what is considered healthy and unhealthy regarding weight to understand their perceptions of their own susceptibility and level of threat.

Perceptions of Weight, Body Image, and BMI Weight Standards

Although the participants' definitions of weight categories varied from the technical descriptions, most participants correctly self-identified their weight. Some identified the correct category but admitted that they did not agree with the classification, either due to their body proportions or because they believed they were healthy. Most disagreed with mainstream standards for weight and the use of BMI as a tool for measurement. A few participants expressed their belief that the current system is derived from white supremacy, and most perceived the medical recommendations for healthy weight ranges were unrealistic. They believed they did not consider ethnic factors. Their perceptions echoed those expressed in prior studies. For example, the participants in a study performed by Cameron et al. (2018) also described BMI as racially oppressive. They believed it is a tool used by White Americans to promote thinner body frames. Lopez et al. (2014) reported that participants described the weight standards as being "White" or "European" and believed that they did not apply to African Americans. These perceptions about the medical and mainstream weight classifications appear to have skewed the participants' perceptions of what is considered healthy and prompted rejection of medical recommendations, likely decreasing their perceived susceptibility.

While some participants had negative body images, most had positive body images despite their weight classifications, which appeared to stem from their cultural perceptions about weight. Each of the participants, including those with positive body images and those that disagreed with the weight standards, all desired to lose weight. However, each of their desired weight ranges still placed them in unhealthy weight

categories, and just as in Cameron et al. (2018) findings, the participants all rejected the idea of being skinny. The participants had concerns about being too skinny or appearing sick. They expressed that many of their peers were also overweight and that it was mostly accepted within their culture. One participant whose weight was considered very obese denied an overall cultural acceptance of obesity. She admitted to mostly different lived experiences related to her weight compared to the other participants. Also, they used cultural weight categories and terms such as the term thick, when describing acceptable weight just as in previous studies. The evidence is clear that their cultural view of weight conflicts with medical recommendations and presents another variable in how they perceive their susceptibility.

Perceptions of Severity

The level of severity perception varied considerably among the participants. They listed eating habits, stress, and mental health issues as causes of their current weight. But only about half of the participants believed they were at risk of developing chronic health conditions due to their lifestyle behaviors or their weight. Five of them thought their weight increased their risk, but only three expressed fear about their risk of potentially severe consequences related to their weight. Other consequences of being overweight or obese, such as appearance, physical limitations, and wardrobe limitations, were discussed among all participants. All except two of the participants denied any social limitations or issues with acceptance or social stigmas. Pickett and Peters (2017) had similar findings from their study. Most of their participants named health outcomes and appearance as consequences, and few were concerned about social limitations, stigmas, or

discrimination. For some of the participants, since they did not currently suffer from any health conditions, their perception of risk was lower than others. Two of the participants had a very low perception of risk related to their weight, despite having weights that were considered severely obese. Some believed that their risk for chronic health conditions, such as high blood pressure, heart disease, or diabetes, were due to ethnicity, family history, or stress.

Theoretical Analysis

According to the HBM, perceived susceptibility and perceived severity are key constructs that are believed to motivate behavior change (Skinner et al., 2015). Although all of the participants desired to lose weight, their perception of ideal weights and healthy weight ranges, and their cultural views and rejection of the BMI weight standards demonstrated the significance of social norms and normative and cultural beliefs and attitudes in examining this construct. Due to these factors, we can assume that there is some level of perceived susceptibility among the participants. Still, the extent to which they perceive does not align with their susceptibility according to medical standards. Most of the participants based their perception of severity on comfort, and for a few, health and physical ability added to their perceived risk. A few of the participants had a low perception of threat related to developing obesity-related conditions. Although their perceived susceptibility can be linked to culture, their perceived severity appeared to be due to limited knowledge about the risk factors and potential consequences of obesity-related health conditions. However, based on the information gathered about their positive and negative health influences and their social environments, it can be assumed

that their regional and ethnic cultures have influenced their knowledge, attitudes, and perceptions of obesity and obesity-related conditions in the manner described.

Perceptions and Attitudes About Participating in Preventative Behaviors

According to Rosenstock (1974), an individual's perception of threat provides the motivation that action. Still, the method of action and the path they will choose depends on their attitudes and beliefs about the outcomes of the proposed behavioral changes. The participants expressed their beliefs about the obstacles they perceived on their path to change, the benefits they perceived they would experience as a result of changing their behaviors, and the factors they believed would make it easier to perform healthier behaviors. They expressed their perceptions based on lived experiences and the perception of their environment. Their strong ties to their culture were demonstrated as they discussed the barriers they perceived and the factors they believed would increase the likelihood of their success.

Perceived Barriers

The participants discussed several factors that they believed to be barriers to performing healthy behaviors. The most significant among most of them was their environment. They believed the abundance of unhealthy cultural foods and the limited healthy options available within their communities, workplaces, family gatherings, and social events made it difficult for them to make healthy choices. The limited healthy options were not only an issue in the community and social situations but also extended to their inability to afford healthier foods, the limited options in the store where they shopped, and their lack of access to health care and health information due to the costs

associated with medical care. The participants perceived these issues to be related to their marginalization and socioeconomic status.

The participants discussed other barriers related to scheduling, self-efficacy, and psychosocial factors. Issues, such as the lack of knowledge pertaining to the types of food they should consume and those they should avoid, menu ideas, and meal preparation, seemed magnified by issues such as chaotic schedules and lack of time due to work. Mental health issues, such as anxiety and depression, were also perceived to play a significant role in their lack of motivation to act. The remaining issues were tied to their cultural beliefs and experiences. For example, they had difficulty committing to healthier recipes due to their taste preferences and lack of social support among their friends and families.

These findings confirm those of the only recent study that discussed the health behaviors of individuals exposed to the same cultural and environmental factors. In their research, Sheats et al. (2018) explored the healthy eating perceptions of overweight and obese men and women in New Orleans. They identified several factors that their participants perceived as barriers to change. Just as the cultural environment was a factor among the current study's participants, they also found that their participants viewed the cultural traditions and environment as obstacles. They believed that "cultural elements unique to African Americans and being a Louisiana or New Orleans native" (Sheats et al., 2018, p. S18) made it harder for them to maintain a healthy diet. In addition, the participants of their study, as well as those in the study performed by Cameron et al. (2018), also admitted to issues such as lack of healthy options in food stores, lack of

affordable options, the influence of family and friends, and difficulty preparing healthy meals in advance. These findings provide additional data that demonstrate that the ethnic culture and the regional culture are perceived as barriers to change among individuals who have experienced the phenomenon being studied.

Perceived Benefits

The participants' perceived benefits of change also aligned with the findings reported by Sheats et al. (2018) about their study's participants' perceptions of the advantages of healthy eating. The current study participants believed that behavior change could lead to improved health, decreased risk of developing chronic conditions, physical comfort, and improved body image. Sheats et al. (2018) said their participants believed that adopting healthier behaviors would lead to better health outcomes, improve their physical appearance, and enhance their romantic relationships, which was likely due to improved body image. Although the participants in both studies believed that improvement in health outcomes would be a benefit of change, their other perceived benefits were subjective and would be difficult measure.

Perceived Facilitators of Change

The cues or motivators for change provided by the participants included factors related to menu options, recipes, cultural adaptation, support and guidance, and body image. The participants believed that if they had access to more recipes and menu ideas, nutritional guidance, and support of family and friends, they would feel more comfortable preparing and consuming healthier meals. Taste preferences, especially those related to cultural and traditional cooking styles and dishes, were also significant factors, according

to participants, in motivating their behavior change. Some of them expressed their belief that more people would be willing to eat healthier if more cultural dishes were modified into healthier dishes. These findings align with those found by Sheats et. al (2018) in their investigation of the perceptions of overweight African Americans in New Orleans, LA. The participants in their study also believed that if they were provided information and assistance with healthy food preparation and taught ways to make healthy modifications to cultural foods, it would be easier for them to eat healthier. They also described body image and observable results as motivators. Still, the participants mostly believed they would be motivated to change if they had more knowledge and support and were able to maintain their cultural traditions. These findings also confirm the results of prior studies that demonstrated the reluctance of African Americans to make behavior changes because of their emotional ties to their cultural traditions and cuisine (Johnson et al., 2014; Long et al., 2017; Sheats et al., 2018; Sumlin & Brown, 2017). Although many understood the benefits of change, they believed that changing their dietary behaviors would require them to abandon their culture and traditions.

Perceptions of Sociocultural Influence

This study's participants perceived that their cultural experiences strongly influenced their attitudes, behaviors, and perceptions about obesity, obesity prevention, and obesity-related conditions. Their culture provided most of them with near-parallel experiences, leading many of them to similar views on topics related to diet, weight, and health. Although some admitted to gaining more knowledge in their adult years, they acknowledged that they were still often driven by their cultural beliefs or traditions. The

factors that perceived as most influential were the African American family and social ideals, their spirituality, and New Orleans culture.

African American Families and Communities

This study's findings demonstrated the participants' belief that their ethnic family culture and traditions influenced their attitudes, beliefs, and health behaviors. They described experiences from both their childhood and adult perspectives. Most of the participants did not recall as children being encouraged to eat healthy fruits and vegetables consistently. Except for playing outside with friends, all but one denied that regular physical exercise was promoted. Most of their meals consisted of traditional and cultural dishes, which they described as high in fat, full of sodium, and unhealthy. They were taught that they should be grateful for their food and eat what was provided. Although two of the participants did admit that they were encouraged to eat healthy vegetables, most of the women agreed that their families demonstrated reactive health behaviors, only encouraging healthy alternatives as a response to illness. However, two of the participants were encouraged to eat vegetables but also admitted to similar memories of instructions to eat their entire serving of food.

The participants perceived that their current health behaviors were connected to those childhood experiences and were fostered by their continued participation and interaction with their families in their cultural environments. These findings align with those of several other studies, which found that African American participants believed that the cultural food traditions passed from generation to generation were the cause of their poor dietary behaviors and prevented them from adopting healthier diets (Cameron

et al., 2018; Sumlin & Brown, 2017; Swierad et al.,2017). In addition, Scott et al. (2019) described what their participants perceived as a deeper meaning and symbolism of food in the African American community, where it can be a symbol of love and given as an expression of appreciation. Their participants also suggested that refusing a food offering could be viewed as rude, and adopting new dietary behaviors could be perceived as the rejection of one's culture. These cultural beliefs and the expectation of respect within their family structure have created a model of behavior in which the participants subscribe. Yet they seem to understand the model and its consequences, but also appear to follow it since they have not been presented with a practical alternative with the ability to preserve cultural integrity.

Health in The African American Family and Community: The Struggle

Several subthemes emerged in the exploration of how the participants perceived the attitudes and behaviors related to health within their families and the cultural community and how they perceived those attitudes and behaviors influenced their own attitudes and behaviors about health. Lack of concern, lack of knowledge, lack of trust, and the lack of preventive health measures were the main issues discussed among the participants regarding health in their families and community. The participants expressed their concern that cultural traditions were prioritized over health, leading to poor health outcomes. However, their concern alone was not enough to motivate change in their behavior. Many admitted to what they described as a struggle between doing what they knew was better for their health or continuing to live their lives according to the cultural norms they had been accustomed to following. The diabetic participants of Sumlin and

Brown's (2017) study also spoke of this struggle when describing the "conflicts between their food practices and management of their diabetes (p.569).

Almost all of the participants described a lack of concern among their family and community members. They believed that many chose happiness and the enjoyment of the cultural events and traditions over their health. The common phrases heard by many of the participants from family members trying to justify their behaviors, appeared to have had some influence on the participants' health behaviors. For example the participants admitted to hearing such statements as, "I gotta die one day" or "we're gonna die from something." In particular, one participant demonstrated an understanding of this relationship when she equated her culture with its members' tendency to make poor health decisions. The examples provided to the participants while growing up in their community demonstrated strong ties to culture with very little to no emphasis on performing healthy behaviors. The participants perceived that this exposure contributed to their personal struggle with choosing tradition over health.

A few of the participants believed that a lack of knowledge contributed to their community's attitudes about health. This was also an issue among the participants themselves when they discussed barriers to performing healthier behaviors. They admitted to a lack of knowledge related to nutrition and the preparation of healthy meals. As discussed previously, they described their family food practices as unhealthy with rarely any encouragement to eat healthy balanced meals. Just as traditions and customs were passed down from one generation to the next, the lack of knowledge of healthier practices was also shared. However, the participants admitted to seeking knowledge

outside of what had been shared culturally, as they understood the consequences associated with only following tradition. They believed that the attainment of knowledge regarding nutrition and healthier menus and recipes would help them by providing the tools to make better decisions. This confirmed findings from Sachs et al. (2017), where their African American participants expressed their desire for nutritional and dietary education so that they could begin making changes. However, although most of the diabetic participants in Sumlin and Brown's (2017) study who received health information from their primary care providers found the information useful, a few of them admitted that the information they received was not helpful because they weren't sure of how to apply it to their everyday life. This is evidence that providing information alone may not be adequate. Public health providers should also consider providing practical skills training on topics such as affordable grocery shopping and healthy meal planning and prepping.

Some of the participants believed that the lack of trust of the medical community among those in their family and cultural community impacted their health knowledge. They explained that many feared doctors because of their and others' past experiences in the healthcare system. A common attitude among the participants' family members was that of not trusting "those white people," "doctors," or "certain hospitals in New Orleans." Mistrust of the medical community was a common finding among studies about African Americans' perceptions about health. Prior studies found that African Americans lacked trust in the medical community for several reasons including, their belief that they received substandard care due to race, ethnicity, and socioeconomic

status, their belief that medical institutions are more interested in making money than helping people, their perception that tools created for medical measurements are based on racial oppression, and their fear of being used for unethical experimentation like those of the Tuskegee Experiment (Cameron et al., 2018; Sachs et al., 2017; Sumlin and Brown, 2017). As believed by the participants, this lack of trust was likely a factor in the lack of knowledge of the participants' families and those within their community, therefore also influencing the attitudes, knowledge, and behaviors of the participants themselves. This was demonstrated in their attitudes about the medical recommendations for healthy weight and their belief that the guidelines were based on "white standards." The participants' perceptions about their own attitudes and beliefs and their families and cultural community's attitudes and beliefs imply that they perceived that the lack of trust among family and community members had influenced their own attitudes and beliefs about the medical community. They still maintain their attitudes and beliefs but demonstrate the desire for more education and communication, implying that the trust issue could possibly be remedied with adequate communication, education, and transparency.

Sachs et al. (2017) reported that participants admitted that rather than participate in preventive health screenings and behaviors, during their childhood years, there was mostly a reactive health response in which they usually only sought care in emergencies or to receive required immunizations or physicals for school. Similar findings in the current study confirm the reactive health responses experienced by many in the African American community. The present study participants denied receiving encouragement

from adults during their childhood years to participate in proactive measures. However, they admitted that the few times they witnessed family members making healthy behavior changes, it usually followed a family member's recent diagnosis of a health condition such as diabetes or high blood pressure. It was during these reactive responses that many of the participants revealed that they learned what foods should be avoided if someone had one of those illnesses. Some participants understood the significance of this and why they should begin to make changes to prevent such diseases. Still, there were two participants who, to a certain extent, continued to follow in the path of reactively responding to their health. Maintaining this reactive thinking could be related to a lack of trust or strong cultural ties and their unwillingness to discontinue the behaviors they enjoy.

Weight and Body Image

The women in this study believed that their ethnicity, race, and culture influenced their perceptions of weight and body image. They opposed the thin ideals they believed were based on “white” standards. Most admitted that they believed that African Americans are naturally curvy, leading them to dismiss the standard recommendations for their personal weights. These findings confirm the findings of Scott et al. (2019) and Baruth et al. (2014). Both found that race, ethnicity, and culture influenced how African American women perceived cultural standards of beauty. Their participants desired curvier figures and rejected the mainstream standards that they believed encouraged them to be thinner. These cultural beliefs were expressed by all of the participants of this study

and each of them demonstrated understanding of the role their culture played in their attitudes about weight.

Religion and Spirituality

In addition to the influence of Catholicism on their diet, which is discussed later, two of the participants had opposing views about spirituality. One participant believed that spirituality could be used as a crutch in the African American community, removing responsibility and allowing individuals to rely on their faith for healing instead of making the necessary behavior changes. Another participant perceived religion and spirituality as a positive influence. She expressed that she believed that her faith and listening to sermons about healthy eating motivated her to make healthier decisions. This was in line with findings by Cameron et al. (2018), Sachs et al. (2017), Scott et al. (2019), and Swierad et al. (2017), in which participants perceived spirituality provided both strength and motivation to make healthy choices and maintain healthier bodies.

Culture and Lifestyle of New Orleans

Among all of the factors that the participants believed influenced their behaviors, the culture and the way of life shared by the native population of New Orleans, especially the native African American community, were believed to be the most influential. When asked about their culture's role in their behaviors, the participants all expressed their belief that their culture was the most significant factor in their lifestyle. Like those in Sumlin and Brown's (2017) study, the current study participants blamed their culture for their weight and dietary struggles. But unlike participants in other studies, this study’s participants also stressed the influence of their cultural environment. They believed the

lack of healthy choices, the abundance of unhealthy cultural foods, and their culture's celebration and overindulgence of food made it difficult for them to make healthy choices. In their investigation of adult overweight African Americans' perceptions in New Orleans, LA, Sheats et al. (2018) reported one participant's description of New Orleans' food as rich. The current study participants also used words such as rich and potent in their descriptions of the food and when expressing their love for their cultural dishes. They believed that living in the GNO was "not the easiest place to try to lose weight or have a healthy lifestyle because of the cultural food."

In addition to the cultural cuisine, the participants also believed their behaviors were heavily influenced by the cultural traditions practiced throughout the area. They felt certain traditions made it more difficult to resist the unhealthy options, especially since there were usually very few healthy options available. Traditions and events such as festivals and seafood boils were believed to encourage unhealthy behaviors, such as overeating, and attendance to them was believed to derail any prior commitments made in the interest of weight management or health concerns. They described these events as frequently occurring and staples within their community and families, which is likely why they perceived them as major influencers of their behaviors and overall way of life.

Catholicism. Religion, specifically Catholicism, has had a significant impact on the culture of New Orleans and the entire state of Louisiana. Although most denied that they were Catholic, they perceived that the traditions that have evolved from the blend of Catholic customs and the city's food culture have also influenced their health behaviors. Mardi Gras and Lent's celebrations were both described by the participants in their

explanations of seasonal food behaviors. Most of the participants admitted that they participated in the Lent custom of eating fried seafood on the Fridays leading up to Easter. Some of them also stated that their families practiced the tradition throughout the year.

Living outside of Louisiana. A couple of the participants stressed the significance of their culture's influence when describing how they maintained certain behaviors and traditions unique to the GNO while living in other states. These findings differ from those of Sheats et al. (2018) who found that the participants believed residing outside of New Orleans made it easier for them to participate in healthier behaviors. Although the current study participants did not speak on the ease or difficulty in performing healthier behaviors while living outside of the GNO, they admitted that they still participated in their cultural traditions, whether intentionally or unintentionally. One participant reported that she continued the tradition of red bean Monday while living in Texas. Another admitted that her cooking career grew from her desire to have traditional cuisine while attending an out-of-state university. Instead of adapting to their new environment, the participants' cultural identity and strong ties to their cultural traditions remained secured and appeared to have been maintained with a sense of acknowledgment and pride.

Examination of Perceptions of Sociocultural Influence as a Construct

Some of the data from this theme is unique to this particular population and very little has been reported about this phenomenon in the recent literature. The population's unique and distinctive cultural experiences have influenced the data across the entire

study and are too complex to limit to one section of this report. Therefore, although the participants' general perspectives about their culture's influence on their attitudes, perceptions, and behaviors were focally described in a specific segment, the culture and its influence can be detected throughout the reported findings. The findings of this study confirmed the findings of several related studies and inform and expanded the knowledge about the influence of the culture of New Orleans on African American women's health behaviors.

Theoretically, although perception of sociocultural influence is not a construct of the HBM, the magnitude of influence of this unique culture justified its inclusion in the process to determine the likelihood of behavior change in the population from which this sample was drawn. The HBM posits that an individual is more likely to perform a preventive behavior if he or she believe he or she is susceptible to the disease, perceive some level of severity if he or she was to acquire the disease, and believed that the benefits of performing the preventive behavior outweigh the costs (Rosenstock, 1974). Therefore, using this model, not only can we predict their behavior, but we can also improve their likelihood of adopting recommended behaviors by utilizing interventions that address those beliefs. However, it may not be enough to only know the participants' beliefs about obesity, obesity-related health conditions, and obesity prevention, without knowing the factors that influence those beliefs. In this population, providing education without an adequate understanding of the cultural factors and experiences from which the beliefs have been created and fostered, as well as the individuals' perceptions of about

the level of influence their experiences have had on their beliefs, would likely only yield superficial results since the depths of their belief system were not adequately explored.

Limitations

In addition to the expected limitations discussed in Chapter 1, there were several unexpected limitations. Due to the circumstances of a global pandemic at the time of data collection, face-to-face interviews and observation were not permitted. I modified the data collection plan for social distancing, which did not allow for observation or prolonged engagement, a strategy used to establish credibility. Secondly, I recruited participants using advertisements and the snowball technique. The advertising method increased the possibility of selection bias. With advertisements, the participants were to contact the researcher if they believed they fit the study's criteria. Considering that prior research has demonstrated that both overweight and obese African American women frequently underestimated their weight, it is likely that there were women who fit the criteria but did not respond because of the weight classification requirement that was noted in the advertisement. The last unexpected limitation was that, although discussed briefly, the study did not explore the socio-environmental factors that influenced behaviors such as accessibility, lack of transportation, and food deserts as it exceeded the boundaries set for this study.

The remaining limitations were as expected. The current study explored the perceptions of a population in a unique geographic locale. Although there are cultural commonalities shared among African American women in different regions of the U.S., the unique cultural experience of the participants in the current study is not generalizable

to a similar sample outside of the setting of this study. Lastly, I used a qualitative methodology to conduct the present research. Although strategies to ensure trustworthiness were utilized, objective methods can potentially threaten the validity of the findings, especially if viewed from a positivist perspective.

Recommendations

This study demonstrated the significance of regional and ethnic culture in the behaviors of African American women living in the GNO. It is important for future researchers to consider regional cultural beliefs and traditions when attempting to understand the factors that influence the behaviors that contribute to overweight and obesity in this population. Also, to gain better insight into the culturally influenced behaviors, it is recommended that, if feasible, researchers should conduct observation during the day to day cultural activities, traditional cultural gatherings, and sociocultural events. Doing this will provide more context to the participants' perceptions, attitudes, and behaviors in this study.

For future researchers intending to replicate this study, it is important to note the unique cultural factors involved may not apply to many populations outside of this region. However, several other sub-groups, such as African American men or more homogenous samples, based on income or education, could be explored with the replication of this study. The current study was homogenous pertaining to race, gender, and cultural experiences, but there was great variability in education and socioeconomic status. In addition, now that sociocultural factors have been identified, further research is needed to understand which factors contribute to specific behaviors or attitudes, for

example, an individual's reluctance to give up reactive health behaviors. Lastly, further exploration of the socio-environmental factors within the cultural environment would also add to the existing knowledge regarding this topic in the population of interest.

Implications

Before embarking on this study, there were no studies exploring the cultural factors that influenced the health behaviors of overweight and obese African American women in the GNO. Their unique experiences had yet to be acknowledged as distinct from the larger population of overweight and obese African American women living in the southern region of the U.S., where their culture bears some similarities but differs drastically in many ways. The findings from this study demonstrated the unique struggles that the sample participants experienced within their sociocultural environment. The data provided insight into common behaviors, attitudes, and perceptions of the population by offering a view from the perspectives of those experiencing the phenomenon. By providing context, which demonstrates the unique struggles rarely addressed, this study provides information that can be utilized for further research and in the creation of culturally tailored interventions to address obesity in this population.

In the U.S., African American women suffer disproportionately from obesity and obesity-related chronic illnesses than any other racial or ethnic group. Various factors have been found to contribute to these health disparities, such as systemic racism and socioeconomic status. Still, several studies have found culture to significantly influence the behaviors, attitudes, and beliefs about obesity, obesity-related conditions, and obesity prevention in African Americans. Using the HBM, I focused on gathering data about the

individual and cultural beliefs that determined the participants' behavior. An examination from this perspective allowed me to view contributing sources to the problem, such as their beliefs, which had been shaped by their experiences and family and sociocultural influences.

By providing culturally-specific findings that can apply to this particular population, this study can potentially impact positive social change at the organizational and societal levels. The findings can be used as a foundation for further research and in the development of culturally tailored community interventions. The information can also be used by health care providers, as the findings demonstrate the importance of considering culture and tradition when providing patient education. And lastly, the data can be used to guide city officials and event organizers in addressing the need, availability, and access to healthy options when planning future projects and events in and around New Orleans. All of these can potentially improve the outcomes of African American women, a marginalized community in the GNO, by increasing their knowledge about obesity and obesity prevention, providing healthier alternatives to traditional behaviors, and thereby improving their likelihood of making healthy behavioral changes.

Conclusion

One nickname of New Orleans is “the city that care forgot.” That name can be interpreted in many ways. Still, one story is that the nickname originates from visitors' assumption that the locals working in restaurants and hotels had care-free attitudes because of the pace in which they worked. But in a time before air conditioning, what visitors to New Orleans, in the heat of summer, hadn’t considered was the energy

required for an individual to work in such conditions. The locals did move slowly and did appear to rest frequently, but not because they lacked care or concern. Either way, it affected local businesses, which led to marketing campaigns to attract more visitors during cooler months. Just as the nickname implied of the locals, it may as well had been implied of the outsiders for their lack of concern about the circumstances that influenced the locals' behaviors. Outsiders forgot to care about the experiences of the locals, as they were only concerned about how they were affected by the locals' behaviors.

New Orleans is known throughout the U.S. for its cuisine, festivals, and unique customs. However, when studies are performed or interventions are developed to address obesity in African Americans, Southern and African American cultures are usually the focus, reminding African Americans of New Orleans that they still live in the city that care forgot. The purpose of this study was to identify and explore the cultural experiences of overweight and obese African American women living in the GNO so that the circumstances that influenced their health behaviors could be understood and no longer forgotten.

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Appendix A: Interest Form

Interest Form

First Name: _____ Last Initial: _____

Age: _____ Birth year: _____

Race/Ethnicity: _____

Height: _____ft _____in Weight: _____lbs

City/town: _____

How long have you lived there? _____

Are you interested in participating in a study about health and living in the Greater New Orleans region? _____

Phone number: _____

When is the best time to contact you? Mornings/Afternoon/Evening

Appendix B: Demographic Questionnaire

Demographic Questionnaire

First Name _____ Last Initial _____ Age _____

Weight (on last measurement) _____ Height: _____ft _____in

Race/Ethnicity: _____

City/town: _____ Total number of years lived in this area: _____

Occupation: _____

Highest level of Education: Circle one.

Grade School/HighSchool/Trade School/Associates/Bachelor's/Master's/Doctorate

Based on your income, what would you consider yourself? Circle one.

Below middle class/lower middle class/middle class/upper middle class/above middle class

Marital status: Married/Single/Divorced/Lives with partner

Do you have any children? Yes/no How many? _____

Appendix C: Interview Guide

I have explained data collection procedures and you have given informed consent. I would like to remind you again that you may withdraw your consent at any time for any reason. The following interview is expected to last approximately 1-2 hours. The interview will be audio recorded and I will take notes throughout. Do you have any questions before we start?

Interview Guide

1. Perceptions and attitudes about obesity:

   What is your definition of being overweight?
   What is your definition of being obese?

   How would you define your own weight?
   -What does that mean to you? (or how do you feel about your weight?)
   How has it affected your life? Do you feel accepted?
   What is your desired weight? Why?

   Do you believe your definitions differ from the medical guidelines and definitions for overweight and obese? If so, how?
   BMI-how a certain height/weight is considered overweight or obese?

   How do their definitions make you feel about your weight?

   Do you suffer with any health conditions?
   Yes:
   What, if any, is the relationship between your diet and those health conditions?

   No:
   How would you describe your risk for developing health conditions such as high blood pressure or diabetes?

   What do you believe to be the cause of your current struggles with your weight?

   How do you feel about your doctor's or other medical or mainstream recommendations for healthy eating? (recommendations regarding the types of foods and how much you should eat)
   - What factors, if any, would cause you not to follow those recommendations?
   - What factors do you believe would make it more likely that you follow those recommendations?'

2. Cultural influence:

   Living in New Orleans, compared to other cities around the U.S., is a unique experience. We celebrate differently, we have many different traditions and customs, and we have a very strong food culture.

   What role do you believe this culture plays in your diet?

   If you think about your everyday life, what cultural traditions or experiences have influenced your food choices?

   What do you believe is the overall attitude about food within your culture?
   Do the cultural norms about food affect your ability to maintain a healthy diet?
   - overall attitude about body appearance and weight within your culture?
   Weight vs appearance
   - overall attitude about health within your culture?
   Health associated with appearance and weight???
   Health (doctors, fears, etc).

**In lieu of observation, the participant will be asked to describe her experience when attending a typical family or cultural event.

1. If you were trying to describe or paint a picture for people who do not live in this area, how would you describe your typical or most recent experience when attending either a local festival or a family gathering?

   Possible follow up questions:
   Can you describe what you see when walking into the event?
   How would you describe your attitude or your emotions?
   What do you enjoy most about the event? You can name more than one.
   What do you enjoy the least about the event?

This concludes the interview. Do you have any questions? Is there anything you would like to add or any information that you would like to clarify or re-explain?

Debriefing:
Did you experience or are currently any negative feelings or emotions due to the questions asked during the interview?
In the case that you do experience any mental anguish due to this interview that includes, but not limited to feelings of regret, sadness, anger, anxiety, or depression, please contact me as I have resources available.

I will be transcribing this interview within the next 2-3 days and will be sending you a copy by email. I am leaving you with my contact information. Please contact me if you would like to provide any more information or if you would like to make any clarifications.

You may be contacted for clarification or to obtain your feedback on the findings of the final study. Is that ok with you?

Appendix D: Recruiting Flyer

DOCTORAL STUDENT RESEARCH STUDY

PARTICIPANTS NEEDED

For a study exploring how the culture of New Orleans influences the health behaviors of overweight/obese African American women.

Participation Includes:

-1-2 hour video conference interview

Volunteers must be:

-African American Women
-at least 18 yrs of age
-overweight or obese (based on BMI standards)
-native resident of New Orleans or surrounding areas

For information, please call 504-296-1989 or email keneitra.brown-mayfield@waldenu.edu

Appendix E: Participant Instructions

Due to Social Distancing recommendations, interviews will be held using Zoom, Facebook, Facetime, or simply by phone. Please inform the interviewer of your preferred option. Instructions for Zoom are below.

Zoom Instructions

On Computer:

1. Download the Zoom desktop app on your computer: https://zoom.us/download
2. Click on the meeting invite URL that the host shared via email or text.
3. Open the Zoom app.
4. Approve the request for permission to use your computer's audio and camera.
5. Click Join Meeting.

On Phone (Android or Iphone)

1. Download the Zoom app for iOS or for Android on Google Play, and set it up using your contact information.
2. Tap on the meeting invite URL that the host shared via email or text, which will open the Zoom app. *The app may ask for permission to use your phone's camera. (Allow)*
3. Click on Join Meeting.

Other options:
Facebook: The interviewer will call you using the FB name: Keneitra Brown
FaceTime(IPhone): The interviewer will call using the Apple ID: krbrown1@yahoo.com
Video call (Android) or telephone : The interviewer will call you from the phone number: 504-296-1989