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# The Perspectives of Parents Who Are Obese on the Standards of Health for Their Children

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Walden University
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Abstract

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MS, Bowie State University, 2001

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Dissertation Submitted in Partial Fulfilment

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## Abstract

Obesity is a burdensome and preventable noncommunicable disease that annually claims the lives of approximately 5% of the global population. Initially, the disease affected only adults, but the increasing prevalence of childhood obesity has become an ongoing concern to health officials and world leaders. Childhood obesity may persist into adulthood and may become a precursor to Type 2 diabetes, some cancers, and socioeconomic complications. Some parents who struggle with obesity may miss signs that their children are obese, which hinders their children's growth at many levels. Research on the lived experiences of parents who are obese and their coping strategies to manage their children's nutrition has been limited. The purpose of this phenomenological study, which was guided by Bandura's social cognitive theory, was to obtain an in-depth understanding of the ways obese parents described their coping strategies and perceptions of nutrition when feeding their children. Data were collected using the Zoom platform from semistructured interviews with 11 parents who were obese to obtain details their lived experiences with food and the impact on their feeding practices. Colaizzi's method of phenomenological data analysis was used to formulate clusters of themes. Four themes emerged from the data analysis. Two themes were (a) parental perceptions of nutrition promote the incorporation of some healthy foods into children's diets, (b) external barriers to healthier choices are perceived as affecting the whole. The results indicated that the participants' lived experiences with food and their personal barriers affected their feeding practices. The results could lead to positive social change by providing parents with the tools to help them make more appropriate nutritional choices.

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# Dedication

In thee, O Lord, do I put my trust; let me never be ashamed...Psalms 31

Heavenly Father, throughout the ages, You have been my tower of strength and have never left me comfortless. Thank you for instilling in me a courageous spirit. Accomplishing this doctoral journey was no small feat, so I dedicate this study first to You. I am forever grateful and appreciative of the endless love and support that my daughter, Amber, and granddaughter, Esther, gave me while I completed this dissertation.

I also dedicate this study to my parents, the late Lloyd Facey, and Mom, Alma Facey, who prayed relentlessly to see me complete my studies. I thank you, Mom, for providing me with a spiritual foundation. To my three siblings, Doreen, Jacque, and Kike, where would I be without your love and support? I love and appreciate you all. Dave Hipp, thank you for your support and faith in me throughout my doctoral journey. I am forever blessed by my COGASOC family, who strengthened my spiritual foundation. Finally, I dedicate this study to all parents who are challenged with obesity and the next generations who are educating themselves to lead healthier lives. Collectively and individually, we will work earnestly to decrease the prevalence of obesity.

# Acknowledgments

Speak your truth quietly and clearly; and listen to others, even to the dull and ignorant; they too have their story…Many fears are born of fatigue and loneliness (Max Ehrman).

To my chair, Dr. Cain-Shields, I am so appreciative of your patience and understanding. Thanks for sharing your knowledge with me and for your quick responses to my requests, even during the weekends. Dr. Tettey, committee member, and Dr. Green, URR, I am forever grateful for your input and encouragement. I also am grateful for and appreciative of the professionalism and knowledge of the Walden University Writing Center staff. There were times when I was at a loss and had no idea where I was going on this journey, but I was always pointed to the right person to get me back on track. Dr. Michelle Mackey, God placed you in my path for a reason: You have been steadfast and consistent, never wavering, and always encouraging me to press on.

I feel blessed for the opportunity that Walden University provided me. I will share the results of my study with local authorities, an effort that may impact the ways that obesity interventions are conducted in my community. Each child should have the opportunity to live a productive and normal life, and nutrition plays a huge role in bringing that to fruition.

To those who supported me throughout my journey, I love and appreciate the daily inspirational words, calls, and letters of encouragement. Barbara Denson, thanks for keeping the 23rd Psalm as my headlight. Dr. Carolyn Person, your humility and wealth of knowledge inspired me. Lisa and Rasheen Johnson, thanks for allowing me to study in

your home and providing tranquility so that I could concentrate on my dissertation. Esther, your computer technology was priceless and greatly appreciated. Amber, your encouragement gave me with the strength to go on, even when I was tired. I thank the Lord for your tenacity.

Education is a perpetual journey, and one should never stop learning. I thank God for the vision and lessons I learned from interviewing a small sample of parents who wanted to help their children to avoid obesity. Together, we can make a change, one family at a time.

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# Chapter 1: Introduction to the Study

The World Health Organization (WHO, 2017) defined obesity as the accumulation of excessive fat on the body that can have a negative influence on health. Obesity has become a global concern, and although there have been copious intervention modalities, the prevalence of obesity continues to escalate. Although interventions have been helpful in reducing the incidence of obesity, the high rate of obesity remains a concern to health professionals and investigators, convincing them of the need to develop alternative obesity reduction techniques (Findholt et al., 2013). According to the WHO (2017), in 2016, approximately 1.9 billion adults were overweight, and more than 650 million of these individuals were obese.

Increasing numbers of children and adolescents are impacted by obesity, which seems to affect underprivileged individuals more than their affluent counterparts (Newton et al., 2017). Young children rely on parents and caretakers to be the gatekeepers of their health. When researchers are seeking solutions to the problem of obesity, they often examine the knowledge base of these custodians to identify their thought processes as they feed their offspring (Turconi, 2013).

If the obesity trend continues, an estimated 20% of the global population will become obese. Individuals who are obese are at potential risk of long-term disabilities, higher rates of illness, and early mortality. Children also are at risk of facing the same challenges, except that the premature onset of obesity often persists into adulthood, which further shortens their productivity and the ability to lead active and fulfilling lives (Hruby & Hu, 2015).

Obesity is a burdensome disease on several levels. It may be a precursor to preventable conditions such as Type 2 diabetes, hypertension, hypercholesteremia, some cancers, and premature mortality. It may be responsible for the high levels of depression, body dissatisfaction, low self-esteem, and low quality of life of individuals dealing with the challenges of living with obesity (J. Ogden & Clementi, 2010). The disease also negatively impacts the U.S. economy, with estimates suggesting that more than $190 billion is spent annually on health care costs, of which nearly 21% is directed toward treating obesity and its associated disorders (Hruby & Hu, 2015).

## Background of the Study

Obesity and its related challenges are risk factors that can have a negative influence on health. Body mass index (BMI) is one of the most common indicators to gauge and characterize obesity, profile risk factors, and develop public health policies. However, one limitation of the BMI is that it is inadequate to measure fat on different parts of the body (Nuttall, 2015). It measures weight based on height and weight, and when used with the appropriate equipment, it can give a fairly accurate calculation of BMI. However, it does not differentiate among excess fat, muscle, or bone mass, and it does not distinguish muscle from fat on the body.

A BMI of 25 to below 30 is classified as overweight, and a BMI higher than 30 is classified as obese. BMIs in children are age specific. Because children's heights and weights change as they develop, BMIs are interpreted among children of the same age and sex. Normal BMIs occur between the 5th and 85th percentiles (Centers for Disease Control and Prevention [CDC], 2017b).

Considering that 5% of global deaths are the result of obesity, it has become essential to understand the extent of its magnitude (Tremmell et al., 2017). Having a positive body image is important to human beings, so the perception of fatness can be personal, cultural, or societal. All individuals have ideas about what a desired weight, whether real or illusory, should be, but the social image can be painful for individuals who are obese. Social stigmatization has the potential to impair the intellectual ability of individuals who are obese, sometimes diminishing their capacity to manifest given talents and possibly limit career choices. BMI is merely a gauge of one aspect of health and does not reflect the total health status of individuals. In addition, individuals who are obese often are perceived as unattractive, which tends to limit their choices in mates, so they tend to marry other individuals who are obese and may produce offspring who are obese (Nuttall, 2015).

Mei et al. (2018) indicated that parental BMI may be a predictor of children's birth weights. The children of parents who are obese are at higher risk than the children of parents of normal weight of being obesity (Mei et al., 2018; Soko & Qin, 2017). Parents occasionally miss indicators that their children are overweight or obese. Recognizing that their children are obese will give parents the ability to help to resolve their children's obesity issues. Although Bahreynian et al. (2017) contended that low socioeconomic status (SES) and limited access to healthy foods seem to be contributing to the obesity crisis, they also argued that some environmental influences, such as shared intrafamilial customs, dietary practices, and parental education may be linked to

childhood obesity. Bahreynian et al. highlighted the importance of sharing family perceptions to reduce the incidence of childhood overweight and obesity.

Rodriquez-Ventura et al. (2014) noted that parents may be oblivious to their children's weight status. Studies have ranged from parents not recognizing the signs of obesity to some parents admitting to recognizing the problem but also believing that problems associated with childhood obesity would lessen as the children matured (Eli et al., 2014; Paul et al., 2014).

Yun et al. (2015) reported on the influence of parents on diet and concluded that family structure may be influential in treating children who are obese when family members have the correct tools. There has been a gap in research relevant to parents' perceptions of determining healthy routes for their children. Previous researchers have highlighted the importance of parental influences on their children's diet (Patel et al., 2018; Yun et al., 2015). There has been a dearth of information about the perceptions of parents who are obese as they strive to prevent their children from becoming obese. The results of my study may help to guide health care practitioners, policymakers, and researchers as they seek to develop interventions that are tailored to the needs of family members who are obese.

## Problem Statement

Obesity rates continue to rise, despite the plethora of intervention strategies. Effective treatments are available for children and adults, but sometimes, these treatments are not easily accessible for a variety of reasons, such as cost and other risk factors (Heymsfield et al., 2018). The allocation of government resources to treat obesity rose

from 6.3% in 2001 to 7.9% in 2015, resulting in an increase in expenditure to address obesity of 29% (Biener et al., 2018). Obesity is a difficult issue to address because the disease can be the result of behaviors such as dietary patterns, inactivity, and medication use (CDC, 2017a). Obesity, once confined to the adult population, has made its way to young children and adolescents, and will likely persist into adulthood (Ogden et al., 2016). The prevalence of childhood obesity has led to organizations such as the Society of Behavioral Medicine recommending the adoption of national programs that might help to reduce children's weight gains during summer vacations (Bohnert et al., 2017).

The challenges associated with obesity are a concern to public health officials, particularly when parents must decide what foods they consider nutritious for their children. Parents and other caretakers often need more education to understand what constitutes a nutritionally balanced diet (Yun et al., 2015). This lack of understanding is especially prevalent in the Black community, whose members have disproportionately higher rates of adult and childhood obesity than their White counterparts (CDC, 2017a). Ethnic minorities and low-income families in some high-poverty communities are unduly affected by childhood obesity. This problem is not entirely unique to low-income populations, because some areas, such as Prince George's County in Maryland, which is home to some of the wealthiest members of the Black population in the United States, still have clusters of poorer households where Blacks do not enjoy basic necessities such as health care (Prince George's County, 2016).

Obesity is a persistent and humiliating stigma. Americans who are obese are regarded as physically unsightly; objectionable; and responsible for weights that are the

result of laziness, greed, or lack of self-control. Consequently, children, adults, and even health care providers who hold antifat views often treat individuals who are obese disparagingly (Phelan et al., 2015). Most research has focused on the stigmatization of individuals who are obese rather than their lived experiences or perceptions (Carr et al., 2008).

Strategists often use models to gain insight into the obesity epidemic and the social influences that can connect health behaviors and demographics. For example, some researchers have posited that obesity may be the result of body image coupled with health behaviors (Min et al., 2018; Weinberger et al., 2016). The social influence hypothesis (Shoham et al., 2015) states that individuals' social networks are closely associated with obesity status and that social contacts may potentially influence obesity-related behaviors. However, the problem is that obese parents do not always have the resources to manage their children's nutrition, which then predisposes them to higher rates of obesity (Turconi, 2013).

## Purpose of the Study

The research literature has supported an association between the involvement of families, including coping mechanisms, and their children's weight management. The purpose of this phenomenological study was to understand the perceptions of obese parents and the coping strategies that they used to manage their children's nutrition. This study is meaningful because (a) children who are obese have the potential to become adults who are obese, and (b) obesity has been recognized as a factor in the development of chronic illnesses (see Schwendler et al., 2017). Despite being an avoidable disease,

obesity and its related comorbidities often strain public health services (Hammond & Levine, 2010). It is important to establish a way in which obesity can be prevented in childhood so that it does not persist into adulthood. The results of my study may increase the awareness of policymakers and health care providers in their efforts to develop appropriate standards of obesity interventions.

I interviewed a sample of parents from Prince George's County, Maryland, to understand the challenges that they faced when providing nutrition for their children while dealing with their personal obesity challenges. My purpose was to explore their issues with food and their perceptions of the prospect of charting healthy nutritional pathways for their children. Dietary behaviors and environmental challenges have roles in the ways that human beings perceive food, which can be symbolic of a social structure. Most cultures have traditions in which food is an essential element. Celebrations are centered on food because it brings people together. However, overindulging in food without engaging in concomitant physical activity may have detrimental effects. The human body needs food to function, but excess body fat puts individuals at risk of serious health issues (Horton, 2015). I used a qualitative approach to explore the customs impacting the obesity challenges and perceptions of Blacks and other ethnic groups.

## Research Questions

I developed two research questions (RQs) to guide the study:

1. To what extent are obese parents' perceptions influential over their children's nutrition?

2. What are parents' perceptions of the factors that would help to promote good health and nutrition for their children?

## Theoretical Framework

The theoretical base of the study was Bandura's (1977) social cognitive theory (SCT), which researchers have used to determine the influence of experiences on individuals' behavioral actions. One of the goals of SCT is to assess the various processes of learning and the pathways that individuals adopt to obtain new information that can be sustained over time to promote health and nutrition. Health educators must be aware of the factors that determine how people make certain choices. SCT has been used widely in health behavior management to visualize health modifications and produce behavioral changes (Doerksen & McAuley, 2014). The core principles of SCT are self-efficacy, outcome expectations, self-regulation, recognized barriers, and enablers of behaviors (Doerksen & McAuley, 2014). Self-efficacy is a key principle of SCT because it results in behavioral changes and the motivation to follow through to maintain the changes. Individuals who have high self-efficacy believe that they can overcome certain barriers to maintain and sustain these new behaviors.

Individuals possess the potential to adjust certain behaviors (Knol et al., 2016). The connection among circumstances, environment, and actions is termed *reciprocal determinism*, meaning that each factor can influence the other. According to Bandura (1977), the environment can help to shape individuals' behaviors. Bandura added a few constructs, such as the environment, behavioral capacity, self-control, observational learning, reinforcement, and self-efficacy. He also revised SCT to include healthy eating

and physical activity as ways to foster the values of food interventions in the home that result in parental behavioral changes and eventually have a positive impact on children's health. Knol et al. concluded that healthy childhood environments exist when family members dine together at home approximately three times per week, there is limited access to unhealthy foods, and parents model healthy eating and physical activity behaviors for their children.

Martin-Biggers et al. (2015) conducted a qualitative study using SCT (Bandura, 1977) to investigate behavioral change strategies to reduce childhood obesity and adult learning techniques to influence the home environment positively. The parents in the sample responded positively to motivational elements that allowed them to personalize generalized applications to suit their families. Some parents, however, did find that certain guidelines did not fit their situations because of time or budget constraints. One difficulty was the provision of healthy varieties of food items in their budgets, but the benefits, such as using the family unit to develop fun activities inside the home, outweighed the challenges. Evolving themes included diversity, suggesting that food items could be adapted to accommodate different ethnicities; parental concerns for their overweight children; and motivational efforts to transform factors in the home environment with little associated costs (Martin-Biggers et al., 2015). However, the literature has not explained or highlighted the lived experiences of parents. Information that the parents in Martin-Biggers et al.'s study shared could be used to develop more family-oriented weight loss programs.

## Nature of the Study

I used a phenomenological approach for this study to obtain the perceptions of parents who were obese and the coping strategies that they used to manage their children's nutrition. Childhood obesity often persists into adulthood obesity, and children tend to carry familiar feeding styles into adulthood (H. S. Kim et al., 2016). Previous quantitative researchers (e.g., Almoosawi et al., 2016; H. O. Kim et al., 2015) have studied the attitudes, behaviors, and perceptions of being overweight and obese, but qualitative researchers have not fully investigated these same factors, thus highlighting the need for more qualitative studies to understand why childhood obesity rates continue to escalate.

Qualitative researchers have focused on exploring their study participants' thoughts, experiences, and perceptions of the phenomena under investigation. I considered a qualitative phenomenological approach appropriate to conduct my study because my goal was to understand how parents residing in Prince George's County, Maryland, who were obese believed that their weight issues impacted their ability to shape healthy habits for their children. I used the constructs of phenomenological research to interview participants who were experiencing obesity challenges. I used this approach to collect and analyze data that I obtained from interviews with the participants to assess their attitudes and behaviors toward food and physical activity for themselves and their children.

The study was limited to parents who were obese and from all SES backgrounds. My rationale for this selection of participants was that despite previous research

indicating that obesity is found predominantly among people from a lower SES, more recent research has shown that obesity also is prevalent in families from a higher SES (Bishwajit, 2017). Peters et al. (2014) stated that the first 5 years of life are crucial in determining and fostering children's healthy dietary patterns. After that, it becomes difficult to change children's diets. Parents are the primary role model for their children, so learning about the lived experiences of parents and their nutritional perceptions through interviews explained why obesity rates continue to rise, despite the plethora of intervention strategies. In addition, the analysis of the interview data may offer health educators another way to implement interventions, such as by tailoring cultural developmental phases.

## Definitions

*Body mass index (BMI):* Obesity is an accumulation of excess body fat that can become a risk factor for chronic diseases such as diabetes and cardiovascular diseases (Tremmell et al., 2017). Medical practitioners use the numbers associated with BMI ($kg/m^2$) to determine health. BMI enjoys wide use because it is a free and easily calculated tool (Dodgen & Spence-Almaguer, 2017).

*Coping strategies:* Coping strategies are approaches that families may use to address children's obesity. Some families do not recognize that their children are obese until the disease gets progressively worse and the children begin to exhibit complications (Borges et al., 2017).

*Family unit:* The family unit has an important role in effecting changes in other family members as well as themselves. Gruber and Haldeman (2009) stated that effective

weight loss is more sustained when the social influence of the family unit is included. Finkelstein et al. (2017) reported that fat reduction programs that include the family unit can have an overall weight loss impact on everyone in the family.

*Health:* Health is the ability of the body to maintain homeostasis by warding off illnesses and other health challenges. Health can impact income, association with family, social environment, and place of residency (Brussow, 2013).

*Healthy weight:* The medical profession considers a BMI between 18 and 24.9 ideal (Tremmell et al., 2017). Parents usually are unaware of what constitutes healthy weights, so they miss the signs that children who are obese need help (Bahreynian et al., 2017; Shoham et al., 2015).

*Nutrition:* nutrition refers to the process of providing energy from food that affects the health of the body. The obesity challenges in the United States are partly associated with nutrition-related disorders. Parents are challenged to identify foods that are nutritious to prevent or treat obesity in their children and themselves (Lu, 2014).

*Obese:* Obesity has been defined as having a BMI greater than 30. BMI is measured differently for children and adults. A BMI in the 95th or higher percentile is considered normal for children, but if it is in the range of the 84th to the 94th percentiles, the children are considered overweight (CDC, 2017a).

*Overweight:* Overweight is a term referring to a BMI between 24.9 and 29. A BMI between 18.5 and 24.9 is considered normal for adults. An easy measurement that often is used in physicians' offices is abdominal girth. A woman with a waist girth higher than 35 inches or a man with a girth higher than 40 inches is considered obese (CDC,

2017a). Parents usually are the primary supporters of their children's health, and they can help to reduce childhood obesity when they have the appropriate tools (Bahreynian et al., 2017; Shoham et al., 2015).

## Assumptions

I made several assumptions in this study. I assumed that the participants would answer the interview questions to the best of their ability. I assumed that the parents in the sample were aware of the foods that their children consumed. I assumed that the parents prepared meals for their children. Finally, I assumed that the parents in the sample were obese and were willing to share their perceptions of what they considered healthy meal choices for their children. I included these assumptions in the study because standards of health can be subjective and parents sometimes customize their nutritional patterns based on culture or tradition.

## Scope and Delimitations

The study was limited to parents who were obese and residing in Prince George's County, Maryland, at the time of the study. The data that I collected from the interviews represented the views of the residents of Prince George's County and may not be generalizable to other county inhabitants in Maryland.

## Limitations

One limitation of the study was its short duration. It would require a prolonged study beyond the scope of this research to understand the culture, traditions, lived experiences, and coping strategies that parents use when attempting to provide healthy food options for their children. I selected a small sample of 11 participants residing in

Prince George's County, Maryland. According to Patton (2002), even though a sample size of 11 participants is appropriate to reach data saturation, it also means that the results may not be generalizable to other target populations.

## Significance

Obesity among children and adults has reached pandemic levels (Knol et al., 2016). The disease initially affected only adults, but the prevalence of childhood obesity has become major ongoing concern of health officials and world leaders. The implications are that childhood obesity may persist into adult obesity and may become a precursor of Type 2 diabetes, hypercholesteremia, some cancers, and socioemotional complications (Paul et al., 2014; Penilla et al., 2017; Zhou et al., 2015).

The results of the study may be used by health care professionals and lawmakers to understand the perceptions of parents who are obese and the coping strategies that they use to manage their children's nutrition. Parents often do not realize that their children are obese, and it appears that deeper issues exist when parents also must deal with their own obesity (Eli et al., 2014). Children depend on parents and other caregivers to provide them with healthy nourishment, so I found it important to understand parents' perceptions and lived experiences so that strategists may be able to develop appropriate obesity reduction interventions.

The feeding patterns of parents appear to be cyclical. Parents tend to model their feeding styles on those of their parents. Parents usually are the primary supporters of their children's health, and they can help to reduce childhood obesity when they have the appropriate tools. They sometimes miss the signs that their children are overweight or

obese, and research has shown that the family structure has a role in curtailing the rates of overweight and obesity (Bahreynian et al., 2017; Shoham et al., 2015).

As children, my siblings and I experienced what I now realize was food insecurity. We were told to eat everything on our plates, and we did, even if we were no longer hungry. In retrospect, we were not children who were obese, possibly because we played outdoors in the year-round sunshine. I became obese in adulthood, but I endeavored to teach my offspring healthier physical activity and food options while I continued to struggle with food insecurity. Because I now have a better grasp of my food challenges, I feel more empowered, and I often revisit my complex involvement with food as a child.

Conducting a study that might help to reduce the incidence of childhood obesity has helped me to understand why I struggled with food. I now choose healthier options and find ways to incorporate physical activity into my daily life. I want to disseminate what I have learned to help parents to understand their own challenges so that they can make healthier nutritional choices for their children. This study is significant because policymakers and local health strategists might be able to use the results to develop interventions customized to addressing childhood obesity rates in Prince George's County, Maryland.

Prince George's County, Maryland, is home to more than 900,000 diverse residents and is considered affluent; however, health outcomes are relatively inferior in many communities, especially when compared to neighboring communities (Prince George's County, 2015b). A key finding of previous research (Prince George's County

2015a) was that approximately 31% of the children in the county were obese or overweight. This percentage was startling because childhood obesity often is a predictor of premature mortality in adulthood.

County officials posited that the rates of obesity were related to residents' difficulty in estimating their caloric needs and misidentifying what foods contributed to sound nutritional health (Prince George's County, 2015b). This position espoused by officials was further motivated by the dearth of nutritional education available and the high concentration of immigrants, whom county officials asserted might have been unaware of food labeling exercises in the United States (Prince George's County, 2015a).

Considering these findings, the perceptions of parents who are obese regarding the standards of health for their children have remained undetermined, indicating a lack of knowledge pertaining to the perceptions of what constitutes sound nutritional health for children. Parents who have sound nutritional education and apply their knowledge in meal preparation can set good standards of health for their children. Moreover, healthy nutritional practices are influenced by cultural, traditional, and familial norms, along with a nurturing environment. Mothers who have high nutritional knowledge can have a positive influence on the health of their children, whereas mothers with low nutritional have children who tend to be overweight or obese (H. O. Kim et al., 2015; Yabanci et al., 2014). Therefore, the general problem that I addressed was that the rates of childhood and adult obesity rates in the Black community were higher than those in the White community in Prince George's County, Maryland. The specific problem was that the

perceptions of parents who were obese specific to the standards of health for their children had been limited.

## Summary

Obesity hurts everyone. It impacts not only the economy but also the individuals who are experiencing its challenges. Interventions are available, but obesity persists. The impact of obesity must be addressed; otherwise, political leaders and health care professionals will face more challenges in terms of rising costs and related difficulties such as food insecurity (Dhurandhar, 2016). Childhood obesity also has the potential to result in premature mortality rates and a higher incidence of comorbid illnesses.

Parents and caregivers naturally want the best standards of health for their children, but they do their children a great disservice when the nutritional outcomes result in childhood obesity. Parents have an important role in establishing nutritional guidelines for their children. The review of the literature in Chapter 2 suggests that public health officials need to be more vigilant to ensure that parents have a basic understanding of food labeling so that they can decide if the nutritional content of various foods is adequate to ensure their children's health (Soederberg Miller & Cassady, 2015).

# Chapter 2: Literature Review

This chapter includes a review of the literature suggesting that parents' perceptions of health, physical activity, and nutrition may be influencing the feeding behaviors of their children. People who are active and conscious of their nutritional intake are more likely to have healthier weights than those who are not (Acheampong & Haldeman, 2013; Jaballas et al., 2011). Various sources, including popular social media and the medical community (Henderson, 2015; Lee et al., 2016), have emphasized the negative influence of overweight and obesity. Even though recreational facilities and resources are available to individuals for their use, they do not always use them for various reasons. People generally want good health; however, for some, there are barriers whether perceived or real, that make it difficult for them to overcome these obstacles (Acheampong & Haldeman, 2013; Cohen et al., 2016; Jaballas et al., 2011). Food labeling is supposed to demystify food contents, yet obesity remains a global challenge. This chapter includes a review of literature indicating that the family unit can be an important component in maintaining normal weights for children (Forestell, 2017; Morin & Roy, 2013).

Caretakers and the family system are the model for engagement in other health-related processes such as physical activity and family interactions. According to the research literature, parental perceptions play an important role in determining the current and future health of children by supporting or neglecting evidence-based practices (e.g., Forestell, 2017; Jarvis et al., 2017; Morin & Roy, 2013). Research on food labeling and its benefits has been extensive. In some instances, food labeling may be instrumental in

helping parents to make better dietary choices, but knowledge is important, meaning that parents must be aware of the impact of something like the high concentration of sodium on blood pressure and be cognizant of recommended servings of fiber per day to make labeling information effective. Some families continue to struggle with intergenerational circumstances of obesity that are partly the result of their limited knowledge of healthy food choices (Chilton et al., 2017; Kumar & Kapoor, 2017; Mhurchu et al., 2017).

Individuals who have access to resources such as dietary education and protected health have the potential to shield their families from hunger and preventable health challenges. These resources are not always available to Black families in the United States, who tend to experience more hunger, food insecurity, obesity, and perceived lower control of their lives, and experience a wider racial wage gap than their White counterparts. Parents' obesity may be a highly identifiable risk factor responsible for their children's' obesity, and in instances where children are obese, parents may be forced to confront their personal challenges with obesity. Breastfeeding may help to decrease weight gain, but there have been mixed results to indicate whether early weaning promotes weight gain (Assari, 2018; Grube et al., 2013; Murillo et al., 2016).

Obesity is a global health issue that affects approximately 13.7 million children and 78.6 million adults. Researchers have described obesity as an essentially preventable disease, yet the rates continue to climb (CDC, 2017a; Goettler et al., 2017; Hruby & Hu, 2015). The prevalence of obesity is not only troubling to the affected individuals but also to communities and economies. Moreover, the disease is known as a precursor to increased risks for Type 2 diabetes, strokes, certain types of cancers, traumas, infections,

osteoarthritis, sleep apnea and respiratory challenges (CDC, 2018; Goettler et al., 2017; Hammond & Levine, 2010). Data from the National Health Expenditure Panel Surveys and the National Health Expenditure Account on health spending showed that approximately $147 billion was spent by the United States in 2008 to manage difficulties related to obesity associated with the direct and indirect costs of decreased work productivity. One example of an indirect cost may be linked to funds for reimbursement processes aimed at disability insurance premiums. Recent studies have confirmed that men who were obese, compared to men who are normal weight, spent an additional $1,152 annually on hospitalizations and medications (Goettler et al., 2017; Hammond & Levine, 2010; Hruby & Hu, 2015).

Parents' perceptions should transcend global and cultural barriers because these caretakers are responsible for ensuring that their children receive healthy nutrition. Obesity affects minorities more so than White Americans because ethnic minorities often lack the financial resources and knowledge to provide nutritionally stable diets (CDC, 2017a; Yun et al., 2015). Although there have been many intervention modalities, the incidence of adult and childhood obesity persists. Engaging in more physical activity and increasing the consumption of fruits and vegetable may help to maintain a desired weight (Briefel et al., 2015).

Parents' perceptions, cultural norms, and economic conditions influence children's health. Parents feed their children based on their knowledge of nutrition. Parental perceptions also contribute to the well-being of children (Evans et al., 2015; Hilpert et al., 2017; Lydecker & Grilo, 2016). I searched the Google Scholar, CDC,

Medline, and PubMed databases for sources to support the study. I also conducted a Google search for articles from the WHO and the National Institute of Health. The most frequently used search terms were *parental influence*, *parental perceptions, obesity*, *overweight, physical activity*, *nutrition*, *culture, body image*, *BMI, childhood obesity*, *health outcomes, size image, stigmatization, disease, adult obesity, body image*, and *risk factor*.

Healthy weights are measured using different methods; however, the most common is BMI. Although not conclusive, BMI is a useful and inexpensive assessment of body size and assists in predicting critical health outcomes and mortality. BMI is measured differently for children and adults. A BMI in the 95th or higher percentile is considered normal for children. However, if it is in the range of the 84th to the 94th percentiles, children are considered overweight. A BMI between 18.5 and 24.9 is considered normal for adults; a BMI over 30 is regarded as obese. An easy measurement that often is used in physicians' offices is abdominal girth. A woman with a waist girth larger than 35 inches or a man with a waist girth larger than 40 inches is considered obese (CDC, 2017a).

Children are socialized initially by their parents, and eating habits are learned in the family structure (Forestell, 2017; Morin & Roy, 2013). According to Forestell (2017), children have an innate preference to gravitate toward sweet food items and to avoid the unpleasant tastes of green leafy vegetables. Taste, one of the five senses, develops during the last trimester of fetal maturity, and the fetus acquires nutrition from the mother, including sweets travelling across the placental barrier. A little later in life, children's

food preferences and levels of physical activity are modeled on the preferences and activities of parents and other household members.

Cultural perceptions of diet and appropriate levels of physical activity are changing. Serving sizes in restaurants have helped to spread the misconception that "more is better." Children and adults often respond positively to larger portion sizes that are full of excessive amounts of salt, sugar, and fat (Bomberg et al., 2017; Forestell, 2017; Morin & Roy, 2013).

Obesity, an accumulation of body fat, is probably one of the most widespread noncommunicable diseases. Its increasing prevalence has world leaders in a quandary because it is associated with physical, emotional, social, and economic backlash at the individual and community levels. Individuals who are obese must make a conscious but sometimes unrealistic effort to maintain healthy weights. The reality is that some families lack the ability to enjoy the benefits of fresh fruits and vegetables, or the convenience of safe surroundings to participate in physical activity. The pervasiveness of obesity has health officials and policymakers now understanding the importance of examining the various issues that impact obesity and the effect of obesity on individuals, communities, and economies (Briefel et al., 2015; CDC, 2017a; Visscher et al., 2017).

Parents often have different beliefs and interpretations about the health of their children. They do not always see themselves and their children as being at risk of the challenges associated with obesity. There are negative stigmas correlated with obesity, and the affected parties often are deemed lazy, unmotivated, and incompetent. Many parents do not consider that these derogatory terms are being directed at them. Public

health messages related to obesity are sometimes ignored by parents because they do not believe that they are the intended recipients. Some parents believe that their children's obesity is a short-term problem that the children will outgrow (Ellis et al., 2014). They also are less apt to report any health incongruencies and are more likely to assert that their children do have appropriate nutrition and are physically active (Ellis et al., 2014; Jaballas et al., 2011; Paul et al., 2014).

Cultural standards and environmental conditions also might have a role in the rising childhood obesity rates among ethnic minorities. Members of the Chinese culture, for example, as described by Zhou et al. (2015), consider fatness a sign of good health and wealth. However, increased exposure to U.S. culture seems to be playing a role in the increasing levels of obesity because of the availability of less-than-healthy dietary options.

Obesity among minority children often is associated either with the mothers' complacency about the children being overweight or their desire for the children to be heavier. These parents perceive their children as being strong and solid, so the social acceptance of being obese places less pressure on the children. The misperceptions of childhood obesity and overweight can be troubling because obesity in one or both parents can mean a lifetime of obesity risks for their children (Fuemmeler et al., 2013; Sarrafzadegan et al., 2012; Zhou et al., 2015).

Researchers focusing on nutrition acculturation (e.g., Azar et al., 2013; Foster & Hale, 2015) have suggested that immigrant children are occasionally exposed to unhealthy diets when they adopt Western dietary behaviors. Foods (e.g., fast foods) that

might have been eaten occasionally in their home countries are now being consumed in abundance. Regular consumption of foods laden with sugar, fats, and salt can lead to obesity and can be problematic because parents sometimes combine their ethnic diets with fast foods such as hamburgers and fries to appease their children.

Immigrants with higher levels of education fare better nutritionally because they have a better command of English and are able to read nutrition labels. On the other hand, individuals with lower levels of education who migrate to the United States seem to consume more unhealthy foods than they might have been accustomed to eating. What used to be a treat in their countries is now easily available in the United States. More research is needed to verify these results and gain a better understanding of these dietary outcomes (Azar et al., 2013; Lesser et al., 2014).

Zhou et al. (2015) indicated that obesity is prevalent among Chinese American youth and that Chinese parents tend to use manipulation to feed their children. This strategy can actually result in weight gain. Latinx parents' feelings of isolation that are the result of cultural differences, coupled with language barriers, compel them to feed their children comfort foods that are familiar to them. Dietary acculturation may be challenging for new immigrants to the United States. Health care providers and researchers (e.g., Carrillo-Larco et al., 2017; Cherrington et al., 2015; Martinez et al., 2017) have concluded that parents are integral to maintaining their children's nutritional health. However, some factors exist that can thwart healthful nutritional pathways and physical activity, such low SES, poor access to high-quality food, unreliable transportation, and an unsafe living environment.

Some Latinx parents, for example, believe in the concept of fatalism, meaning that they are destined to face such health challenges as diabetes, overweight, and obesity. Therefore, they do not believe that changing their diets will make a difference in their health. This thought process also may impact their children's health. Some mothers did not work outside their homes prior to migrating to the United States. The strain of learning a different language, struggling economically, being forced to work, and familiarizing themselves with children's school routines can make it difficult for parents to provide adequate healthful foods for their children (Carrillo-Larco et al., 2017; Cherrington et al., 2015; Martinez et al., 2017).

There is a wealth of research indicating that low-SES families can rationalize their children's obesity by believing that it is out of their control. Some explanations that parents have given for their children's obesity have included the lack of reliable transportation, unsafe neighborhoods, and the limited availability of quality grocery stores (Penilla et al., 2017; Schalkwijk et al., 2015; Zhou et al., 2015).

Concerned health professionals may wonder if obesity is perceived as a risk factor and disease. Individuals who are obese and are seeking help to deal with the challenges associated with the disease are aware of the consequences of obesity. The WHO (2017) deemed obesity a disease associated with several chronic illnesses and a negative impact on quality of life. In addition, although stigmatization is prevalent against individuals who are obese, perceptions seem to play a role in the decision to seek help. As stated earlier, individuals who seek help are aware of the consequences, but individuals who are obese often underestimate their weight and outnumber those who seek help.

Parents who are obese often perceive that the weights of children who are obese are normal, so they believe that their children inherited their genes and are healthy. Children with parents who are obese are more likely to be obese. Parents are usually the gatekeepers of their children's health and create food environments that include eating behaviors. Children early in life mimic the eating patterns of their parents. Parents use strategies that they perceive to be the best ways for them to control their children's eating patterns. Some factors associated with children's high BMI include coercive feeding, use of food to bribe and threaten, or intake of food beyond satiety (Patel et al., 2018; Russel et al., 2016; Visscher et al., 2017).

The food industry, especially fast food, has exacerbated the incidence of obesity. According to Kramer et al. (2012), parents find it easy to purchase meals that are usually inferior in quality at convenience stores. These establishments are known to add excessive amounts of fats, salt, and sugar to their food choices that can add to the obesity crisis (Mulherin et al., 2013; Phelan et al., 2015; Watkins & Jones, 2015).

The limited access to healthy food options is an element of food insecurity in some communities. Fast food establishments do a lucrative business in some poor neighborhoods in providing low-cost meals that are nutritionally deficient to low-SES parents for their children. Another challenge facing low-income earners is their lack of health literacy, defined as the inability to read food labels effectively to make appropriate food choices. According to H. D. Gibbs et al. (2016), only 15% of parents in the United States are able to read food labels adequately. It remains unclear if this lack of knowledge increases the rates of childhood obesity, but what is known is that being able to

understand food labeling allows parents to know what their children are consuming (Evans et al., 2015; H. D. Gibbs et al., 2016; Visscher et al., 2017).

Parents might not understand the connection between the physical appearance of children who are obese and their actual perceptions of their children's weights. Paul et al. (2014) contended that children who are raised in households with overweight parents are more likely to be in environments that promote increased weight gain. Researchers (e.g., Vangeepuram et al., 2016; White et al., 2016) have attempted to comprehend parents' understanding of their children's obesity challenges and the ways they have addressed them. White et al. (2016) found that approximately 50% of parents did not realize that their children were at risk of obesity.

Parents may not be ready to make nutritional and possibly physical activity changes until they see that their children need help to address obesity challenges. Parents want their children to be healthy, but the ways that they express their health concerns to their children may not always be received positively by the children. Problematic encounters might ensue when parents cannot communicate health messages to their children effectively. The children may hear negative messages that can be distorting, whereas the parents may think that they are helping to promote good nutritional behaviors. For example, a parent may tell a child not to eat a certain food because it will make the child fat, but what the child hears is the parent describing the child as fat. Parents in similar situations may fail to see that their words can have a negative impact on their children, one of which might be unintended weight gain. Sometimes, parents need resources to help them to communicate effective coping strategies and to deal with

their own perceptions of standards of nutrition for their children (Nepper & Chai, 2017; D. M. Thomas et al., 2014; White et al., 2016).

Some parents may not intentionally use hurtful words, but their perceptions about food items can be just as damaging to their children's health. Some parents know that fruits and vegetables are healthy options, but the short shelf life of fresh fruits and vegetables, coupled with high prices, may become barriers to their purchase. One misconception that some parents hold is that healthy food is clean, raw, and unprocessed only. Parents might need to be educated about the fact that canned fruits and frozen vegetables may contain comparable nutritional benefits at lower cost (Nepper & Chai, 2017; D. M. Thomas et al., 2014; White et al., 2016).

Parents often internalize their obesity issues in ways that make sense to them and rationalize how they feed their families. Researchers (e.g., Danford et al., 2015; Noonan et al., 2016) have begun to explore the relationship between heredity and the environmental factors associated with parental and childhood obesity. What is known is that obesity can be destructive, causing emotional and physical pain, so more strategies are needed to restrain this increasing trend.

Danford et al. (2015) disagreed that childhood obesity is associated with parental SES, whereas Noonan et al. (2016) agreed that obesity is more rampant among low-SES families. Other researchers (e.g., Goryakinet al., 2015; Sheikh et al., 2017; Turconi, 2013) have posited that obesity may result in reciprocity between the environment and genes. Their research endeavors identified genes that are susceptible to hereditary obesity. In some instances, genetic disorders occur when the hypothalamus fails to sense

that the stomach is full. The result means that some individuals may eat beyond satiety, a problem that can eventually lead to obesity. Some parents are more likely to make behavioral changes when they realize that their children's health is at risk.

Comorbidities are affecting more young children. According to Turconi (2013), children whose overweight status extends into adulthood are at increased risk, after adjusting for parents' obesity. Even after weight loss has been maintained successfully, the mortality rates are higher among adults who were obese as adolescents. Parents sometimes need resources to help their children and themselves to combat obesity and the subsequent challenges (Brown et al., 2015; Danford et al., 2015; Vangeepuram et al., 2016).

Another parental misconception is that children do not have obesity challenges. Again, parents may not understand that their children need help to lose weight until the condition escalates. Health educators and other medical professionals also have noted that changes in body composition and size among peripubertal children may be attributed to parents missing the signs of overweight. With increasing rates of childhood obesity, parents may compare their obese or overweight children to friends and family members and visualize their children to be normal weight. The weight shift toward heavier children, coupled with parents' obesity, may result in parents not seeing the potential risks of childhood obesity (Bahreynian et al., 2017; Hansen et al., 2014; Rodriguez-Ventura et al., 2014).

Health challenges occur when parents are unaware of their own obesity status and often underestimate the correct weights of their children. This underestimation seems to

cross cultural boundaries. Researchers (e.g., Caprio et al., 2008; C. L. Ogden et al., 2010) have implied that obesity is mostly centered in areas of low SES. The link between low SES and individuals with obesity seems to be more prominent among Blacks, Mexican Americans, and Native Americans, along with is the higher prevalence of obesity, than among other ethnic groups. Obesity is increasing at all income and education levels, but the pervasiveness of obesity seems to be higher for men and women with lower earning potential than for those with higher incomes (Caprio et al., 2008; C. L. Ogden et al., 2010; Sobal, 2001).

Although SES may be a contributing factor to the obesity epidemic, other influences must be considered. The CDC (2017a) stated that obesity rates are overwhelmingly on the rise and that approximately 100,000 deaths annually in the United States have been attributed to obesity. The low cost of industrially processed food in the United States gives families on fixed budgets easy access to food items that are inexpensive and of poor nutritional quality. Reduced physical activity, especially in communities where people with low SES reside, also seems to contribute to obesity (Papas et al., 2007). In environments where predominantly Hispanic and Black individuals reside, reduced access to recreational facilities and safe walkways have been identified as factors contributing to increased rates of obesity (Papas et al., 2007).

Another explanation comes from human behavior ecology, which suggests that high-income earners face less stress in terms of obtaining high-quality nutritious food. Because low-income earners have more food-related stress and risk factors for chronic health-related challenges, they overeat inexpensive, calorie-laden, and nutritionally poor

food. Food behaviors are learned from parents and close social structures through generations of familial traditions and cultures. Food behaviors are sometimes determined not only by cultural behaviors but also by nutritional needs and families' financial resources (Bentley et al., 2018; CDC, 2017a; Nettle et al., 2017; Sobal, 2001).

## Perceptions of Weight Management in Early Adulthood

Young parents gain weight for various reasons: pressure, a dearth of resources, and perceptions of what obesity is. All of these factors can cause undue stress. These parents sometimes reflect on their childhood years and may continue their parents' habit of providing inappropriate, unhealthy, or bigger portion sizes than what the children actually needed. Individuals who struggle with obesity sometimes fear stigma, feel powerless, and assume that improvements in their health are unlikely (Cha et al., 2016; Nelson et al., 2008; Tate et al., 2014).

The transition to adulthood is a period of health refection based on parental influence; however, levels of physical activity and weight control behaviors often decline during this early transitioning phase (Nelson et al., 2008; Tate et al., 2014). The prevalence of obesity is escalating in this age group, probably as the result of lifestyles that are different from those of older adults. Tate et al. (2014) suggested that young adults gain approximately 1 to 2 pounds per year and that if this weight gain continues toward obesity, it can be associated with increased mortality and morbidity (Cha et al., 2016; Fildes et al., 2015; Tate et al., 2014).

Weight loss takes concerted effort, motivation, and time, but individuals often lack the ability or drive to start or complete costly programs. This is often true of families

from lower SES backgrounds. Blacks may be exposed to shoddy housing, substandard health care, high levels of unemployment, and stressful environmental exposure, all of which may have a negative impact on health outcomes and result in inadequate access to nutritious food.

Being obese sometimes is accompanied by various health and social challenges. Some parents are in denial of their children's obesity status, whereas other parents are cognizant of the relational issues of obesity in their children. Some parents reject their children's obesity status, and others who engage in some levels of physical activity may perceive themselves and their children as exhibiting normal weight (Murillo et al., 2016; Sonneville et al., 2015; Willis & Lawton, 2014).

Parenting can be a challenging job, and sometimes, parents are unsure how to approach the reality that their children are overweight or obese. These parents usually wrestle with personal obesity challenges and are inclined to send mixed messages to their children. This lack of admission that their children need help may delay obtaining professional help. The first step to obtaining help is to realize that there is a problem that they may not be able to handle alone (Sonneville et al., 2015; Willis & Lawton, 2014).

The reasons for the rates of obesity to escalate are endless, and there is no universal solution to the obesity pandemic. Examples of some reasons for obesity are individuals' perceived stress, perceived weight discrimination, self-efficacy regarding perceived health behaviors, and willingness to lose weight (Faghri et al., 2016; Richardson et al., 2015; Sutin & Terracciano, 2013). Individuals who are severely obese

can face such adverse impacts as chronic diseases and premature mortality. It is not clear how stress complicates obesity, but it may be a factor associated with compulsive eating.

Following a healthy diet and increasing levels of physical activity can have a positive impact on health, but the ability to make these choices seem to be based on factors such as the personal constructs of self-efficacy. Self-efficacy refers to the decisions of individuals to engage in behaviors that facilitate attainment of desired goals. One behavior may be the ability to overcome challenges in the environment; another may be the perception that they can regulate their behaviors (Faghri et al., 2016; Richardson et al., 2015; Sutin & Terracciano, 2013).

The belief that people who are obese are underproductive and weak willed is endemic in Western society. These weight biases may have an influence on individuals' lives, work, health, and incomes. These issues are important to note because parents often relay their nutritional perceptions to their children, and children whose parents are obese tend to become obese adults. Obesity can be cyclical if it is not addressed, and the consequences might be a generation of children with shorter life expectancies than their parents. Similarly, children who have parents of normal weight tend to be of a normal weight in adulthood (Faghri et al., 2016; Richardson et al., 2015; Tripp & Choi, 2015).

Parents who are obese sometimes recall their childhood obesity experiences and the stares or hurtful words directed at them. These weight biases can wreak havoc on their relationships or interfere with the delivery of their health care. If their childhood obesity persists into adulthood, they continue the same pattern as their parents and miss the signs indicating that their children are struggling with obesity. Families that engage in

physical activity and eat nutritionally dense foods are more aware of the importance of the quality of life offered by healthful behaviors (Murillo et al., 2016; Sonneville et al., 20156). Educators and policymakers need information to tailor or modify interventions, particularly when parents who are obese identify the barriers that they face to improving the well-being of their children.

Children who are obese or overweight may find that their weight problems continue into adulthood. The seriousness of this disease can lead to other consequential health conditions, including Type 2 diabetes, hypertension, cardiovascular disease, asthma, and some cancers (J. Ogden & Clementi, 2010; Tripp & Choi, 2015). Other social conditions may include poor self-esteem, depression, anxiety, low SES, poor academic performance, and eating disorders. Some mothers in the study by Peters et al. (2014) expressed concern that even though their uncontrollable food satiety could affect their young children, they did not know how to address the problem. They knew that their poor feeding habits and lack of physical activity affected their children, but they did not understand that their own eating disorders required intervention. Evidence-based analyses have shown that childhood obesity can increase the incidence of premature mortality (Nipher et al., 2015; J. Ogden & Clementi, 2010; Tripp & Choi, 2015).

Living in an obese body in a society fixated on skinny bodies can be painful and humiliating. For some individuals, their coping strategies might include problematic binge eating and less engagement in physical activity. Social media have portrayed thinness as the ideal body image, and individuals, especially female adolescents, who do not meet this standard of health may be subject to societal marginalization. Women who

are obese may face more stigmatization than men who are obese. Women have been perceived as the caretakers of themselves and their families, and obesity does not equate to being in control (J. Ogden & Clementi, 2010; Sadati et al., 2016; Sutin & Terracciano, 2013; Toft & Uhrenfeldt, 2015). The lived experiences of some parents who are obese have exposed intense emotions of stigmatization, burying of emotional scars, self-loathing, and ineptitude. The social context of being obese often results in negative self-worth, and parents are faced not only with dealing with their emotional challenges but also being responsible gatekeepers of their children's nutrition (J. Ogden & Clementi, 2010; Sadati et al., 2016; Toft & Uhrenfeldt, 2015).

Nepper and Chai (2017) posited that adding appropriate amounts of physical activity and consuming more fruits and vegetable can help individuals to maintain their desired weights, but these goals are not easy to attain. Parents have different concepts of health, and what they consider normal weights may be quite different from the standards set by health officials. To entertain interventions, it is important to understand parents' thinking when they provide nourishment for their children.

Health educators are responsible for helping families to make sense of obesity and its potential challenges for the family unit. It is important not to overwhelm parents with too much information when providing them with nutritional education. The idea is to inform them so that they can make more appropriate nutritional decisions to reduce or prevent obesity in their children (Bishwajit, 2017; Nepper & Chai, 2017; Peters et al., 2013).

## Culture and Parents' Perceptions

Perception of standards of health seems to cross cultural boundaries. The Latinx population is increasing exponentially in the United States, so it is important to note that Latinx children experience poor health outcomes such as heart disease and are at a higher risk of obesity than any other ethnicities (Salahuddin et al., 2017; Woo Baidal et al., 2015). The CDC (2017b) guidelines specified that children with a BMI greater than the 95th percentile are obese. Latinx mothers are sometimes blamed for their children's obesity status, but researchers such as Cerin et al. (2016) and Penilla et al. (2017) have identified other factors that may be adding to the frustrations of parents wanting to feed their children appropriately. Feelings of isolation and social abandonment in a different culture can be overwhelming and often see the mothers feeding their children familiar, but not necessarily nutritionally sound, food (Cerin et al., 2016; Penilla et al., 2017).

Obesity is associated with considerable health costs and is a tremendous threat to public health. Because everyone's experience is meaningful, I found it necessary to capture the values and perceptions of parents who were obese. When parents underestimate their children's weights, it may make behavioral changes more challenging.

Misperceptions may negatively impact weight reduction opportunities because parents are largely responsible for their children receiving a sound nutritional diet and engaging in physical activity. Opportunities for outdoor play and a positive social environment are strong factors in children's physical activity. However, it is important to note that Latinx parents may have perceptions of the significance of parks and their

neighborhood that are different from those of parents from other cultures. There also seems to be less play equipment than in the homes of other cultures where preschool children reside. Latinx parents also seem to encourage less participation in outdoor physical activity than their White counterparts (Cerin et al., 2016; Foster & Hale, 2015; Sadati et al., 2016).

Blacks also tend to underestimate the weights of their children. Food preparation, including types of food, seasonings, and quantities eaten, is connected to religion and other traditions. Blacks who were once enslaved continue to experience the worse health and health care, despite improvements over the years. Systemic discrimination has resulted in poor health due to low wages and high-crime environments (Noonan et al., 2016).

Sometimes, parents lack the knowledge to make appropriate dietary and physical activity decisions for their children. Having health literacy skills enables parents to make appropriate decisions about food preparation. A good nutritional regimen consists of an assortment of fresh fruits and vegetable, whole foods, and physical activity. Black parents have identified some of the barriers to healthful eating: limited access to healthy food, lack of knowledge to prepare healthy food, time constraints, and limited social support. More culturally tailored programs would help parents to understand the difference between normal and aberrant weights to start the process of determining healthy meal options and increasing physical activity (Acheampang & Haldeman, 2013; Adams et al., 2019; Noonan et al., 2016; Park, 2017; Rivera-Soto & Rodríguez-Figueroa, 2012).

Researchers (e.g., Rivera-Soto & Rodríguez-Figueroa, 2012; Taverno Ross & Francis, 2016) have shown that ethnic groups such as Hispanic Americans, Asian Americans, and Blacks are subject to inequalities regarding childhood obesity, which obesity is associated with poor health and social and psychological challenges such as low academic attainment. Obesity is one of the 10 major causes of premature death in the United States, and its increasing prevalence has public health officials wondering how to reduce it. Health officials must find the right plans to help parents to provide an appropriate food environment for their children. Parents often struggle with challenges specific to their own obesity, which makes it even more difficult for them at times to admit that their children are facing the same predicament. Often, they miss the signs and underestimate the actual weights of their children. Obesity now affects all social groups, but children who reside in rural environments are more prone to obesity than their urban counterparts. Parents who have participated in other studies have mentioned the lack of easy access to healthy food as a factor; in addition, their children tend to spend more time playing with electronics and are less likely to engage in afterschool activities (Park, 2017; Rivera-Soto & Rodríguez-Figueroa, 2012; Tripp & Choi, 2015).

Understanding the reasons parents do not realize when their children are heading for nutritional challenges is important. Parents generally underestimate the weights of their children. They are more apt to underestimate the weights of their sons than their daughters, which may be credited to social media downplaying the obesity status of male individuals while paying more attention to the weights of female individuals. Parents who struggle with obesity may have personal dietary self-control issues for various reasons

and sometimes are unaware of the ways to supervise children's nutrition appropriately. On the other hand, parents who have higher levels of education are more likely to realize when their children are overweight or obese, suggesting that SES may play a role in the obesity status of family members. Parents who are educated have the ability to feed their children appropriately and reside in communities where their children can participate in outdoor activities safely (Rivera-Soto & Rodríguez-Figueroa, 2012; Taverno Ross & Francis, 2016; Tripp & Choi, 2015).

Parents and caregivers are agents of change for their children. To plan effective intervention strategies, the cultures of the families involved should be taken into consideration when using interviews to identify strengths, weaknesses, and readiness to change their behaviors. The interventions may not be successful, but they should be tailored to the needs of the specific families. Obesity affects people at all social levels, but low-SES individuals seem to fare worse in the obesity epidemic. It remains unclear why obesity continues to be so widespread, despite the prevalence of information available on social media and other venues about the challenges associated with obesity. Although one universal strategy cannot reduce obesity, plans that center on culture, food preferences, environment, education, and social affiliation should be considered for implementation (Findholt et al., 2013; Rhee et al., 2014; Tripp & Choi, 2015).

The limited incomes and reduced access to transportation of families in rural settings are other barriers to healthy diets. Subsequently, parents who are already on tight budgets are forced to purchase low-quality food items at higher cost. When researchers asked parents about purchasing fruits and vegetables, they responded that the high cost of

food prevented them from buying more nutritious food items. Researchers have suggested that rural children experience more obesity challenges than their urban counterparts (Evans et al., 2015; Tripp & Choi, 2015).

Should school administrators agree with nutritionally based standards of health? Parents look to health educators and school officials for guidelines, so all officials should agree with evidence-based guidelines to answer their questions appropriately. Rural school administrators and teachers have asserted that obesity should be dealt with at home, not by school personnel or leaders. If parents' perceptions of standards of health are attributed partially to SES, they need answers so that they can take the necessary steps to help their children to reduce their obesity. Moreover, if parents have misperceptions of their children's weight status, the condition may go unsolved, leading to more complications from obesity (Evans et al., 2015; Hudson et al., 2012; Tripp & Choi, 2015).

Parental perceptions of their children's' correct weight status may be associated with parental characteristics such as sociodemographic characteristics and standards of living (Hudson et al., 2012; Tripp & Choi, 2015). Parents are likely to be more perceptive of the correct weight status for their daughters than for their sons. However, when mothers and daughters in Soweto examined their eating preferences, they had similar concepts of the importance of appropriate dietary standards (Phillips et al., 2016). Even though no particular theory is flawless, health theorists should attempt to design interventions that are tailored to groups that are disadvantaged and in need of assistance. Russell et al. (2016) posited that children growing up in low-SES families are more prone

to overweight and obesity because of such factors as parents being obese and needing professional help with dietary guidelines. However, the introduction to solid food, breastfeeding, parental restrictions, or pressure to eat seem to be some factors associated with weight gain in children (Hudson et al., 2012; Russell et al., 2016; Tripp & Choi, 2015).

## Parents' Misperceptions of Their Children's Weight

Childhood obesity is a global challenge with negative consequences (Hope et al., 2014; Jaballas et al., 2011; Towns & D'Auria, 2009). Obesity can lead to serious health outcomes that can include Type 2 diabetes, heart disease, hypertension, and psychiatric conditions, as well as social challenges such as low self-esteem. Parental interventions are fundamental to helping children to attain normal weights, but many parents may have different ideas of what healthy weights mean for their children. Rhee et al. (2014) stated that parents have a role in determining standards of health for their children and may require motivation to help their children to lose weight. Parents can benefit from more health education to avoid underestimating the actual weight status of their children and the potential associated risks. If health care providers were to express more interest in childhood obesity, they could raise parental awareness of obesity and its health risks (Hope et al., 2014; Towns & D'Auria, 2009; White et al., 2016).

Some parents know that their children are overweight, but they do not see it as a problem, believing, instead, that the children will outgrow their weight issues as they get older. Other parents may agree that their children are overweight or obese, but they do not know how or where to seek help. Wabitsch et al. (2014) asserted that although the

incidence of childhood obesity may be tapering off among young children, childhood obesity rates remain high and that more interventions and education are needed to ensure that they do not continue to climb. Other researchers (e.g., Hope et al., 2014; Jaballas et al., 2011) have provided evidence that obesity among children ages 2 to 5 years escalated from 5% between 1976 and 1981 to 12.1% between 2009 and 2010. In the same years, obesity rocketed from 6.5% to 18% for children ages 6 to 11 years and from 5% to 18.4% for children ages 12 to 19 years.

Parents determine their children's nutritional intake during the formative years. When parents perceive correctly that their children are obese or overweight, health care professionals can begin to offer assistance with intervention modalities. The challenge seems to be that more than 50% of parents have inaccurately assessed their children's weight status as normal (Lydecker & Grilo, 2016; Nemecek et al., 2017; Robinson & Sutin, 2016).

The perceptions of some parents who consider their children of normal weight as being overweight can lead to negative consequences, depending on the communication skills of the parents when interacting with their children. Parents' correct perceptions are critical in reducing the incidence of childhood obesity. Parents' comments or behaviors may communicate that children's body size is unattractive. The long-term disappointment and dieting among youth may lead to more unintentional weight gain (Lydecker & Grilo, 2016; Nemecek et al., 2017; Robinson & Sutin, 2016).

## Weight Loss

The simple approach to most weight loss is to restrict caloric intake and increase physical activity, but if it were that seamless, the increasing prevalence of obesity and its consequences would diminish drastically. Despite the use of social media, politicians, and the medical community to spread the message about the dangers of obesity, the success of weight reduction strategies has been disappointing (Daigle et al., 2018). Furthermore, even if weight loss is attained, the rebound effect may result in more weight gain (Luley et al., 2010). Individuals dealing with obesity who also are facing social exclusion may believe that losing weight will make them more attractive and more popular and that people will see them as ambitious and self-controlled, not lazy. Sometimes they set lofty weight loss goals, and when they do not attain the desired weight loss, they become more dissatisfied with their body image, leading to binge eating and even more weight gain (Jung et al., 2017; Tomiyama et al., 2018).

Reed et al. (1993) contended that environment is a minor factor associated with obesity, which is largely determined by genetics, instead. Genes, environment, and eating behaviors influence obesity. Genes may have some influence in determining how diet and physical activity interact, but gene interactions take time to develop. The fact is that obesity happens when people consume more calories than they expend. Researchers (e.g., CDC, 2018; Thaker, 2017) have highlighted that obesity and weight loss are multifaceted, and they have identified the need for more scrutiny of weight loss and its implications. One might ask why one cultural group might have more challenges than another in dealing with obesity. It may be associated with a combination of genetics,

social affiliations, and environment, along with family income, education, and environment (CDC, 2018; Reed et al., 1993; Thaker, 2017).

## Parental Feeding Practices

Parents are the gatekeepers of their children's health, so they should be motivated to boost the health of their children right from birth. The United States is experiencing a wide range of challenges associated with childhood obesity, and parents are an important factor in reducing its prevalence. Infant learn how, what, and when to eat by observing other individuals in their environment. Lee et al. (2016) stated that children's dietary patterns are established early in life and that there is a connection between the food that children are familiar with and their dietary behaviors. For example, children who are not introduced to vegetables early may develop behaviors that involve eating few, if any, vegetables later in life.

Babies favor the sweet taste of breastmilk, and as they mature, they are drawn to other sweet tastes. Having an affinity for sugary food makes children more prone to obesity. However, if children are encouraged by their parents to eat healthy food from an early age, then the incidence of obesity is reduced. Interventions are helpful when family members already follow healthy nutritional patterns before children are born. Parents often are aware of the reasons for childhood obesity, and researchers have identified such factors as long work schedules, scarce resources, environmental safety concerns, and the high cost of food (H. Lee et al., 2016; National Academies of Science, Engineering, and Medicine, 2016; Penilla et al., 2017).

If parents are oblivious to their own or their children's weight issues, they may be unwilling or unmotivated to seek help. The success rate of weight reduction efforts is high when parental influence is equally high. D. M. Thomas et al. (2014) conducted a study indicating that the obesity rate may be tapering off in some areas of the United States. However, some individuals have questioned the efficacy of the intervention modes used in the study, which population was observed in the study, and the impact of the results on health care costs. In other areas in the United States, obesity rates continue to escalate. However, unsuspecting parents who are gatekeepers of their children's health may not realize that their children are already obese or are heading toward obesity status, perhaps because of the accepted norms that adults and children are heavier.

Hansen et al. (2014) referred to the increasing prevalence of obesity as a generational shift in perception of obesity being accepted as normal. They further stated that parents sometimes weigh their children's weight status against their children's friends who are obese, so they perceive their children as being of normal weight. If the majority of their children's peers are obese, parent may not know what the appropriate weights should be for their children based on height and weight (Hansen et al., 2014; Lundahl et al., 2014; D. M. Thomas et al., 2014).

## Nutrition

Nutrition is an important aspect in maintaining health. Many dietary guidelines are available to help parents to provide their children with adequate nutrition. However, barriers prevent some families, especially those of low SES as well as recent immigrants, from having adequate nutritional support (Francis-Ganderson & McDonald, 2018; Pour et al., 2014). Knowing about health literacy is helpful to gain a better perspective of food ingredients and determine appropriate dietary behaviors. According to Persoskie et al. (2017), a significant number of the individuals whom they studied were unable to estimate the caloric level of a container of ice cream, nor could they determine the number of calories in a single serving.

Childhood obesity rates continue to climb, and more public health interventions are necessary to educate parents of the importance to read and understand nutritional labels. The Nutrition Labeling and Education Act was passed in 1990 to help consumers to make better dietary decisions and to reduce the number of diseases association with obesity. The act has assisted many individuals, especially those with high nutrition literacy, but the language of the labeling has been difficult for many consumers with low health literacy to understand. The lack of dietary education poses challenges because parents are expected to interpret and act based on the nutritional information available to them. Parents need clear and easy-to-understand information because of the increasing prevalence of obesity (Francis-Ganderson & McDonald, 2018; Persoskie et al., 2017; Pour et al., 2014).

Trofholtz et al. (2017) sought to determine if a link existed between the dietary intake of children and the factors of family meals, emotional atmosphere, and distractions such as screen time. Results indicated that even though the presence of television did not alter enjoyment of meals, children's dietary intake was higher when the television was turned off during meals. Trofholtz et al. also suggested that dietary intake is higher when families eat together, leading to strong emotional bonds.

Poor nutrition, including the quality of snacks given to children, and inadequate physical activity can lead to obesity. Snacks are mostly nonnutritious, and parents sometimes offer them as rewards to control their children's behavior. McCafferty et al. (2019) stated that even though parents are naturally nurturers, there has been a dearth of information on the long-term effect of snacking and its overall impact on children's dietary behaviors. Researchers have tended to identify the mother figure as the primary caretaker of children's well-being (McCafferty et al., 2019; Trofholtz et al., 2017).

Diverse ethnicities, coupled with international trade, have allowed an impressive array of food choices to transform, improve, or worsen health conditions. Obesity is a global problem, and individuals who used to be viewed as overweight or obese are now considered normal or desirable weights. This new misguided social influence has unwittingly placed these individuals at higher risk, particularly if they are unaware of the challenges and are not already experiencing health issues related to obesity (Hansen et al., 2014).

Good nutrition, which is sometimes deficient in low-income Black and Hispanic American households, is necessary for the healthy development of children

(Acheampong & Haldeman, 2013; Zhang et al., 2014). Acheampong and Haldeman (2013) posited that although low SES may play a role in health disparities in the United States, the lack of sound nutrition guidelines also may be helping to explain why Hispanic Americans fare worse nutritionally than Blacks do. Hispanic Americans are at higher risk of obesity partly because of their limited English proficiency, poor health literacy, unsafe living environments, and reduced access to health care (Acheampong & Haldeman, 2013; H. D. Gibbs et al., 2016; Rolling & Young Hong, 2016).

Briefel et al. (2015) conducted an analysis inferring that most parents whom they studied thought that their children were eating adequate amounts of fruits and vegetables, but the results of their study indicated that approximately 30% of toddlers met the recommended guidelines of five daily servings. Restricting food intake may be related to elevated BMIs, and researchers have suggested that this practice may be related to SES, age, gender, or parental ethnicity. Ventura and Birch (2008) noted that parents often pressure their children to eat and that this behavior leads to poor food consumption and dislike for the food.

The next section is a brief discussion of the impact of parenting views, weight status, and influence of the Supplemental Nutrition Assistance Program (SNAP) on the quality of diet. Parents want the best for their children. However, Black and immigrant families seem to fare worse than their White counterparts. Dietary acculturation seems to account for some of the higher obesity rates in the immigrant population (Vaccaro et al., 2019). Lack of preventative health care, poor sleep patterns, exposure to cigarette smoke, and negative body image are a few of the factors contributing to childhood obesity.

Parental perceptions of food and physical activity are closely associated with children's weight status. Some parents are either unconcerned about or are not ready to accept that their children need help to address weight issues. This lack of concern often is centered on the parents' own issues with obesity. According to Paul et al. (2014), the prevalence of childhood obesity is so high that some mothers either are content with the sizes of their overweight children or want them to be heavier. However, parents who are aware of the potential health challenges facing children are more likely to begin following a pathway of positive health behaviors. It may not be easy for parents to change their children's eating behaviors, but concerted efforts by extended family members may help them to achieve this goal. Success also requires motivation from the children, who are dealing with their own insecurities (Gerards et al., 2014; Hernandez et al., 2015; O'Neil et al., 2010).

SNAP helps families to purchase food to reduce food insecurity. Some reviews have indicated that the program has done more harm than good, with parents purchasing more calorie-dense foods, a situation that place them in the same position before receiving the benefit. Andreyeva et al. (2015) assessed the efficacy of SNAP. Results showed that children had a higher consumption of calorie-dense food and that children and adults on SNAP tended to eat fewer than three meals per day. Skipping meals is a sign of food insecurity that may be evident among low-SES families.

Parents are responsible for using their available budgets to make the best food purchases for their children. They often compete with junk food advertisements, making it more difficult to prepare healthy food options (Andreyeva et al., 2015; Bleish et al.,

2019; Sherman & Smith, 2019). Policymakers and public health officials should be cognizant of the obstacles that parents are facing as they develop their intervention modalities. They should be aware of parents' perceptions about food preparation, and if families are receiving SNAP, they should be educated about basic food literacy so that they can make wise food choices. These are only a few suggestions that may help parents on tight budgets to make decisions about the purchase and preparation of food for their children.

## Obesity in the Families of Obese Women

Other factors may be involved in obesity challenges. Women, who usually make the food choices for their children, are blamed more than men for their families' feeding practices (Acheampong & Haldeman, 2013); however, negative forces may be involved in struggles with obesity. Soeliman and Azadbakht (2014) asserted that weight loss can be a challenge and that it is even more difficult to maintain new lower weights. Researchers such as Greenway (2015) and Kapoor et al. (2017) have posited that hormonal imbalances may be partially responsible for sustaining or counteracting long-term weight management. Is it possible that food additives also could be involved in the increased incidence of obesity? Poti et al. (2017) as well as Simmons et al. (2014) indicated that the manufacturing processes and additives responsible for increasing the shelf life of food and reducing the cost may be affecting people's health. As noted previously, parents, especially the parents who are responsible for buying food and preparing family meals, need to become health literate. Families that are unaware of the

additives in their food supplies may be more vulnerable to obesity simply because they are underprivileged.

## Lived Experiences of Individuals Who Are Obese

The lived experiences of some parents who are obese have exposed intense emotions of stigmatization, buried emotional scars, deep self-loathing, and feelings of ineptitude. J. Ogden and Clementi (2010), Sadati et al. (2016), and Toft and Uhrenfeldt (2015) concurred that physicians have tended to associate obesity with being lazy, immoral, and dirty, so when patients perceive these aversions, they become even more uncomfortable and unwilling to seek help. Binge eating appears to be unassociated with hunger; rather, it may be something that offers unconditional and nonjudgmental pleasure. The social context of being obese often results in negative self-worth.

Individuals who are obese want the respect and consideration that others of normal weight receive. Davison et al. (2005) suggested that girls who have mothers and fathers who are obese are at greater risk of obesity than girls who have parents of normal weight. Obesity tends to persist into adulthood, so unless interventions are successful, the obesity cycle continues as a generational pattern (Patel et al., 2018). Individuals who are obese tend to delay appropriate health care. Examples of the factors contributing to delay or avoidance include ill-fitting medical equipment such as blood pressure cuffs, exam tables, and gowns. Other individuals think that they will be diagnosed as fat and that their other health challenges may not be addressed, so they avoid seeing health care providers. People who are struggling with obesity often perceive that their primary physicians stigmatize them, with the result being a domino effect of shame, guilt, and stress leading

to more weight gain. These are some factors that parents who are obese struggle with continually. They often have to delay their personal insecurities and attempt to make decisions about feeding practices for their children (Hoeeg & Grabowski, 2018; Paul et al., 2014; Phelan et al., 2015). The social context of the current study was to expand awareness among personnel who conduct obesity reduction interventions so that they may help to reduce the incidence of obesity in Prince George's County, Maryland.

## Theory

The theoretical support for the study was Bandura's (1977) SCT. Theory in general refers to the art of explaining the rationale for behaviors. It attempts to predict by testing a phenomenon, gaining understanding, exploring the environment, and examining the interactions of individuals. SCT has been used widely as a behavioral change theory in the management of obesity challenges. It highlights the significance of monitoring behaviors through self-regulation, judging, and evaluation. According to Bandura, learning occurs through a process of observation, modelling, and motivation.

Bandura's (1977) SCT recognizes that individuals are products and elements of their different environments. In other words, people can perform as individuals, or they can choose to learn from their social systems to elicit new behaviors. The concept of efficacy is a major component of SCT. Efficacy infers that individuals have a strong belief that they are capable of amending their actions to reach the desired behavioral changes. Individuals with high efficacy assess challenges as obstacles to overcome, whereas people with low efficacy are overwhelmed by personal challenges and are fearful of making difficult obligations (Harinie et al., 2017; Middleton et al., 2018).

People are in different stages of inclination to make behavioral changes, so past experiences play a role in stages of change. One advantage of SCT (Bandura, 1977) is that it facilitates the exploration of the challenges and reinforcements that result in behavioral changes and how individuals maintain the new behaviors. Health educators and policymakers must increase their knowledge of the influences that compel individuals to make specific choices. SCT suggests that people can observe others and then model their own new behaviors on the successful behavioral changes of others.

According to Bandura (1977), behaviors can be changed to incorporate healthy nutrition and physical activity. SCT has been tested, focusing on the construct of self-efficacy in physical activity. However, it does require trained personnel and a combination of proper guidance, support, and receptive participants to assist in improved outcome expectations (Knol et al., 2016; Oyibo et al., 2018; Young et al., 2016). SCT has been used widely in the development of home food environment interventions. The premise is that parents' behavioral changes can lead to behavioral changes in children and promote their well-being (Knol et al., 2016).

Lack of proper nutrition, low engagement in physical activity, impaired health, and obesity can yield serious negative health consequences. Oyibo et al. (2018) asserted that weight loss intervention modalities may result in modest results but that when theories are introduced into weight loss regimens, improved weight loss results have been documented. SCT has been used widely in obesity reduction programs to guide behavioral changes. Tougas et al. (2015) suggested that using SCT in a weight loss study was appropriate if used correctly. They reviewed interventions that used theory, more

specifically SCT. It appears that compared to not using theory, theory is more helpful in developing weight loss interventions. However, researchers and clinicians must be able to identify the correct components of SCT that best fits their aims. One study using SCT only resulted in a 52% success weight loss rate. Researchers have established that trained personnel, adequate resources, and participants who are ready to make behavior changes are key components of successful interventions (Dickin et al., 2012; Pietrabissa, 2018; Tougas et al., 2015).

To further test the efficacy of SCT, researchers have recognized that individuals are usually socialized by their particular environments and that changes may occur if their motivation is to achieve the desired objectives (Harinie et al., 2017; Rolling & Young Hong, 2016). Behavioral changes can be the result of interactions with the internal and external environments. In addition, self-efficacy is boosted when individuals are encouraged to change unwanted behaviors. Individuals are more prone to have successful weight loss endeavors if they are knowledgeable of the benefits of physical activity and healthy diets. Two or more behavioral change techniques, such as physical activity and nutritional control, offer more likelihood of realizing weight loss goals. As weight loss becomes apparent, increased self-efficacy leads to greater goals or behavioral changes, and individuals exhibit more confidence (Harinie et al., 2017; Rolling & Young Hong, 2016).

One reason that professionals rely on SCT is that the maintenance component is helpful for individuals to sustain newly acquired behaviors. This aspect of maintenance is critical because once individuals lose the weight, there often is a tendency to regain the

weight. Tougas et al. (2015) indicated that although SCT may not be as efficient as stated, individuals who have maintained their weight loss a year later continue their relationships with their weight loss counselors. Tougas et al. believed that the bond between individuals and their counselors is one way to provide the support to maintain the weight loss.

## Phenomenology as a Research Method

I chose to conduct this study following a phenomenological design. As stated by Patton (2002), it is a suitable design for researchers who seek rich descriptions of their study participants' lived experiences. For example, I explored the lived experiences of parents who shared their perceptions of and experiences with obesity, and the personal turmoil of repeating the same feeding practices as their parents. I gained a better understanding of the coping strategies that these parents who were obese used to manage their children's nutrition. I considered other research designs and investigated grounded theory and phenomenology because they shared similarities and differences.

Codes and analyzed data come from several sources. In phenomenology, the sample size is small. In my study, the unit of analysis comprised parents who were obese who volunteered to share their lived experiences and perceptions of standards of health for their children. The issues of obesity can easily be misunderstood by those who do not experience the challenges and the pain. I wanted the readers of my study to gain a strong sense of the different emotions that the participants experienced to manage their children's nutrition. I wanted them to have a deeper understanding of the participants' individual experiences of the phenomenon under investigation. Merriam (2009)

supported Patton (2002) by indicating that the phenomenological design is appropriate for studying poignant and often intense human experiences.

## Summary and Conclusion

Obesity has the potential to reduce the quality of life and increase the risk of early mortality. If left untreated, it may lead to certain cancers, Type 2 diabetes, and hypertension (Hruby & Hu, 2015). The prevalence of obesity in the United States seems to be the most evident among individuals who often lack the resources to purchase high-quality food items or who live in unsafe neighborhoods (Cherrington et al., 2015).

At one time, obesity was considered an issue facing adults, but children have become just as disposed to being obese, and the prevalence of childhood obesity continues to escalate (Paul et al., 2014). According to Turconi (2013), parents must be educated about the risks associated with obesity to protect their children. If obesity persists into adulthood, the risks factors increase, even if the individuals accomplish their weight loss goals and maintain them. Parents need a clear understanding of their perceptions about childhood obesity and nutrition (Finkelstein et al., 2017; S. L. Thomas et al., 2014).

Parents do not realize when their children are at risk of overweight and obesity challenges. Bleish et al. (2019) noted that parents of normal weight usually raise children of normal weight, whereas parents dealing with obesity tend to raise children who have inappropriate weights for their ages and heights. One challenge arises when parents do not seek help for their overweight children because other children whom they know are

of similar weights. This generational shift in perceptions may have serious consequences for children, including social isolation, bullying, and depression (Patel et al., 2018).

My study focused on the lived experiences of a sample of 11 parents regarding their obesity challenges and how or if they were able to make strides in curtaining or managing their children's obesity issues. I conducted semistructured interviews with the participants, all of whom were residing in Prince George's County, Maryland, at the time of the study. The county is affluent, but the obesity rates are high, and it is also home to many residents who may be facing poverty, ill health, language barriers, poor health care, and inadequate nutrition. The results may help health care professionals to tailor ongoing weight reduction interventions currently being implemented in Prince George's County. Chapter 3 includes details about the research method.

# Chapter 3: Research Method

The purpose of this phenomenological study was to obtain the perceptions of a sample of parents who were obese and the coping strategies that they used to provide nourishment to their children. Despite being preventable, obesity is ubiquitous, and it is far more pervasive in low-SES Black communities (Hruby & Hu, 2015; Nepper & Chai, 2017; Taber et al., 2016). One of the challenges of dealing with obesity is that parents do not realize that their children are either headed toward or are already overweight or obese (Eli et al., 2014). Having a support system that encourages healthy food options and physical activity is beneficial, but challenges arise partly because of the lack of effective approaches that can reinforce new behaviors and maintain long-term weight loss. Recognizing the strengths and weaknesses of family members may help to influence ways to reduce obesity (Gruber & Haldeman, 2009). Accomplishing weight loss by way of dietary changes and increased physical activity requires behavioral changes and maintenance. In this chapter, I provide details about the research design, participant selection, and data collection and analysis.

## Research Design and Rationale

I conducted the study using a qualitative approach and a phenomenological design. Researchers who conduct phenomenological studies have the advantage of obtaining and analyzing data of the phenomena under investigation based on details that the participants provide (Eddles-Hirsch, 2015).

Two RQs guided the study:

1. To what extent are obese parents' perceptions influential over their children's nutrition?
2. What are parents' perceptions of the factors that would help to promote good health and nutrition for their children?

Problems are more likely to be resolved when their origins are known (Hefferman & Teufel, 2018). Obesity rates continue to climb, despite interventions focusing on family structure, school systems, and community efforts. Prince George's County, Maryland, is an affluent county, yet the rates of poverty and obesity are more prevalent there than in neighboring counties (Eddles-Hirsch, 2015).

I formulated the interview questions and used a qualitative phenomenological approach to give the 11 participants who were obese the opportunity to share their perceptions and lived experiences of the coping strategies that they used to provide nutrition to their children. I collected the data from interviews with a sample of parents who were obese. This data collection process was convenient and appropriate for a qualitative study (Creswell, 2009). I prepared the interview questions (see Appendix A) in advance and asked all participants the same questions to address the RQs.

## Role of the Researcher

My role as the researcher was not to measure or define the participants' obesity status. Instead, my role was to encapsulate the core of their experience with obesity and the practices that they followed to feed their children. I designed the study, prepared the open-ended interview questions, recruited the participants, conduct in-depth interviews,

and collected and analyzed the interview data. Qualitative researchers are responsible for obtaining the perspectives and perceptions of their participants about the phenomena being investigated. They must set aside personal beliefs and biases when collecting and analyzing their data.

Researchers have several ways to protect the participants while collecting data (Sorsa et al., 2015). For example, participants whom researchers interview must be allowed to share their narratives in safe, private, and comfortable settings. Researchers also need to perform self-evaluations to determine if they can conduct their studies honestly and with a reasonable amount of neutrality.

All researchers bring preconceived beliefs and biases to their studies. To mitigate their influence, researchers can use bracketing to postpone their perceptions of the phenomena and reach a deeper understanding of the participants' viewpoints. Making a conscious effort to diminish researcher bias can result in data worthy of analysis (Sorsa et al., 2015).

There are various approaches to phenomenological research. Phenomenology is a research method that researchers use to obtain information from participants who have experience with the phenomena being investigated. Earlier psychologists had challenges understanding individuals' experiences of the phenomena being investigated, but Husserl (as cited in Eddles-Hirsch, 2015) developed a plan that resulted in a better understanding of the lived experiences of individuals. Husserl developed the concept of transcendental phenomenology as an alternative to scientific research. Husserl argued that application of the transcendental process allows researchers to delve deeply into the participants'

consciousness to capture and interpret their realities of the phenomena. He also stated that human consciousness and the world are not separate entities and must be studied as one.

## Researcher Bias

Ethical and humane actions imply that researchers are aware of the participants' vulnerability and rights. Because it is impossible to consider all of the ethical codes of conduct and parameters that may be present in studies, researchers must engage in retrospection to minimize the use of power and reduce any chances of harm to the participants (Orb et al., 2001). Researchers must be cognizant of ways that their biases may impact the quality of their studies. I documented and addressed my own biases throughout the study. No ethical issues arose while I was conducting this study.

## Methodology

### Participant Recruitment

Qualitative researchers may use a variety of sampling methods to recruit their participants. I used purposeful sampling, meaning that the participants were knowledgeable of the phenomenon and were willing to share their perceptions (see Palinkas et al., 2015). Qualitative researchers use purposeful sampling, or purposive sampling, to select participants who can facilitate saturation of the data, a process that involves interviewing the respondents until no new data emerge. In addition, purposive sampling allows researchers to choose participants who are best able to provide rich data that answer the RQs (Maxwell, 2013). Suri (2011) posited that more precisely stated interview questions yield data saturation more quickly than more broadly stated questions do. Vaguely stated interview questions are less likely to result in data saturation.

My goal was to interview parents who were obese to obtain their perceptions and coping strategies that they used to provide nutrition to their children. I chose Prince George's County, Maryland, to conduct my study because I am a resident of the country, which is home to more than 900,000 diverse residents. Although the county is considered affluent, health outcomes are relatively inferior in many communities, especially when compared to neighboring communities (Prince George's County, 2015b). The results of one study (Prince George's County, 2015a) estimated that of all the children in the county, 31% were either obese or overweight.

The sample comprised 11 parents who were obese and had at least one biological child living in the household. Qualitative researchers try to conduct interviews in the participants' natural settings so that they can observe them while conducting the interviews. Because of COVID-19 pandemic restrictions in place at the time of the study, I conducted the interviews via the Zoom platform. All 11 participants chose times convenient to them to be interviewed. Another distinguishing factor of qualitative research is to collect the data directly from the participants to establish camaraderie and trust (Creswell, 2009).

Upon obtaining approval from Walden University's Institutional Review Board to conduct the study (IRB approval #10-15-20-0433217), I solicited potential participants by posting fliers at community centers and faith-based organizations, on social media such as Facebook and Instagram, and at the local community health department. I included my email address to allow potential participants to contact me if they were interested in joining the study.

To determine their eligibility, I gave potential participants a few prescreening questions via e-mail (see Appendix B). I interviewed 11 parents who were knowledgeable of the topic under investigation. Participants were selected based on their responses to my survey poster to ensure that they were knowledgeable of the phenomenon under study (see Carter et al., 2014). Interested volunteers had to meet specific criteria to join the study: They had to be parents who were obese, there had to be at least one biological child in the household, the parents had to be over the age of 18 years, and they had to be able to speak and read English. Individuals who did not meet the inclusion criteria were sent letters of thanks for responding to the flier.

Qualitative sampling does not require a set number of interviews to answer the RQs. The richness of the data is more critical than the number of participants (see Lopez & Whitehead, 2013). Data saturation, which happens when no new information emerges from the data analysis, is more likely to be reached if data collection is purposeful. Data saturation is a determination that researchers make based on their judgment and experience. Researchers can end data collection once they obtain no new information from the participants. This is an indication that they have reached data saturation (Van Rijnsoever, 2017). I reached data saturation after completing 11 interviews. Before conducting the interviews, I asked the participants to sign the written consent, which ensured that the privacy of all participants was secured and protected. All participants chose their preferred pseudonyms for security purposes.

## Data Collection Method

I interviewed the participants using a semistructured format guided by open-ended interview questions. Prospective participants contacted me via the email that I had included in the flier. I discussed the criteria for eligibility with prospective participants to be in the study before we agreed on dates and times for the interviews on the Zoom platform. I explained the informed process via telephone, and the participants signed the consent form and emailed it to me with their choices of interview dates and times. I also discussed the purpose of the study with the participants and described how I planned to protect their identities and how I would use their interview responses in the study. I prepared the interview questions before conducting the study. Each interview lasted for approximately 30 minutes.

All of the questions that I asked during the semistructured interviews were open ended. The participants knew in advance that I would audio record the interviews. I gave all participants $15.00 gift cards to thank them for agreeing to join the study. Once the individual interviews were finished, I thanked the participants. I then proceeded to transcribe the interviews Microsoft Word documents.

## Instrumentation

I developed the interview questions to answer the RQs. To improve and clarify the interview questions, I pilot tested them on two colleagues who were willing to share their own lived experiences with the phenomenon being studied. It also gave me insight into the coping strategies that the parents used when providing nutrition to their children.

## Procedures for Pilot Study

Researchers usually conduct pilot studies to evaluate the effectiveness of the research instrument as well as test the performance characteristics and capabilities of study designs. This process allows researchers to be more informed and prepared for challenges that may arise when conducting subsequent studies. I conducted a pilot test of the interview questions to ensure that the questions addressed the phenomenon and the participants understood the wording of the interview questions.

## Procedures for Recruitment and Participation

All participants signed and submitted their informed consent forms to me before I interviewed them. I informed them of the purpose of the study and how I would use their information in the study. At the end of each interview session, I transcribed the data into Word documents, and I used NVivo v.12 to assist with the analysis of the data. I then used member checking to ensure that I had captured the interview responses correctly. Some participants preferred email responses; others preferred a phone call so we could share the responses.

## Qualitative Data Analysis Plan

### Unit of Analysis

Patton (2002) stated that organizations, institutions, clients, students, or entities being studied are the units of analysis that represent the who or what being analyzed. The focus of data collection in my study were parents who were struggling with obesity and their perceptions of their coping strategies to provide nutrition for their children. Therefore, the unit of analysis for the study referred to parents struggling with obesity.

## Data Management

I transcribed the audio-recorded interviews verbatim into Word documents. I verified the accuracy of the transcriptions by reading them multiple times while listening to the recordings. I conducted member checking by emailing nine of the participants with a request that they check their transcriptions for accuracy. I then imported the transcriptions into NVivo v.12 for analysis. Researchers should evaluate the information obtained from their study participants and then organize the data into emerging themes and codes, as described by Lewins et al. (2010). Scrutiny and clarification occur until data saturation occurs and no new themes emerge from the data analysis. To enhance the progress of their studies, researchers must be cognizant of personal and preconceived biases. They must approach their studies with flexibility, be willing to seek other explanations, and accept criticism from participants and colleagues (L. Gibbs et al., 2007).

## Method of Data Analysis

I used Colaizzi's (1978) method of phenomenological data analysis to extract, organize, and analyze the data. By using Colaizzi's strategy, I was able to generate an exhaustive description and interpretation of the lived lives and coping strategies that the participants, all of whom were parents who were obese, used to feed their children. Conducting phenomenological studies give researchers deeper insight into the lived experiences of the participants (Abu Shosha, 2010).

Colaizzi's (1978) strategy to data analysis has seven steps. Researchers use these seven steps to identify themes based on the analysis of the interview responses. The

interview responses were coded separately before being combined to build emerging themes. I used the themes to interpret the participants' experiences of the phenomenon (Creswell, 2007).

1. I conducted the interviews with parents who were obese, and I read the transcriptions several times to understand the participants' personal experiences.
2. I reviewed the transcriptions to identify significant phrases pertaining to the participants' experiences. In NVivo v.12, each block of text identified as relevant was assigned a node. A total of 136 blocks of text from across the 11 transcriptions were assigned to nodes.
3. Meanings were formulated from all significant phrases.
4. The formulated meanings were clustered into themes.
5. The emerging themes described the participants' lived experiences. This step allows researchers to confirm that they have found enough terms to provide richness of the data that sufficiently and correctly describes the participants' perceptions of the phenomenon).
6. Redundant data were removed from the findings.
7. I member checked the transcribed interview responses.

## Evidence of Trustworthiness

### Credibility

Credibility establishes that the data are truthful and interpret the participants' perceptions accurately. Credibility also can be accomplished by researchers who invest

ample time to become sufficiently familiar with the participants to establish rapport and trust. Peer debriefing is a process of checks and balances that allows researchers to share their analysis with participants to ensure that the researcher did not misrepresent the participants' meanings in response to the interview questions. Being aware of the most appropriate research methods and relevant peer-reviewed literature of the phenomenon under study also helps to increase credibility (Nowell et al., 2017).

To ensure that I had interpreted the participants' experiences of the phenomenon accurately, I read reviews of previous research literature to be aware of the target population and the phenomenon. Knowing the target population and understanding what other researchers had already discovered about the phenomenon under investigation helped me to develop the interview questions. Member checking was another significant way to enhance the credibility of the results (Guba & Lincoln, 1994). I used member checking to give the participants the opportunity to read; confirm; or amend, as necessary, their interview transcriptions.

**Transferability**

Qualitative researchers establish transferability based on information that the results can be applied to other target populations, times, situations, and so on (Korstjens & Moser, 2018). I provided clear descriptions of the data collection, data analysis, demographics of the participants, and the participant recruitment processes to address transferability in my study.

## Dependability

Dependability refers to the consistency of the data analysis. Dependability audits allow other researchers to reproduce the studies. To enhance the dependability of the study, I asked the 11 participants the same interview questions in the same order. I also followed a research design that was appropriate. Careful documentation of the participants and the interview process, along with consistency in the data collection process, increased the possible replication of the study. Lincoln and Guba (1985) suggested that to increase dependability, researchers should use accepted research designs that are appropriate for their studies and are not personal preferences. An audit trail helps to increase dependability by providing thorough and well-detailed notes explaining how decisions were made, how themes evolved, and how data were managed during the study.

## Confirmability

Confirmability establishes that researchers are aware of personal influences that could impact their studies. Objectivity can be difficult to prove, so researchers must consider using a method such as an audit trail indicating the source or sources of the collected data so that the reader can track how the data were collected and analyzed. Triangulation of the data using several methods can help to reduce bias (Shenton, 2004).

## Ethical Procedures

Ethical measures must be evident in all research endeavors. Ethics are strongly rooted in the principle that researchers are committed to maintaining and protecting the confidentiality, privacy, rights, and dignity of all participants (Fouka & Mantzorou,

2011). University IRBs must approve research involving human participants, and researchers must take moral and ethical responsibility for protecting their participants (Orb et al., 2001). Participants are assets to all studies, and IRBs and other regulatory bodies have instituted protocols to ensure that participants, gatekeepers, and other stakeholders are treated with respect and dignity. Qualitative studies usually comprise volunteer participants in their respective environments. Researchers must be cognizant of IRB protocols and rules before conducting their studies. They also must be aware of the importance of following ethical procedures when handing their data and engaging with their study participants (Orb et al., 2001).

Researchers must be aware of and prepare for issues that may arise while they are conducting their studies. The research literature has indicated that the topic of obesity can generate various emotions in individuals. I was prepared that some of the participants might not have been open to discussing some of their challenges with obesity.

Researchers must comply with several requirements when conducting their studies. These requirements are informed consent, beneficence, respect for anonymity and confidentiality, and respect for privacy. Each one is briefly discussed next.

**Informed Consent**

The informed consent is a document that clearly explains to the prospective participants the purpose of the research, and it provides them with details ensuring that they are aware of any potential risks of joining the study and that they have chosen to participate without coercion. I informed the participants in my study that even though

being in the study offered them no personal benefits, the results could influence future weight loss programs (Fouka & Mantzorou, 2011).

**Beneficence: Do No Harm**

Researchers are required to pursue studies that will benefit and promote the welfare of the participants and the broader target population. Beneficence is associated with the potential risks of joining studies. The phrase "do no harm" means that researchers are cognizant that the topics being studied may be of a sensitive nature. I did not encounter any issues during the interviews, but I was prepared to either discontinue or pause the interviews if any of the participants found the questions emotionally wrenching. Researchers must weigh the benefits against the risks and consider revising their studies if need be (Fouka & Mantzorou, 2011).

**Respect for Anonymity and Confidentiality**

Participants must know that researchers will protect their identities. I used numbers to identify the participants on all study documents. I then assigned pseudonyms to the participants. I assured them that I was the only person who had access to the codes and that I would store all data and other information relevant to the study in a locked and safe environment in my home office. One component of confidentiality is to assure the participants that whatever information they choose to share in response to the interview questions will remain private and confidential. It was my responsibility as the researcher to protect the data and guarantee the participants' privacy, anonymity, and confidentiality.

## Summary

Conducting a qualitative study of this nature required intense preparation. I read peer-reviewed articles to gain a deeper understanding of the phenomenon under investigation. Included in Chapter 3 were details about my phenomenological study, including the IRB approval process, informed consent, data collection and analysis, ways to reduce bias, the interview process, and ethical considerations. In Chapter 4, I present the results of my data analysis.

# Chapter 4: Results

I conducted this phenomenological study to obtain the perceptions of parents who were obese and understand the coping strategies that they used to manage their children's nutrition. This study is meaningful because children who are obese have the potential to become adults who are obese, and obesity has been recognized as a factor in the development of chronic illnesses (see Schwenler et al., 2017). Despite being an avoidable disease, obesity and its comorbidities often strain public health services (Hammond & Levine, 2010). It is important find alternative pathways to prevent childhood obesity so that it does not persist into adulthood. I also conducted this study to increase the awareness of policymakers and health care providers as they strive to develop appropriate obesity reduction standards.

The sample comprised 11 parents who volunteered to share their lived experiences and perceptions of the nutritional management of their children. I conducted a pilot study with two colleagues whose data were not included in the data analysis.

I developed two RQs to guide the study:

1. To what extent are obese parents' perceptions influential over their children's nutrition?
2. What are parents' perceptions of the factors that would help to promote good health and nutrition for their children?

I describe the study procedures and the results of the data analysis in Chapter 4. Also included in the chapter are details about the data collection and analysis, participant demographics, and evidence of trustworthiness. A summary concludes this chapter.

## Pilot Study

I conducted a pilot study to increase the clarity and appropriateness of the interview questions. Based on feedback from two participants, I did not have to make any changes to the 11 open-ended interview questions. By asking open-ended questions, I gave the participants the opportunity to speak freely and myself the freedom to ask probing questions or to seek clarification or elaboration of their responses (see Lopez & Whitehead, 2013). The pilot study participants were two colleagues. I provided them with an overview of the study, and they both signed the pilot informed consent. They agreed to be audio recorded during the interview, which lasted approximately 35 minutes.

## Setting

I conducted the interviews using the videoconference application Zoom at times chosen by the participants. Participants were invited to join the videoconference from safe, quiet, and convenient locations of their choosing. A condition that may have influenced the interpretation of the results was that data were collected during the COVID-19 pandemic. Four of 11 participants referenced the pandemic as a barrier to managing their obesity (e.g., through limitations on physical activity).

## Demographics

The purposeful sample comprised 11 parents from Prince George's County, Maryland, who were obese and had at least one biological child living in the household. All participants were over the age of 18 years and could speak and read English. Table 1 is a summary of the participants' demographic characteristics.

**Table 1**

*Participant Demographics*

| Pseudonym | Marital status | Employment status | Income |
|---|---|---|---|
| Brianna | Married | Employed | No response |
| Thelma | Married | Employed | > $75,000 |
| Elizabeth | Widowed | Employed | > $75,000 |
| Eva | Married | Employed | $40,000 |
| James | Single | Employed | > $75,000 |
| King | No response | No response | No response |
| Louise | Divorced | Employed | > $75,000 |
| Mary | Married | Employed | > $75,000 |
| Noda | Married | Employed | > $75,000 |
| Sharon | Married | Employed | > $75,000 |
| Zumba | Married | Employed | $39,000 |

## Data Collection

I conducted one-on-one semistructured interviews with each of the 11 participants through the videoconference application Zoom. I audio recorded all 11 interviews using Zoom's integrated audio-recording feature. The average duration of the interviews was 30 minutes. No unexpected conditions arose during data collection, and there were no deviations from the data collection plan described in Chapter 3.

## Data Analysis

I transcribed the completed and recorded interviews verbatim into Word documents. I verified the transcriptions by reading them multiple times while listening to the recordings. I conducted member checking by asking the participants to verify the accuracy of the transcriptions via email. I then imported the approved transcriptions into NVivo v.12 for analysis.

I analyzed the data using Colaizzi's (1978) seven-step strategy. In Step 1, I read the verified transcriptions multiple times to become more familiar with the participants'

experiences. In Step 2, I reviewed the transcriptions to identify phrases that described the participants' lived experiences. Using NVivo v.12, I assigned a node to each block of text identified as relevant. I assigned a total of 136 blocks of text from the 11 transcriptions. In Step 3, I formulated descriptive labels for the extracted blocks of text to summarize their meanings. This step involved labeling the nodes and consolidating the 136 blocks of text with the same descriptive labels into 21 labeled codes (see Table 2).

**Table 2**

*Initial Codes*

| Initial code | No. of participants with responses assigned to codes | No. of blocks of text included |
|---|---|---|
| Better parental example | 5 | 9 |
| Changes to media messaging | 2 | 2 |
| Convenience of fast food versus healthy foods | 4 | 4 |
| Emotional eating | 5 | 8 |
| Enjoyment of eating | 6 | 6 |
| Financial barriers to healthier eating | 3 | 7 |
| Incorporating fruits and vegetables | 8 | 9 |
| Incorporating protein sources | 6 | 7 |
| Making healthy dietary changes more appealing | 2 | 3 |
| Making healthy foods easier to access than unhealthy foods | 5 | 6 |
| Nonjudgmental health care providers | 1 | 1 |
| Nutrition is perceived as balanced meals | 2 | 2 |
| Nutrition is perceived as eating healthy foods | 9 | 11 |
| Pandemic as a barrier to physical activity | 5 | 6 |
| Perception of a need to overcome habits and set a better example | 5 | 5 |
| Perception of a need to overcome resistance from child | 4 | 6 |
| Some cultural foods are healthy | 3 | 5 |
| Success in placing well-defined categories of food off-limits for children | 7 | 10 |
| Time and energy as barriers to healthier habits | 5 | 8 |
| Time as a barrier for children | 3 | 3 |
| Unable to break bad eating habits | 7 | 20 |

In Step 1, I clustered the formulated meanings into themes when the data assigned to them were similar or related. In Step 5, I used the emergent themes to describe the

participants' lived experiences. In Step 6, I removed redundant data from the descriptions. Step 7 consisted of member checking the data by emailing a summary of my interpretations of the participants' respective transcriptions to them with a request that they verify them or recommend modifications. Table 3 indicates the themes and the initial codes grouped in forming them.

**Table 3**

*Initial Codes Grouped to Form Themes*

| Theme<br>(Initial codes included in themes) | No. of participants with responses assigned to codes | No. of blocks of text included |
|---|---|---|
| Theme 1. Parental perceptions of nutrition promote the incorporation of some healthy foods into children's diets<br>• Incorporating fruits and vegetables<br>• Incorporating protein sources<br>• Nutrition is perceived as balanced meals<br>• Nutrition is perceived as eating healthy foods<br>• Some cultural foods are healthy<br>• Success in placing well-defined categories of food off limits for children | 11 | 38 |
| Theme 2. Parents' internal barriers to making healthier choices for themselves are perceived as barriers to their making healthier choices for their children<br>• Emotional eating<br>• Enjoyment of eating<br>• Perception of a need to overcome habits and set a better example<br>• Perception of a need to overcome resistance from child<br>• Unable to break bad eating habits | 11 | 45 |
| Theme 3. External barriers to healthier choices are perceived as affecting the whole family<br>• Convenience of fast food versus healthy foods<br>• Financial barriers to healthier eating<br>• Pandemic as a barrier to physical activity<br>• Time and energy as barriers to healthier habits<br>• Time as a barrier for children | 10 | 27 |
| Theme 4. Removing parents' barriers to making healthier choices for themselves and their children is perceived as the greatest need<br>• Better parental example<br>• Changes to media messaging<br>• Making healthy dietary changes more appealing | 10 | 20 |

- Making healthy foods easier to access than unhealthy foods
- Nonjudgmental health care providers

## Results

I organized this section of Chapter 4 by RQ. Under each RQ are the results, which I organized according to the themes that emerged from the analysis. Quotes that I took from the transcriptions support the themes.

### RQ1: To What Extent Are Obese Parents' Perceptions Influential Over Their Children's Nutrition?

Three themes that emerged from the data analysis addressed RQ1: (a) parental perceptions of nutrition promote the incorporation of some healthy foods into children's diets, (b) parents' internal barriers to making healthier choices for themselves are perceived as barriers to their making healthier choices for their children, and (c) external barriers to healthier choices are perceived as affecting the whole family.

#### *Theme 1: Parental Perceptions of Nutrition Promote the Incorporation of Some Healthy Foods into Children's Diets*

All 11 participants understood that good nutrition meant consuming healthy foods. In accordance with these perceptions, the participants attempted to incorporate healthy foods, particularly fruits and vegetables, into their children's diets. Some participants also limited their children's consumption of unhealthy foods by prohibiting them from consuming certain clearly defined categories of food (e.g., canned foods).

When the participants explained what they meant by healthy foods, four of them referred to fruits and vegetables; three referenced balanced meals; two mentioned

vitamins; one mentioned oatmeal; and one mentioned a sufficient, but not excessive, number of calories.

Mary expressed her understanding of good nutrition by stating that "eating healthy, well-balanced food. Lots of vegetables and fruits [is] something I need to do better at."

Eva defined the healthy foods associated with nutrition as "salad, like lettuce and stuff like that that are good for me. Water fruits."

Louise similarly referred to "healthy foods like fruits and vegetables."

Noda referenced balanced meals and distinguished good nutrition from eating by commenting that "first thing is, you can be eating food, but not getting nutrition. Nutrition is eating balanced meals to maintain good health."

Brianna, who referred to vitamins as an important part of nutrition, said, "Like your vitamin A and B, and those kinds of vitamins or nutrients, I think of building blocks for the body to maintain its homeostasis."

Although the participants' perceptions of nutrition focused on eating healthy foods, they did not report detailed knowledge of their or their children's nutritional needs or of all components of a varied balanced diet that would meet those needs.

Eight of the 11 participants indicated that their perceptions of nutrition helped them to incorporate fruits and vegetables into their children's diets.

Brianna said of her husband, the primary food-preparer in their household, that "he loves to cook . . . and so, he does add vegetables and different kind of things to incorporate in our food that are healthy."

Leroy stated that to provide good nutrition for his children, “I make cauliflower fried rice and try to be creative with vegetables.”

Noda said that to provide good nutrition for her children, “we do collard greens, broccoli, spinach, and easy vegetables to cook. Apples, papaya. We realize that grapes are high in sugar, but we have a craving for sugar.”

Zumba stated that he provided “fruits, vegetables, and salads” to his children for their nutrition.

The participants’ descriptions of the healthy foods that they provided to their children were consistent with their perceptions of a nutritional diet. Although only three participants referred to protein explicitly, six of the 11 participants indicated that they incorporated lean protein sources into their children’s diets to promote good nutrition.

Louise stated, “We like chicken and fish.”

Noda said, “We do chicken, beans, we can cook beans without having guilt. We do a lot of fish.”

Sharon referred to protein in saying that she fed her children “some protein. Eat more baked [than fried foods].”

Seven of the 11 participants acknowledged that good nutrition required not only the incorporation of healthy foods into dietary plans but also the elimination of excessive consumption of unhealthy foods. To reduce their children’s consumption of unhealthy foods, the participants imposed restrictions on easily recognizable categories of food.

James described prohibiting his children from eating canned or boxed foods based on the perception that such foods were processed and unhealthy:

> I tried to help my children with their diet and not have anything in a box or canned food items in the house. My son was getting fat, and I had to cut out any food item that came in a box because they are processed.

Mary described a substitution to reduce the amount of animal fat that her children consumed by noting that "we don't drink milk. We do almond milk."

Noda stated, "We minimize frying."

Leroy reported a similar nutritional strategy in stating that he fed his children "not a lot of fried foods."

Noda, who did not allow her children to consume some sugary beverages, stated, "We don't do soda."

Brianna did not allow her children to consume soda in the evenings, telling them that "you need to drink some water for your kidneys, and you will not drink a cup full of sugar because this is going to turn into what I call jelly rolls."

### *Theme 2: Parents' Internal Barriers to Making Healthier Choices for Themselves Are Perceived as Barriers to Their Making Healthier Choices for Their Children*

All 11 participants reported internal barriers to making healthier food choices. The internal barriers included a tendency to eat for emotion regulation rather than for nutrition (i.e., emotional eating); taking pleasure in consuming unhealthy foods; and following unhealthy eating patterns learned and established as habits in childhood. The participants indicated that their internal barriers to making healthier eating choices for

themselves negatively influenced the choices that they made for their children, such as buying and sometimes serving unhealthy foods or setting a poor example of healthy eating choices.

Six of the 11 participants reported that their pleasure in eating unhealthy foods was a significant internal barrier to making healthier choices.

Eva described this pleasure in emphatic terms, noting that "I love food. I'm in love with food. Food excites me. I like trying new food like chips. I live to eat."

James used similar language to Eva's and added that he understood that the foods he took pleasure in eating were often unhealthy for him by asserting "I love food. I realize that over the years, the foods I have been eating are hurting me."

Sharon described herself as sometimes becoming so engrossed in the pleasure of eating that she forgot to control portion size, sharing that "I sometimes cook and eat and don't stop because it tastes so good. I can fill the whole bowl. I need to remember not to eat all of it."

Zumba acknowledge that excess consumption of unhealthy foods for pleasure was not adequately balanced by limited physical activity, saying of her household that "we eat too much. We indulge until we get sick. Then we exercise, but it does not balance. Once in a while I walk, but it's a challenge."

Five of 11 participants admitted struggling with the internal barrier of habitually relying on food for emotion regulation.

Mary stated, "I center my emotions around food," and added as an example, "[When] something sad happens, or the kids get all As, I order pizza."

Noda said, “When I am stressed, I eat more. It's not because I am hungry, but [because] it is comforting.”

Like Noda, Sharon referred to stress in stating that she used food for self-soothing. She commented, “Sometimes when I am stressed I eat junk food to compensate. I realize it is not a good way of eating. I eat a lot of junk food when I am stressed.”

Elizabeth described her food choices as “very much tied to my emotional well-being.” Regarding her overconsumption of unhealthy foods, she explained, “It’s way too connected to my emotions—in celebration, disappointment—and not what it is supposed to be [for nutrition]. People sometimes think I don't know how food works.”

Seven of 11 participants shared their struggles with the internal barrier of unhealthy eating patterns learned and established as habits in childhood.

Brianna described unhealthy eating habits established in childhood by responding that “hot dogs and ‘Oodles of Noodles’ and all that processed food, all that hidden sugar, is what I grew up with. And I know it wasn’t intentional, but my mom just didn’t know better.”

Thelma stated, “My barrier is sticking to the food I grew up with. It’s not necessarily that I love it, but that’s what I grew up with: rice, bread, and yam fufu are all filled with carbohydrates.”

Thelma added that eating habits established in her childhood were difficult to overcome, despite a strong awareness that doing so was important:

> I'm a health care professional. I am not proud of the way I eat. I know what I should not eat. My family has a history of diabetes, and it should make me eat right. My father died of diabetes. My uncle is blind due to diabetes.

Thelma added that in spite of the perceived need to change her eating habits, "I should buy healthier stuff, and I don't see myself changing …. I need to develop a new mindset to be able to make a change."

Brianna reported that she learned unhealthy eating habits "definitely [during] my upbringing. My mom didn't expose me to a wide variety of foods or fresh foods. To eat bad is cheap."

Elizabeth, who reported that her habits of emotional eating and limited physical activity were established in childhood, shared, "Food was always given as a reward and punishment. That pattern developed as a child. My parents recognized physical activity as a sport. My parents did not push exercise. That was mostly for people who were athletic."

Eva attributed her overconsumption of food to "the way I was raised. My parents stressed that we did not waste food."

As a result of her parents' teaching, Eva said:

> I eat 'til I am full. I overeat. I eat [until] it is gone. When I eat like that, it makes me feel awful, but it's the way I was raised. I was raised that if it's placed on my plate, I should eat it.

The participants stated that their internal barriers to making healthier food choices for themselves were associated with enabling their children to develop similar barriers.

Thelma, who stated that her habit of carbohydrate overconsumption was established in her childhood, indicated that she was enabling a similar eating pattern for her children. As she explained, “We buy cookies to make the children happy, but my middle child is putting on weight … my children love to eat cereal or pancakes or muffins in the morning. This pattern is Monday through Friday.”

Thelma also stated that even though she understood the need to buy and prepare healthier foods for her children, she did not report a definite intention to do so, saying of her wishes to improve her children’s nutrition that “I need to buy healthy cereal, cook more vegetables. [My children] may not like it, but we have to teach them. Let them know these are the right foods and it will stick with them.”

Sharon, who described herself as preferring unhealthy foods over healthy foods for emotion regulation, stated that her distaste for vegetables also appeared in her child because “I find it sometimes difficult to eat vegetables and so does my baby girl. It could be the way it’s cooked or the way it tastes why she does not particularly like vegetables.”

Mary reported that she perceived herself as passing unhealthy eating habits down to her children by example, saying that a barrier to getting her children to eat healthier foods was “what my children see me do. My children do not see me setting good example …. I have to do better to show my children a good example.”

Like Sharon, Noda perceived herself as not adequately modeling healthy eating choices for her children, adding that to improve her children's nutrition, she would have to meet the following needs:

> I have to be a role model. My children have to see me make good food choice selection. I have to practice what I preach. Your children are observing the choices you make. Your children can watch you when you buy your groceries. I want to make a good culture in our home of good nutrition.

Like Sharon and Noda, Zumba said, "I need to exercise more and eat less to set examples for my children."

Brianna stated that setting a better example for her children would involve "being that responsible parent and finally buckling down with this weight and giving [my children] my best self and making sure that they have that good foundation."

Elizabeth said that although she did not want to pass the eating habits that she learned in her childhood down to her children, she was uncertain if the habits she was teaching them were healthier than those she learned as a child. She remarked, "When it comes to food, some of the factors [barriers to healthier choices for my children] are how I was raised. I try not to pass on these practices to my child, but I'm not sure if it's better."

The participants perceived themselves as relaying their internal barriers to their children. The internal barrier of relying on food for emotion regulation was perceived as being transmitted through habits such as buying the children unhealthy foods to "make the children happy" (Thelma) or as an expression of parental approval, such as when Mary stated, "The kids get all As, [so] I order pizza." The participants indicated that the

internal barrier of taking pleasure in eating unhealthy foods was being cultivated in their children, such as when they described their children as wanting unhealthy foods and resisting healthy ones.

Elizabeth said of her son, “He will choose junk food over healthy food.”

Eva stated, “It’s a challenge making my children eat what is good for them.”

The participants perceived the internal barrier of unhealthy eating habits established in childhood as being passed down through the modeling of unhealthy eating. The participants also perceived their internal barriers as compounded by significant internal barriers, as described in Theme 3.

### *Theme 3: External Barriers to Healthier Choices Are Perceived as Affecting the Whole Family*

Ten of 11 participants perceived significant external barriers as impeding their ability to make healthier dietary choices for themselves and their children. A significant way in which external barriers were distinguished from internal barriers was that the participants’ internal barriers impacted their children’s eating patterns indirectly, such as by determining the nutritional habits that the parents would model or the food choices that they would make available. The participants perceived external barriers as affecting all family members directly, meaning that a change in the parents’ habits or mind-set would not necessarily diminish their effect. External barriers included the higher cost of healthy versus unhealthy foods, the easy convenience of obtaining unhealthy versus healthy foods, the limitations that the COVID-19 pandemic placed on physical activity, and the availability of limited time.

Three of 11 participants described the cost of healthy foods as prohibitive under their budgetary constraints.

James reported that he and his children lived in an urban area where obtaining healthy foods was costly and inconvenient:

> I live in a food desert. Our community used to have two grocery stores where we could buy quality and fresh food. Now both stores are gone. It's hard to find a store with fresh food. When I do find a store, it's usually the Whole Food market or the organic market, and the prices are really high.

James added that less financial strain would enable him to buy healthier foods for his children. He shared, "If I had better access to money, I could afford to buy whatever I want. The luxury of money would allow me to choose healthier food options, which are pricey."

Louise said that the greatest barrier to buying healthier foods for her children was "finances. We have to pay bills first, and eating healthy is expensive …. Sometimes we can get free food stuff, but it is not always what I need."

Mary said of the obstacles to purchasing healthier foods for her children that "food price is definitely a factor …. I must find foods that are on sale since money is a factor."

Four of 11 participants stated that the ready availability of unhealthy foods in the area where they lived versus the comparative inconvenience of obtaining healthy foods was a barrier to improving the nutrition that they provided to their children.

King, who spoke of fast food as convenient and healthier foods as time consuming to prepare, said, “I find myself going to the fast food restaurants to get fries or something because it is a quick option.”

James stated, “My main barrier is so much access to fast food. I try not to buy fast food, but with easy access, just so many fast food establishments, it’s hard to resist. The healthy options are limited.”

James elaborated on this response by adding that healthy eating habits were difficult to enforce for his children:

> My children are surrounded by four 7-Eleven stores that are all within walking distance of our home. My daughter walks there all the time to buy junk food. It’s difficult telling my children the right thing as far as getting healthy food items when they have such easy access to fast food establishments. It’s hard to establish normalcy.

Five of 11 participants described the restrictions around the COVID-19 pandemic as barriers to improving their children’s health through increased physical activity.

Brianna contrasted her family’s pre-COVID exercise patterns with their lower level of physical activity at time of study by stating that “before COVID, we got out all the time, biking and skating and whatever the case may be.” During the pandemic, Brianna said, “I have to find activities that the children can do, that we can do as a family … currently we’re at home really sitting for that 5 to 7 hours online [for remote learning and work].”

Elizabeth said of her family's options for physical activity at the time of the study were that "right now, there are not many choices things to do due to the pandemic."

Mary reported that her energy level was often too low for her to ensure that her children got adequate exercise because working from home made her more sedentary. She commented, "I am tired from being at home all day. The tiredness is different during the pandemic."

King said of his and his family's low level of physical activity, "It's due to the COVID pandemic …. I can't get out as much as I would like to."

Seven participants cited a lack of time as an external barrier to making healthier choices about eating and exercising for themselves and their children.

Louise discussed the most significant barrier to ensuring she and her children had adequate physical activity:

> Time. I am tired after work. I have a second job, so time does not allow me to work two jobs and get the exercise that I need. It's hard keeping up with an exercise schedule with the way I work. Time does not allow me to get in all the exercise.

Sharon described her lack of time for self-care in general as a barrier to making healthier eating choices by explaining that "time is a factor. I have no time for myself. I don't always look at what I eat. It is difficult to measure how many calories I consume each day since I'm always on the go."

Brianna stated that a lack of time often meant that she served more sugary foods to her children because those foods were easier to prepare. She shared, "I find that I run

out of time just trying to get all the boys up and get them dressed. Sometimes the healthiest foods take a little bit more time to prepare versus that bowl of cereal."

Like Brianna, King referred to the preparation times required for nutritional foods as a barrier by noting that "time is a barrier. I am so busy [that] we don't have time to fix nutritious food."

Thelma referred to a lack of time as a significant barrier to offering healthier foods to her children, noting that "time is one of my barriers. I need to start telling my children, 'Maybe I could cut up fruits and package them so they look nice?' I think of all I want to do, but time is a big, big factor."

**RQ2: What Are Parents' Perceptions of the Factors That Would Help to Promote Good Health and Nutrition for Their Children?**

One theme emerged to support RQ2.

***Theme 4: Removing Parents' Barriers to Making Healthier Choices for Themselves and Their Children Is Perceived as the Greatest Need***

Ten of 11 participants supported the emergence of this theme. King was the only participant who did not response to the relevant interview question. The 10 other participants perceived the removal of internal or external barriers as the most urgently needed factor to help them to promote good health and nutrition for their children.

Six of 11 participants perceived removing their internal barriers to making healthier choices as the factor needed to help them to promote better health and nutrition for their children.

Thelma wanted to solicit her children's assistance in choosing healthier foods at the grocery store to circumvent her interior barrier associated with high-carbohydrate cultural foods to making those choices for them by "getting them involved in grocery shopping and let them look at the contents in the food so they can get involved instead of me making all the decisions."

Noda said that she tried to use education to counteract the effect of her own example on passing down the unhealthy eating habits that she learned in her childhood. She said that "it's a struggle to lose weight, so I have to educate my children on the impact of eating badly."

Noda, who added that she needed to overcome her internal barriers to set a better example for her children, explained that "I am a nurse, so I know better. I have to train my patients on the benefit of good nutrition. I have to be a role model. My children have to see me make good food choice selections."

Brianna, who responded previously that "being that responsible parent is finally buckling down with this [my] weight and giving [my children] my best self and making sure they have that good foundation," added that in order to model healthy eating, she would need to overcome her internal barrier of an unhealthy eating pattern learned in childhood in order to "plan and stick to it."

Zumba also referred to a need to overcome his internal barriers by sharing, "I need to exercise more and eat less to set examples for my children."

Eva suggested that she might overcome the barrier that unhealthy foods were more appetizing by making the effort to "make more creative food so that it will look

appealing and tasty. I could add good stuff like colors to the food to make them more appealing."

Five of 11 participants needed to overcome external barriers to making healthier choices to improve their children's nutrition.

Louise, who cited a lack of time as a barrier to providing better nutrition for her children, suggested that she might reduce that barrier somewhat by preparing food in advance. Louise did not perceive preparing healthier foods in advance as a complete solution, however, noting that "to prepare food in advance, the challenge is, when the prepared food runs out, we eat on the fly."

Mary said that she needed to overcome the external barrier of lacking enough money to buy healthier foods, identifying the factor that she needed as "more money for groceries."

Elizabeth wanted to address the external barrier of the comparative convenience of obtaining unhealthy foods by making those foods unavailable to her children, saying that she intended to "keep the junk out of the house. Make it harder to choose."

Brianna indicated that she would like to make healthier foods more readily available to her children and introduce more variety into their diets. She shared that "part of what makes dieting difficult for me is my diet choices are very limited, and so my hope for my children is to give them enough diet foundation."

## Summary

I prepared two RQs for my study. Three themes emerged to support RQ1. All 11 participants understood good nutrition as consisting of the consumption of healthy foods.

In accordance with these perceptions, the participants attempted to incorporate healthy foods, particularly fruits and vegetables, into their children's diets. Some participants also limited their children's consumption of unhealthy foods by prohibiting them from consuming certain clearly defined categories of food.

All 11 participants reported internal barriers to making healthier choices about the foods that they consumed. The internal barriers included a tendency to eat for emotion regulation rather than for nutrition (i.e., emotional eating); taking pleasure in consuming unhealthy foods; and changing unhealthy eating patterns learned and established as habits in childhood. The participants indicated that their internal barriers to making healthier eating choices for themselves negatively influenced the choices that they made for their children.

Ten of 11 participants reported that they perceived significant external barriers as impeding their ability to make healthier dietary choices for themselves and their children. The external barriers included the higher cost of healthy versus unhealthy foods, the easy convenience of obtaining unhealthy versus healthy foods, the restrictions on physical activity because of the COVID-19 pandemic, and limited time.

One theme emerged to support RQ2. Ten of 11 participants perceived the removal of internal or external barriers as the most urgently needed factor to help them to promote good health and nutrition for their children. Included in Chapter 5 are a discussion of the findings, an interpretation of the results, and implications for social change.

# Chapter 5: Discussion, Conclusion, and Recommendations

I conducted this phenomenological study to explore the strategies and coping methods that parents who were obese used to provide nutrition to their children. I followed a phenomenological approach to understand how the lived experiences of 11 parents with food manifested in their nutrition practices with their children. Phenomenology is a research design that helps researchers to understand the participants' experiences of the phenomenon under investigation (Patton, 2002).

The WHO (2017) defined obesity as the accumulation of excessive fat that can impact health negatively. Obesity has become a global concern, and although there have been copious intervention modalities, the prevalence of obesity is escalating. Interventions have been helpful in reducing the incidence of obesity, but its high rate remains a concern to health professionals and investigators, convincing them of the need to develop alternative obesity reduction techniques (Findholt et al., 2013). According to the WHO, in 2016, approximately 1.9 billion adults were overweight, and more than 650 million of these individuals were obese.

Obesity is impacting increasing numbers of children and adolescents, and it seems to affect underprivileged individuals more than their affluent counterparts (Newton et al., 2017). Young children rely on parents and caretakers to be the gatekeepers of their health. Therefore, when researchers are seeking solutions to the problem of obesity, they often examine the knowledge base of these custodians to identify their thought processes as they provide nutrition to their offspring (Turconi, 2013).

If the obesity trend continues, an estimated 20% of the global population will become obese. Individuals who are obese are at potential risk of long-term disabilities and higher rates of illness and early mortality. Children also are at risk of the same challenges, except that the premature onset of obesity often persists into adulthood, which further shortens their productivity and the ability to lead active and fulfilling lives (Hruby & Hu, 2015).

Obesity may be a precursor to preventable conditions such as Type 2 diabetes, hypertension, hypercholesteremia, some cancers, and premature mortality. It may be responsible for the high levels of depression, body dissatisfaction, low self-esteem, and low quality of life of individuals dealing with obesity (J. Ogden & Clementi, 2010). The disease also impacts the U.S. economy negatively, with recent estimates suggesting that more than $190 billion is spent annually on health care costs, of which nearly 21% is directed toward treating obesity and its associated disorders (Hruby & Hu, 2015). Obesity is difficult to address because it can be the result of behaviors such as dietary patterns, inactivity, and medication use (CDC, 2017a).

## Interpretation of the Findings

I interviewed 11 parents who were obese and wanted to provide healthier nutritional choices to their children. The parents revisited their lived experiences with food and shared the ways that they wanted to introduce healthy food options into their dietary plans that would appeal to their children. The parents were cognizant of the internal and external barriers affecting the ways that they provided nutrition for their

children. The participants also were aware of the need to set standards to help their children to obtain proper nutrition and engage in physical activity.

## Social Cognitive Theory

I used Bandura's (1977) SCT to understand the coping mechanisms that the parents used to manage their children's nutrition. Bandura (1986) stated that behaviors are based on environment, interactions, and observations. The parents' coping strategies in dealing with their children's nutrition stemmed mostly from behaviors that they had learned from their own parents. Bandura identified the components of SCT as emotional coping, observational learning, self-efficacy, environment, outcome expectancies, self-control, and situations. Details of the first three components follow.

### Emotional Coping

Emotional coping is a construct of SCT that I used in this study. It is a strategy that individuals use to deal with emotional stimuli (Fertman & Allensworth, 2010). One participant in the study stated that she was an emotional eater and that eating was her way of coping with intense emotions of happiness or sadness. Another participant shared that she ate beyond satiety, which sometimes made her uncomfortable. This construct was important to the study because the parents did not want their children to think they had poor coping skills. The coping strategy that one parent used was to "keep junk out the house, which makes it harder to choose."

### Observational Learning

Observational learning is a construct of SCT. Children often mimic the actions of the people in their immediate environment (Fertman & Allensworth, 2010). In my study,

the parents had difficulty preparing nutritious meals consistently because they often reverted to the feeding practices of their own parents. One parent who was a teacher said that even though she was doing things differently from her parents, she was not sure if her feeding practices were better. Another parent described feeling trapped because she was not given the tools by her parents and she thought that she was doing a disservice to her children by way of their nutrition.

### Self-Efficacy

Self-efficacy, another major construct of SCT, is the perception that that individuals can exercise control over events that affect their lives. Individuals who have high self-efficacy believe that they can overcome certain barriers to maintain and sustain the new behaviors (Bandura, 1990). In this study, the participants had various hurdles to overcome. Some of the participants had started an exercise program, but COVID-19, time constraints, or other perceived barriers forced them to either delay or stop physical activity. Time slated for physical activity was deemed a priority or an event that the participants saw happening soon. The participants wanted to be able to manage their children's physical activity. Mary and Brianna understood the importance of exercise and wanted to incorporate it routinely at home.

## Discussion of the Themes

### Theme 1

The first major finding of the study was that parental perceptions regarding nutrition influenced how the parents incorporated healthy foods into children's diets. This

concept was not perfectly reflected in the literature. However, the literature did make it clear that parental perceptions did impact how they fed their children.

Research has indicated that parents often do not believe that they are at risk of health challenges resulting from obesity, and that they do not perceive that their families are obese at all (see Ellis et al., 2014). In some cases, fatness is perceived as a positive trait (see Zhou et al., 2015). Parents often are receptive to the ideas of their children being overweight in some cases because they associate it with being strong or healthy (see Fuemmeler et al., 2013).

Research also has shown that increased education could have a positive influence on diet and nutrition (see Azar et al., 2013; Lesser et al., 2014). The results of the current study indicated that the parents' perceptions of nutrition could change through increased exposure to facts regarding health, nutrition, and obesity. Noda, who was a nurse, emphasized that there should be a balance between eating food to maintain good health and eating mindlessly. Theme 1 partly supported this premise because parental perceptions could be altered to encourage increased incorporation of healthy foods into nutritional plans. Consequently, this theme was consistent with past findings.

**Theme 2**

There was partial support in literature for Theme 2, which indicated that perceived barriers to healthier personal choices also were perceived as barriers to healthy choices for their children. Researchers have noted that parents sometimes wrestle with obesity, which can lead to mixed signals being conveyed to the children (see Sonneville

et al., 2015; Willis & Lawton, 2014). Research has identified a connection between the weight struggles of parents and the weight struggles of their offspring.

Murillo et al. (2016) noted the connection between parental obesity and the obesity of their children. Parents who often experienced obesity in their own childhood led to biases regarding whether children should engage in specific healthy behaviors. The literature on the subject has found a connection between parental struggles with obesity and their children's struggle with obesity (Yun et al., 2015).

What has not been clear in the research literature is the notion that perceived obstacles to healthier choices among parents also are barriers to healthy choices among children. Elizabeth indicated that her relationship with food was problematic and that she wanted to do a better job with her son than her parents did with her. However, she was not sure if she was achieving her goals. As such, Theme 2 was a relatively novel entry into the literature.

**Theme 3**

Theme 3 showed that that external barriers to healthier choices impacted the family. However, was no clear indicator in the literature that this theme was supported by previous research. The 11 parents in the current study indicated that their challenges with obesity began in childhood. Some of their external barriers such as time constraints, financial challenges, lack of nutritional discipline, and other factors, coupled with their personal obesity challenges, were perceived as barriers that affected the family unit.

Researchers have noted that parents who were obese as children experienced various kinds of stigma and declining perceptions of self-worth (see J. Ogden &

Clementi, 2010; Sadati et al., 2016; Toft & Uhrenfeldt, 2015). There also has been some evidence that parents have felt unable to address the problem of obesity in their children (see Peters et al., 2014). The literature generally has indicated that obesity is a family problem. Seven of the 11 parents acknowledged that providing good nutrition required incorporating healthy food into dietary plans while eliminating excessive amounts of unhealthy food. However, some of the participants were still working out details to provide healthier food options that their children would like.

The results indicated that the participants perceived obesity as a difficult topic to address with family members. One parent stated that although she was not proud of her eating habits, cultural habits ingrained in her led her to continue to eat "the old way." There was no clear evidence in the literature that external barriers to healthier choices were perceived as impacting the whole family unit. Consequently, research produced only marginal support for Theme 3, which is a novel contribution to the extant literature.

**Theme 4**

Theme 4 supported the perception that removal of parents' barriers to making healthier choices for themselves and their children was the greatest need. This theme was not previously explored in the literature. However, the research literature was clear that improving the health choices of families is critical, even if it is not perceived as such by the families. One participant in the study stated that she wanted her children to help her to shop for food to circumvent her interior barrier associated with craving cultural food choices that were high in carbohydrates. Her intention was to have the children read the nutritional labels on food items so that they could help to make food decisions. Noda

educated her children to reduce the effects of her personal obesity challenges and avoid passing down the unhealthy eating habits that she had learned in her childhood.

Research has indicated that obesity can have a negative impact individuals by predisposing them to Type 2 diabetes, hypertension, and cardiovascular disease (J. Ogden & Clementi, 2010). Obesity is a risk factor for these and many more diseases. The WHO (2017) deemed obesity a chronic disease with significant negative impact on individual wellness. Consequently, health official and policymakers have identified obesity as a threat to individuals, communities, and economies (see Briefel et al., 2015; CDC, 2017a; Visscher et al., 2017). Thelma, whose dad died from diabetes, was concerned that her food preferences could hurt her children. She was concerned that one of her children was already facing overweight issues. Brianna was nurse who felt stymied because despite knowing what was required to create healthy food options for her children, she sometimes reverted to her childhood experience and made quick and unhealthy choices to feed her children.

Even though decision makers understand the importance of reducing obesity, the research literature did not hold studies indicating that parents perceived the removal of barriers to healthier choices as a great need. In many cases, parents accepted obesity in family (see Fuemmeler et al., 2013; Zhou et al., 2015). Theme 4 is a novel theme in the literature because it contradicts prior findings suggesting that parents were comfortable with their children being obese. Instead, there was some indication that the parents in the study realized that obesity was a serious health issue. They also recognized that reducing

the barriers to healthier choices was a priority, even if they were unsure what behaviors or actions would be necessary to make the goal a reality.

## Limitations to the Study

There were several limitations to this study. I conducted the study with a small sample of parents who were obese. This small sample size was not representative of the target population of parents who are obese because the study was limited to parents residing in Prince George's County, Maryland, at the time of the study. It is possible that parents in the surrounding county may have had different perceptions of obesity and how they provided nutrition to their children. Discussing obesity may cause emotional stress, so some of the participants may have been reluctant to share private information, although I had informed them that their information would remain private and confidential. Another limitation was that I realized at least one of my interview questions was directed toward female participants. The questions should have been gender neutral.

## Recommendations

Obesity can have deleterious effects on families, communities, and economies. Interventions to reduce obesity should be structured so that everyone can benefit. My research indicated that although the parents wanted better health for themselves and their children, they sometimes lacked the tools to achieve better nutritional health. They tried to find several coping strategies to manage their children's nutritional health, but they often fell back into nutritional habits that were familiar to them. The literature has suggested that despite health officials being aware of the obesity crisis, current intervention modalities have been ineffective (WHO, 2017). My recommendation for

future research is that researchers should use technology to continue to explore the barriers that parents need to address to reduce obesity.

Obesity is a complex disease, and although the simplistic suggestion of lowering caloric intake and increasing physical activity seems obvious, as health care professionals have confirmed, reducing the level of obesity is not easy for a large percentage of individuals to attain. According to Paul et al. (2014), the prevalence of childhood obesity is high, and some parents seem content with the sizes of their overweight children. The results of my study indicated that some of the parents in the sample realized that their children were close to becoming obese and were making attempts to curtail it. However, they were either not consistent in their efforts either because of other barriers such as time and financial challenges or simply because they lacked the necessary educational tools.

The results also suggested that the parents were faced with internal and external barriers that made it more difficult for them to provide appropriate nutrition to their families consistently. One parent commented that her busy work schedule often limited the time available for personal physical activity. Another parent obtained food from a food bank that was not necessarily nutritious, but necessary, to feed her family.

One of the participants in this study continued to face health care barriers, such as fear of receiving nutritional help because of stigmatization from health care providers. I recommend that health care providers receive more cultural training and that parents make an effort to know that their health care providers are trained in cultural sensitivity. One parent had not seen a doctor in years because of the negative stigma that she

experienced with her last physician. In situations like these, families could benefit from receiving care from culturally diverse health care teams that include physicians, psychologists, social workers, nurses, and other allied health professionals. Parents often continue to follow the feeding patterns of their parents, known as intergenerational circumstances of obesity (see Chilton et al., 2017; Kumar & Kapoor, 2017; Mhurchu et al., 2017).

Four themes emerged themes from the analysis of the participants' responses to the interview questions. The themes were associated with the coping strategies that the parents used to deal with their individual obesity issues and those of their children. My sample of 11 parents came from one county in Maryland, but future researchers might consider obtaining participants from wider demographic and geographic ranges.

## Implications for Positive Social Change

The results may help health care providers and policymakers to understand the challenges that parents who are obese sometimes face as they struggle to manage their children's nutrition. Not all parents are comfortable with their own health status and what they feed their children. Some parents realize that past experiences with food may be acting as barriers to changing their feeding habits and nutritional choices. The parents in my study were nurses, teachers, homemakers, and technical staff. They all wanted to provide optimum nutritional choices and physical activity for their children, but they did not always possess the tools to do so effectively. The results could potentially benefit parents by helping them to understand and find more effective coping strategies to deal with their challenges with obesity. Policymakers and health strategists could use the

findings to develop healthy educational programs tailored to the specific needs of different families. When individuals receive appropriate educational tools and guidance, they are more apt to follow the guidelines necessary to help their children (Doerksen & McAuley, 2014).

## Conclusion

Obesity is a concern to health care professionals and the U.S. economy. It is a threat to public health associated with rising health costs. Numerous interventions and recommendations have been offered to reduce the incidence of obesity. The recommendations to prevent or retard the spread of obesity seems simple to implement, but successful obesity reduction endeavors require a collaborative approach from culturally diverse health care professionals and policymakers.

Research has indicated that individuals are influenced by their environment (Knol et al., 2016) and possess the potential to amend certain behaviors. This connection among circumstances, environment, and action is reciprocal determinism, meaning that each factor can influence the other. Teamwork among health care professionals, teachers, school officials, lawmakers, and parents is required to reduce the incidence and impact of obesity. The results of this study may help policymakers and health care strategists to understand that developing obesity interventions requires imagination and creativity. Taking a one-size-fits-all approach will not work.

I currently do presentations on health and nutrition locally and would like to continue this practice after the study has been published. The results of my study may help health care providers, community workers, nutritionists, and physicians to gain a

better understanding that inappropriate words and body language may hurt individuals who need nutritional help. I would like to present my findings to the local health department with the hopes that they may help to reduce the incidence of obesity in the community.

Obesity can cause emotional and physical pain (Danford et al., 2015). The rates of obesity are climbing, but with continued guidance, meaningful education, active listening, and appropriate responses to the individuals affected by obesity, its prevalence may begin to decline. Researchers may use the findings to increase awareness of appropriate nutritious standards in local communities, churches, and health departments. Parents use various coping mechanisms to perceive their situations, and for parents seeking help to manage their children's nutrition, they should have assistance made available to them in a positive and nurturing environment that will help to reduce the incidence of obesity in themselves and their children.

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# Appendix A: Qualitative Interview Guide

The purpose of this questionnaire is to assist the interviewing

Q1: Opening question: How would you describe your relationship with food?

Q2: When you hear the word nutrition, what is the first thing comes to your mind?

Q3: What is your lived experience with food?

Q4: What are barriers you face as an individual living with obesity?

Q5: What are factors that contribute to your challenges with obesity?

Q6: What kind of barriers do you face as you promote good health for your children?

Q7: What do you perceive as barriers to promote physical activity for yourself?

Q8: /What types of food do you feed your children on a regular basis?

Q9: What do you consider to be healthy food choices for your children?

Q10: What do you think would be helpful for you to promote good health for your children?

Q11: What else would you like share concerning your experience with food and physical activity?

Appendix B: Prospective Study Participants Screening Questionnaire

The questions in this questionnaire are created to determine if potential study participants are eligible to participate in the study.

Recruitment Screening Questions:

Question purpose: To explore race/ethnicity

Question: What is your race? _____

Question purpose: To establish residency

Question: Do you reside in Prince George's County?

Yes____

No_____

Question purpose: To explore marital status

Question: Are you (please select one)

Married__ Single___ Divorced____

Question purpose: To explore age of participant

Question: Are you 18 years or older? _____

Question purpose: To explore that participant has given birth to at least one of the children in household

Question 1: Do you have children in your household?

Yes _____

No_____

Question: Of these children in your household, are there any you gave birth to?

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Question purpose: To explore that participants have lived experience with obesity

Question: How would you describe your lived experiences with overweight/obesity?

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Question purpose: To explore there may be challenges rationalizing standards of health when preparing meals for their children

Question: What is it like preparing meals daily for your children? -

_____

Question purpose: To determine socioeconomic status:

Which of these describe your family's annual income?

$20,000-40,000 $40,000- $55,000 55,000-$70,000, over $75,000

Question purpose: To determine eligibility in understanding English

What language do you speak fluently? _____

Question Purpose To ensure participant understands and agrees that interview will be audio recorded

Question: Are you in agreement that the interview will be audio recorded?

Yes _____

No _____