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# Low Income African American Parents Experiences Managing Obese Young Children Weight Loss

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Abstract

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MAPC, Ottawa University, 2008

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Dissertation Submitted in Partial Fulfilment

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Abstract

In the United States, 17% of children between the ages of two to 19 years are diagnosed with obesity more than any other chronic health condition. African American children living in the United States have an obesity rate of 22% compared to White children who have an obesity rate of 14.1%. These high obesity rates created situations in which these children are likely to experience significant lifelong health problems. The purpose of this descriptive qualitative phenomenological study was to describe the experiences of African American parents of low-income managing weight-loss in their young children with obesity between the ages of three to ten years old. Engel's biopsychosocial model was the framework used to explore the experiences of this population. Data was collected from ten participants through semi-structured open-ended interviews over the phone following Giorgi's five-step data analysis process. The interviews were transcribed and analyzed using hand coding for themes. The results uncovered the following themes: High Fat Consumption, Denial of Obesity, Health Risks Awareness, Fast Food Consumption, Childhood Obesity Awareness, Weight Loss Strategies, Transportation, Healthy Food Cost, Weight loss Participation, Lack of Income, Unsafe Parks, and Traditions. The results of this study have the potential to educate health care professionals about the experiences of this population.

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# Dedication

This dissertation is dedicated to my husband James and children Detrice, Troy, Nevaeha and Nalah. Thank you for your patience, love, and support.

# Acknowledgments

I want to acknowledge that this dissertation would not be possible without the assistance of my committee. I want to specifically acknowledge my committee Chair, Dr. Ethel Perry, because she provided the persistent guidance and support that I needed to focus academically throughout this dissertation journey. I want to acknowledge my husband, James, as he was the one that I could count on to celebrate all the success milestones within this dissertation journey even when others did not understand or notice. He was there when I wanted to give up and cry, but he encouraged me to push through to the next step by believing in me. Lastly, I would like to thank God for continuing to bless me with my strength and health to achieve this goal.

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# Chapter 1: Introduction to the Study

## Introduction to the Study

In this study I investigated how African American parents of low-income described their experiences of how they are managing weight-loss in the young children with obesity between the ages of three to ten years old. This study provided insight into the weight-loss strategies and challenges African American parents of low-income experience managing weight-loss in young children with obesity. The positive social change from this study has the potential to educate health-care professionals of the experiences of this population.

In Chapter 1, the background summarized the study's scope, addressed the gap in the literature, and explained why the research is needed. Further, the problem statement discussed the problem, explained the problem's significance, and revealed current findings on the topic. The purpose of the study justified the need for this study. Also, the research question and theoretical framework explain its relationship to the study. Next, the nature of the study provided a rationale for the design. Throughout the research study, the terms and definitions are explained. Further, assumptions about the research design, scope, and delimitations described and explained why this topic was chosen. Furthermore, limitations of the study are described and any biases. Moreover, the significance of study elaborated on the problem addressed and potential implications for positive social change. Finally, the summary and conclusion summarized the main points of Chapter 1.

## Background to the Study

Obesity is one of the leading health problems in the United States (Abdeyazdan et al., 2017). Obesity and overweight have tripled since 2013 with more than 40 million children being overweight or obese (Abdeyazdan et al., 2017). The Centers for Disease Control and Prevention (CDC) (2012) reported during 2015–2016, childhood obesity is classified as being at or above the 95th percentile of body mass index for their age, and overweight children are classified between the 85th and 95th percentile of body mass index for their age. The CDC (2012) indicated that there are contributing factors related to childhood obesity that included adverse events in childhood, sleep problems, genetics, physical activity, eating behavior, and neighborhood safety.

The National Health and Nutrition Survey reported data during the 2015–2016 years that 18.5% of children aged between the ages of two to 19 years old were obese (Hales et al., 2017). The prevalence of obesity in children aged two through five years old increased from 5% to 13.9%, in those aged six through 11, the prevalence increased from 6.5% to 18.4%, and in those aged 12 through nine, the prevalence increased from 5% to 20.6%. African Americans children living in the United States have an obesity rate of 22% compared to White children at 14% (Hales et al., 2017). In the United States, from 2007 to 2017, obesity in children and adolescents has significantly increased according to the NHNS as presented by Hales et al. (2017) research. According to World Health Organization, obesity in children is the product of a combination of various social and environmental factors (Lee et al., 2019). One reason African American parents of low-income was chosen because when they enrolled in a weight management program with

obese children between the ages of two through 20 years old, they dropped out of the program due to the inability to pay for the program (Ligthart et al., 2017). Also, African American children living in the United States have a 22% higher rate of obesity as compared to 14.1% for White children (Hales et al., 2017). In reviewing the literature, what is unknown is the essence of the lived experiences of how African American parents of low-income are managing weight-loss in young children with obesity ages three to ten years old. This study is needed to potently educate healthcare professionals of the experiences of this population.

## Problem Statement

In the United States childhood, obesity is a significant concern. Skinner et al. (2016) found that obesity rates increased from 16.4% to 27.9% in children aged two through five years old since 1999. Skinner et al. (2018) Furthermore, the authors found that obesity rates were higher in African American children compared to White children, as well as childhood obesity is associated with severe health conditions, such as cardiovascular disease and diabetes.

According to Schalkwijk et al. (2015), parents of children between the ages of two and 21 years with weight issues had little success with participation in lifestyle intervention programs due to the parent's struggles with inconsistency and reluctance to consults with professionals. African American parents enrolled in a weight management program with children between the ages of two and 20 years old dropped out of the program due to time constraints, transportation, and the inability to pay for the program (Ligthart et al., 2017). Vedorato et al. (2016) reported that many low-income African

American families have no grocery store within a mile of their homes. Moreover, the authors found that children living in areas where there are no grocery stores within a mile of their homes had unhealthy diets compared to children with grocery stores within a mile of their homes (Vedorato et al., 2016). The gap missing from the literature that this study addressed are the lived experiences of how African American parents of low-income are managing weight-loss in their young children with obesity ages three to ten years old.

## Purpose of the Study

The purpose of this qualitative descriptive phenomenological study was to understand and describe the lived experiences of African American parents of low-income managing weight-loss in their young children with obesity between the ages of three to ten years old.

## Research Question

RQ: How do African American parents of low-income describe their lived experiences of managing weight-loss in young children with obesity?

## Theoretical Framework

The theoretical framework used for this study is Engel's (1977) biopsychosocial model. Engel's biopsychosocial model views health within the biological, psychological, and social aspects influencing the well-being and health of the individual (Borrell-Carrio et al., 2004; Fava & Sonino, 2007; Sul & Rothman, 2004). The biopsychosocial model explained in detail in Chapter 2. The biopsychosocial model explored the biological, psychological, and social experiences of African American parents of low-income managing weight-loss in young children with obesity. The biopsychosocial model and

descriptive qualitative phenomenological approach related to the research question explored and described the experiences of low-income African American parents managing the weigh-loss of obesity in young children three to ten years old.

## Nature of the Study

A descriptive phenomenological approach was selected because it explained, described, and elicited rich descriptive data to understand the participant's lived experiences (Giorgi & Giorgi, 2003). This study's data collection method is semi-structured interviews that gathered a rich, in-depth understanding and described this population's lived experiences. Interviews were conducted over the phone or through video conference using Zoom. This population was selected because data reported from the National Health and Nutrition Examination Survey 2015-2016 showed that the prevalence of obesity in children aged two through five years increased from 5% to 13.9%, and obesity in children aged six through 11 increased from 6.5% to 18.4% (Hales et al., 2017). The purposeful sampling snowball strategy was appropriate to use to recruit participants for this research.

## Definitions

Some of the key terms related to the lived experiences of African American parents of low-income managing weight-loss in young children with obesity between the ages of three through ten years old are defined in this study. Other terms needing clarification are also defined.

Biopsychosocial model: The biopsychosocial model views health within the biological, psychological, and social aspects influencing the well-being and health of the

individual (Engel, 1977).

Body Mass Index (BMI): Is a measure of body fat that is the ratio of the weight of the body in kilograms to the square of its height in meters (Hales et al., 2020).

Co-Morbidities: Are coexistence of two or more disease processes (Sahoo et al., 2015).

Food Desert: An area, usually low-income, in which many residents cannot quickly get to the stores that sell affordable, healthy foods (Ingram, 2018).

Food Insecurity: Is the lack of available household financial resources for food (Ingram, 2018).

Food Security: Access to sufficient amounts of nutritious, affordable, and quality food (Ingram, 2018).

Hypertension: Is another term for high blood pressure, which increases the pressure and flow of blood against the walls of blood vessels (Sahoo et al., 2015).

Minority or Minorities: Refers to characteristics of individuals based on race or ethnicity (Peng et al (2018).

Obesity: Childhood obesity is defined as a BMI above 95% for the child's age (Hales et al., 2020).

Overweight: Overweight is defined as a BMI within 85% and 95% for the child's age (CDC, 2012).

Socio-Cultural: A psychology theory that looks at the important aspects that culture contributes to society (Barr-Anderson et al., 2018).

Socio-Economic Status: Is a structure of hierarchical financial position that includes income, education, residence, or occupation (Barr-Anderson et al., 2018).

Transit Desert: A lack of public transportation to individuals that live in underserved neighborhoods (Williams, 2018).

## Assumptions

Assumptions are a part of the study that assumed, but not proven with any truth. This qualitative research study assumed that it was possible to obtain an adequate sample of African American parents of low-income managing weight-loss in young children with obesity. African American parents of low-income were willing and available to participate in the study. Another assumption is that low-income African American parents were forthcoming in their responses and opinions about how they describe their experiences about managing weight-loss in young children with obesity. Many assumptions are related to the lived experiences of this population however, the three assumptions are relevant to this study.

## Scope and Delimitations

This research study focused on the lived experiences of African American parents of low-income managing weight-loss in their young children with obesity. The population sample was ten African American parents with obese children between three and ten years old living in the United States. The scope of this study focused was on children instead of infants, toddlers, and adolescents. The study's delimitations focused on how African American parents of low-income are managing weight-loss in their young children with obesity age three to ten years old. The study is limited to African

American parents of low-income 18 years and older living in the United States. This research can be transferred to other populations generalized to similar situations. However, this research may not represent the whole African American population.

## Limitations

This descriptive qualitative phenomenological study was limited to African American parents of low-income managing weight-loss in young children with obesity between the ages of three to ten years old. Another limitation of the study is that the interview responses will represent the parents' experiences participating in this study. It is further limited by a small sample size of participants, which prevents other African American parents with different experiences from participating in the study. This research study may limit the entire low-income African American population's transferability, managing weight-loss in young children with obesity. No biases have been identified that could influence the outcome of this study.

## Significance of the Study

According to Alexander et al. (2017), childhood obesity rates among African American children are higher than among other racial and ethnic populations creating situations in which these children will experience significant lifelong health problems that could be avoided through obesity prevention efforts. It is also widely recognized that parents influence childhood obesity risk factors and their child’s susceptibility to health complications (Alexander et al., 2017). The present study focused on the lived experiences of African American parents of low-income managing weight-loss in young children with obesity, which offered a unique opportunity to add to the research gap.

Gardner et al. (2015) and Alexander et al. (2017) explained that parents are responsible for being more aware of their children's weight in relationship to health and support of obese children in their weight loss. Many parents in African American community of low-income with obese children find it difficult to be supportive of their children health and face challenges in affording and accessing high-quality foods (Davison et al., 2015). Davison et al. (2015) identified challenges that many African American families in low-income communities face in affording and accessing high-quality foods while avoiding the appeal of fast-food restaurants. This study's results provided in-depth, rich information about the experiences of low-income African American parents managing weight-loss in young children with obesity. This study has the potential for positive social change to educate healthcare professionals on the population's experiences.

## Summary

The background of the problem to be addressed and the problem statement, purpose of the study, research question, theoretical framework, and nature of the study, definition of terms, assumptions, scope, significance, and delimitations, and its limitations were identified. The issues introduced in Chapter I of this study include obesity rates, health problems related to obesity, weight-loss strategies, and challenges that African American parents of low-income face when managing weight-loss in young children with obesity. These issues were discussed further in the literature review in Chapter II. The methodology was discussed in Chapter III, and the data analyses and the

results were provided in Chapter IV. The findings, recommendations for future research, and conclusions were presented in Chapter V.

# Chapter 2: Literature Review

## Introduction

Obesity is defined as excessive body fat (Ogden et al., 2018). In the United States, childhood obesity is a great concern. Skinner et al. (2016) found that obesity rates increased from 16.4% to 27.9% in children two to five years old since 1999. Further, obesity rates were found to be higher in African American children than White children (Skinner et al., 2018). Childhood obesity is associated with severe health conditions, such as cardiovascular disease and diabetes. Furthermore, parents of children between the ages of two to 21 years old with weight issues had little success with participating in lifestyle intervention programs due to the parent's struggles with many challenges and inconsistencies (Schalkwijk et al., 2015).

Moreover, African American parents that enrolled their children in a weight management program between the ages of three to ten years old dropped out of the program due to educational information being inappropriate for their child's age group, inconvenience of program locations, and programs appointment scheduling (Ligthart et al., 2017). Vedorato et al. (2016) found that many African American families of low-income had no grocery store within a mile of their homes. These authors' findings revealed that children living in areas with no grocery stores within a mile of their households had unhealthy diets compared to children with grocery stores within a mile of their homes (Vedorato et al. (2016). The purpose of this qualitative descriptive phenomenological study is to understand and describe the lived experiences of African

American parents of low-income managing weight-loss in their young children with obesity between the ages of three to ten years old.

## Literature Search Strategy

The following databases used for this literature search: Pub Med, Medline, Google Scholar, and PsychInfo were used for most of the articles. The databases explored research studies that address the target population. For databases that did not have full-text articles the Walden University online library was used to obtain locate full-text articles.

Databases used in the literature review ranged from 1977 to 2020. The following literature search terms were used, *body mass index, obesity health risks, obesity, overweight, weight obesity prevention, obesity and food choice, health foods and obesity, healthy foods and obesity, management, exercise, African American parents and childhood obesity, parents and childhood obesity, weight management and children, childhood obesity, poverty and obesity, weight loss challenges, weight-loss strategies, low-income African American and obesity, and the biopsychosocial model.* Dissertations were reviewed for content. This literature search found articles relevant to low-income African American parents of low-income managing weight-loss in young children with obesity between the ages of three to ten years old and the theoretical framework.

## Theoretical Foundation

To explore the relationship between how African American parents of low-income are managing weight-loss in young children with obesity the biopsychosocial model was used as the theoretical foundation. The biopsychosocial model relates to the

research question by explaining the various factors that contribute to this population in managing weight-loss in young children.

The biopsychosocial model was developed in 1977 by G. Engel, described by Kusamanto et al. (2018) the biopsychosocial model derived from the General Systems Theory (GST) extended to include a living system of human interest. It calls upon medical and psychological caregivers to acknowledge the interaction between an intricate blending of biological, psychological, and social factors described in the system hierarchy. Family medical practitioners used the biopsychosocial model as part of their holistic approach to see how the patient's environment contributed to their perceptions (Kusamanto et al, 2018).

Kusamanto et al. (2018) used a hermeneutic circle literature review to examine the studies on the biopsychosocial model's assumptions, uses, and efficacy. The results indicated that model developed by Engel slowed in various clinical practice areas (Kusamanto et al., 2018). The same study found limited research conducted to validate the model. Still, its findings provided a sound foundation for assessing health and well-being.

Rodgers et al. (2020) also acknowledged the efficacy of the model to social media use and body image, eating disorder, and muscle-building behavior among young boys and girls. The researchers utilized a sample size of 681 adolescents, of whom 49% were female participated in a survey linking their social media use to body image, eating disorder, and muscle building. The findings revealed that social media images were significant influences on psychological self-esteem, particularly among girls.

Environmental or social factors needs consideration when addressing health issues (Rodgers et al., 2020). The researchers wanted to gain an understanding of obesity and eating disorders; they found that gender was a factor that is significant when these problems exist among young children (Keller et al., 2019). The same study found that socioeconomic status, place, type of residence, family composition, and race/ethnicity were partial predictors of cultural beliefs and values linked to risk factors for overweight and obesity.

This review of the literature offered an exploration of the various biological, psychological, and social factors associated with obesity, focusing on issues that affect African American parents of low-income managing weight-loss in young children with obesity between the ages of three to ten years old. The biopsychosocial model was chosen because it looked through the lens of the biological, psychological and social and provided insight into the influences that affected the individual's health and behaviors.

## Literature Review Related to Key Variables and/or Concepts

### Biological Factors

#### Obesity

One of the leading nutritional related disorders of public health is obesity (CDC, 2013). According to Ogden et al. (2014), 16% of children between the ages of 2 to 18 were obese in the U.S., as estimated by the National Center for Health Statistics (NCHS). Obesity has been defined as excessive body adiposity (Ogden et al., 2018), and Hales et al. (2020) described obesity as a mass of body fat. Additionally, obesity is excessive amount of unhealthy fat tissue causing the person to gain over 20% more than their ideal

body weight CDC, 2013. To consider an individual to be overweight, the body mass index must be between 25.9 and 29.9, and to be identified as obese, the body mass is between 30 and 39.9, according to Ogden et al. (2020).

**Obesity in African American Children**

Beech et al. (2018) conducted a systematic review on African American youth, and the finding revealed that 42 percent of the youth under the age of 16 meet the Centers for Disease Control (CDC) criteria for overweight or obesity with BMI being a major indicator of this problem. Winkler et al. (2017) identified a connection between the environment and developmental factors to childhood obesity. Another critical study revealed that childhood obesity perceptions are an essential issue with obesity among young African American parents (Alexander et al., 2018). In a study conducted by Alexander et al. (2018), they explored caregiver perceptions about childhood obesity prevention. The authors found themes that emerged from this study focused on culture, environment, physical effects, social effects, psychological effects, and perceptions of childhood obesity. The study revealed that the parents were aware of childhood obesity risk factors and acknowledged the existence of multiple challenges in relations to healthy eating behaviors and childhood obesity (Alexander et al., 2018).

In a survey conducted by Campbell-Boytal et al. (2018), the biological, environmental, and social influences on childhood obesity relationships were examined. The authors found that young girls in low-income minority families were likely to be at a higher risk of developing obesity at a young age. The survey revealed a consistent theme

that African American parents did understand health risk factors associated with obesity in their children.

Maternal and overweight/obesity was identified among African American children of low-income in Alabama (Janjua et al., 2012). The authors found that 740 mothers of the African American children of low-income were receiving services at the University of Alabama Prenatal Clinic during early pregnancy, as well as their children ranging from birth through five years of age. This revealed that children of overweight and obese mothers were more likely to be obese and overweight by the time they reached the age of five.

**Health Risks**

The prevalence of childhood obesity is significantly higher among African Americans and minorities in the United States (Isong et al., 2018). Still, Isong et al. (2018) suggested that it is unclear to what extent obesity risk factors in infancy and preschool explained these disparities. The authors found data from an Early Childhood Longitudinal Study with more than 10,700 children who were followed from the age of nine months through Kindergarten. The survey included socioeconomic factors, maternal, infant, early childhood risk factors, disparities, and BMI scores. The authors revealed African American children had the highest risks for obesity than White children (Isong et al., 2018). The authors also found that the lack of fruit and vegetable consumption played a role in explaining why African American children had higher rates of obesity and risk factors than White children.

The authors found data from the National Health and Nutrition Examination Survey (NHANES), which demonstrated that hypertension and hypertension-related outcomes place African American children at a higher risk for developing obesity than White children (Lackland, 2014). The survey included rate increases and disparities in African Americans of all ages compared to Whites (Lackland, 2014). The authors revealed health risks like hypertension found in many African American children at an early age could lead to lifelong health complications.

The NHANES survey found that genetics, culture, nutritional habits, physical activity, and fat acceptance played a major role in development of obesity in African American children (Dhoble et al., 2020). This survey revealed that African American children between the ages of two to 19 years old are obese. These factors play a major role in the development of obesity based on the genetics of the person. Cultural beliefs about the children needing to be a little heavier as a child or the lack of physical exercise and poor nutrition was also revealed (Dhoble et al., 2020).

Sahoo et al. (2015) meta-analysis study on childhood obesity in African American communities as well as in developing countries pointed out that maternal weight, maternal weight gain during pregnancy, nutritional preferences based on culture, tolerance for overconsumption of foods that are high in sugar and fat and socioeconomic status were linked to childhood obesity. Isong et al. (2018), Dhoble et al. (2020), and Sahoo et al. (2015) all agreed that risk factors associated with childhood obesity included socioeconomic status, nutritional preferences, and maternal weight gain during

pregnancy. Sahoo et al. (2015) study revealed that several factors influence obesity in African American children.

## Psychological Factors

### Self-Esteem, Impulsivity, and Self-Control

Individuals who are overweight, obese, or disabled are more than likely to have low self-esteem than individuals without these issues (Lehman et al., 2017). The authors' study surveyed overweight and obese African American children between the ages of five through seven. The authors wanted to determine whether there might be an association between BMI and low self-esteem in young overweight and obese children. Self-reported instruments were used to collect the children's BMI levels determined an association between BMI and self-esteem. The results revealed that obese and overweight African American children's weight directly impacted their self-esteem (Lehman et al., 2017).

Bennett and Blissett (2020) wanted to determine whether an association between impulsivity and dietary intake restraints children between the ages of seven and 11. The authors examined dietary intake restraints with no supervision of the children in a lab with access too many snacks. Impulsivity was examined based on self-report restraints from the children. The authors found that children who could not retrain themselves from snacks ate more than the children who consumed less snacks. The results revealed impulsivity and dietary intake restraints, when combined with no supervision of the children, leads to overeating of snacks (Bennett & Blissett, 2020).

Datar and Chung (2018) found that self-control in eating consists of pursuing, setting, and reaching goals. In a longitudinal study, 7,060 children of various ethnicities

between the ages of six through 14 years old, the authors wanted to determine if there was a connection between self-control and dietary intake. The children were assessed based on a teacher reported scale. The results revealed that low self-control at kindergarten was associated with more weight gain when the child reaches the fifth grade. The researchers also demonstrated that high self-control in children at the kindergarten level slowed down the development of obesity (Datar & Chung, 2018). Lehman et al. 2017; Bennett & Blissett, 2020; and Datar & Chung, 2018 revealed self-esteem, low impulsivity, and lack of self-control influence weight gain that leads to obesity.

## Social Factors

### Food and Culture

Food in African American culture played an essential role in determining attitudes toward obesity and overweight. The researcher pointed out, African American parents needed to show love and care through food (Skala et al., 2012). The researcher further noted that foods were prepared high in fat, sugar, and salt in many African American families. Questionnaires measured access and availability of various foods in the home, parental practices, and food consumption behavior with African American families comparing them to Hispanics. The questionnaires showed that African American families were more likely than Hispanics to restrict and reward with dessert and serve children fewer fresh fruits and vegetables. Furthermore, the researcher's findings revealed that African American families displayed more authoritarian characteristics to

food behaviors and less concerned with integrating fresh fruits and vegetables into the home (Skala et al., 2012).

In a study conducted by Arlinghaus et al. (2018), their findings agreed with Skala et al. (2012) that many African American family dinner meals lacked fresh fruits and vegetables. Arlinghaus et al. (2018) found that parental feeding styles and diet quality of Head Start preschoolers of African Americans of low-income and Hispanics needed to increase fruits and vegetables in their diets. However, both Arlinghaus et al. (2018) and Skala et al. (2012) indicated that African American parents were not as concerned with providing their children with a high-quality diet. Furthermore, Arlinghaus et al. (2018) revealed authoritative African American parents to be less concerned with integrating fresh fruits and vegetables into the home. The researchers concluded that obesity and overweight were common among preschoolers in both African American and Hispanic households.

Porier (2016) study assessed family eating and physical activity patterns among 100 hundred African American parents and a few other minorities. The study found that African American parents were more likely to provide snacks between meals to their children, offer second helpings, and permit television viewing during mealtime. Moreover, Porier (2016) study revealed that African American parents were concerned about their children's weight but tolerate overweight and obesity in their children. Both Porier (2016) and Skala et al. (2012) concluded that the diets within many African American of low-income were heavy in fat, sugar, and salt which were associated with obesity.

## Weight Management Strategies

### Limit Snacking

Overconsumption of snack foods is generally associated with overweight and obesity in children (Liang et al., 2016). Liang et al. (2016) found 117 overweight and obese children seeking treatment with an average age of 10.4 years old; 48 percent were African American. The children participating in research consumed a dinner meal and completed the Eating and the Absence of Hunger and Child Report of Parent Behavior Inventory while the parents completed the Child Feeding Questionnaire. The research revealed that parental monitoring is associated with child sweet snack food intake and maternal psychological control. Furthermore, African American children and their parents consumed more frequent snacks than did White children and their parents.

Blaine et al. (2015) and Porier (2016) agreed that parents of low-income offered snacks to children more than higher socioeconomic status parents do. Blaine et al. (2015) revealed that the parents took an intervention study to prevent childhood obesity in low income Massachusetts communities with a sample of 271 parents of children ages two to 12 who completed surveys regarding reasons for offering snacks, demographics, and perceptions of overweight and obesity in young children. Further, the researchers revealed that African Americans and other minority groups with low-income status offered more snacks, particularly those containing high amounts of sugar and fat, while also providing standardized meals heavy in fat and salt. The authors concluded that household food security was an essential contributor to snacking patterns but many

African American of low-income with children experiencing obesity selected own their snacks (Blaine et al., 2015).

Blake et al. (2015) study interviewed African American and Hispanics parents of low-income with preschool-aged children in two cities. The interview examined the parent's child snacking definitions, purposes, contexts, and frequency. Analyzing the parent's race, ethnicity, education, and household food security status took place. The study revealed, both groups in this study allowed children to determine both portion size and snack type. Blaine et al. (2015), Porier (2016), and Blake et al. (2015) agreed that African American parents were less likely than non-Hispanic White or Hispanic parents to offer fruits, snacks low in sugar, and snacks low in salt to their children.

Finally, Davison et al. (2015) reported his findings from a study of a sample of 18 Hispanic's that are not White, 22 African Americans, and 20 Hispanic parents of low-income preschool children. The results of the study needed analyzing for permissiveness and indulgence. The results suggested that African American parents and all of the other low-income families demonstrated a risk of obesity and poor diet quality in their children. The study concluded that low-income mothers, regardless of race or ethnicity, perceived snacking as serving a more important role in child behavior than nutrition.

**Limit High Fat Foods**

Chambers et al. (2015) found that high-fat foods were prevalent in low-income African American families. When children have unlimited access to television and other media advertisements, the researchers revealed that they are more likely to convince their parents to provide them with foods high in fat, sugar, and salt. The study further showed

that parents were more likely to allow these foods as acceptable to their children regardless of nutritional value. The researchers revealed a link between high-fat foods and parents in low-income households and the relationship to food choices for their children.

Damaudery (2020) conducted a study on the relationship between maternal high-fat diets and early stress on offspring behavior was of interest. Using a sample of mostly low-income African Americans and other minorities, the researchers found that maternal high-fat diets and single parenthood both had negative impacts on offspring behavior as it relates to cognition and food intake. The researcher concluded low-income parents who experience maternal stress have a high chance of their children consuming high-fat foods, which is linked to overweight and obesity during childhood (Damaudery, 2020).

Food and nutrient intake related to obesity and overweight in African American children was the focus of Anyoha (2015) and Kolahdooz et al. (2016) study. However, Anyoha (2015) study focused on children between the ages of ten to 18 years old identified as having a high BMI. The study involved weekly educational sessions and follow-up calls and the 5210 Healthy Habits Questionnaire administered at the start and conclusion of the program. Findings suggested that in African Americans and other minority families of low-income, obesity is standard, and high-fat foods were present in most diets (Anyoha, 2015). The study concluded that limiting high-fat foods was made more complicated by low-income status (Anyoha, 2015).

Kolkhoz et al. (2016) examined food and nutrient intake among low-income African American children ages five to 16 and their caregivers. Each of the children

identified as having a high BMI by the public and other health care providers. The study measured the children's BMI at the start of the study and after its completion through a Youth Food Frequency questionnaire. The researchers wanted to identify the association between ethnicity, socioeconomic status, and high-fat food diet consumptions. Kolkhoz et al. (2016), Anyoha (2015), as well as Damaudery (2020) findings revealed a strong relationship between ethnicity, socioeconomic status, and the consumption of a high-fat food diet.

**Increase Physical Activity**

Increasing physical activity for children ages three to ten years old was an essential aspect in response to obesity. Olvera et al. (2013) found in an intervention study conducted with 99 African American girls and other youths under the age of 14 participated along with their mothers. The girls attended daily exercise, nutrition, education, and counseling sessions from 9;00 am to 5:00 pm while the mothers attended two-hour weekly exercise, nutrition, and counseling sessions. BMI, abdominal fat and aerobic were collected at pre- and post-intervention. The study revealed that the girls exhibited significant reductions in bodily fat, abdominal fat, and aerobic endurance. The researchers concluded that this study is significant because it demonstrates the efficacy of increasing physical activity to reduce obesity and overweight (Olvera et al., 2013).

Research by McGee et al. (2017) used a series of six children's focus group sessions in two Louisiana parishes in the lower Mississippi Delta. The researcher found that of the 70 African American participants 46 were girls and 24 were boys, between the ages of eight to 13 year-olds. McGee et al. (2017) study revealed parental lack of

knowledge of children's food intake patterns and lack of recognition of the importance of physical activity as a significant component of lifestyle programming (McGee et al., 2017).

In a different study, McGee et al. (2014) found a culturally designed intervention used to increase adherence to dietary guidelines and age-appropriate physical activity among focus group participants consisting of children aged eight to 13. The parents and the children participated in the groups with knowledge regarding appropriate diet and physical exercise assessed. The researchers concluded that cultural influences on food habits and interest in physical activity and team sports availability influenced both parents and children significantly. The researchers recommended the development of culturally appropriate interventions that target African American families of low-income.

Kelley and Kelley (2018), McGee et al. (2014), and Olvera et al. (2013) found that exercise and nutrition interventions are essential in reducing body fat among obese and overweight children. Kelley and Kelley (2018) found 11 studies representing 28 groups, and 427 overweight or obese children were collected. The research suggested a trend for reducing the percentage of body fat among individuals who participated in combining exercise and nutrition interventions. Kelley and Kelley (2018) and Olvera et al. (2013) revealed that exercise alone was not enough to reduce body fat but combined with nutrition and physical activity to improve weight status. Kelley and Kelley (2018) recommended research specifically involving randomized trials on low-income African American families on exercise to reduce body fat among obese children.

**Decrease Calorie Intake**

Decreasing total caloric intake by children ages three to ten years old is an essential element in responding to obesity. Briefel et al. (2013) found that calories with added sugars can be reduced by switching from sugar-sweetened beverages to un-sweetened and reducing snacking. The researchers revealed that 2,314 participants were African American children of low-income and other minorities receiving free meals from the National School Lunch Program. Results showed that the children increased their caloric intake with sweet beverages and snacks in the home environment. Briefel et al. (2013) and Fisher et al. (2019) concluded that parental education on daily recommendation of caloric intake and nutrition offered to their children.

Portion sizes linked to excessive caloric intake are at risk for obesity (Johnson et al., 2014). Johnson et al. (2014) found in a study that included 145 parents and their preschoolers; of the sample, 57 were African American, and 82 were Hispanic; all participants received the National School Lunch Program. Associations between the amounts served to adults and children at three home meals; child and parental weight, height, and BMI were calculated. Multiple linear regression used to determine whether maternal characteristics, including race, ethnicity, and socio-demographic data, were associated with amounts served to children. Findings revealed that African American parents served more food to themselves and their children and that this held whether parents were employed or not. Johnson et al. (2014), Briefel et al. (2013), and Fisher et al. (2019) recommended interventions to educate parents regarding appropriate caloric intake for their children.

In a study conducted with 97 African American and Latino parents of low-income with children. Diet quality and caloric intake assessed using two 24-hour dietary recalls and analyzed through comparison to the Healthy Eating Index-2010 (HEI-2010). Results indicated that meals, as described by participants, filled with excessive amounts of high-calorie foods, with limited fruits and vegetables. The researchers revealed an association between overweight/obesity and high BMI levels in both parents and children (Kong et al., 2018). Kong et al. (2018), Briefel et al. (2013) as well as Fisher et al. (2019) concluded that there is a link between caloric intake and food choice as one as a possible cause for overweight and obesity.

Abdeyazan et al. (2017) conducted a quasi-experimental study with 150 mothers of obese and overweight children in fifth and sixth grades. Surveys collected data during and post-intervention. Although the study conducted in Iran with Iranian participants, their research has implications for the present study. After assessing the children's physical status and BMI, the authors revealed interventions offering healthy dietary choices and lifestyle choices based on the mothers' health belief model in groups of 16 for 4 sessions. Results indicated that mothers in the educational sessions demonstrated an enhanced understanding of the importance of limiting children's caloric intake. Unlike, Briefel et al. (2013) and Fisher et al. (2019) study, Abdeyazan et al. (2017) study concluded with improvements in the children's total weight and BMI.

**Weight Shaming**

Pont et al. (2017) highlighted that weight shaming and stigmatizing people were obese is widespread and causes harm. Pont et al. (2017) further explained that weight

shaming is tolerated in society because of beliefs that stigma and shame motivated people to lose weight. Christensen (2018) agreed and discussed parental weight-based victimization towards obese children. In a recent study, Christensen (2018) explored weight teasing and obese children's bullying by their parents. This study revealed that 37% of the youths attending the weight loss camp reported being bullied or teased by their parent about their weight. Pont et al. (2017) and Christensen (2018) found that children who are ridiculed by their parents about their weight to motivate their child to lose weight gain more weight. Pont et al. (2017) explained that instead of motivating positive change, this type of shaming contributed to behaviors such as binge eating, social isolation, decreased physical activity, and increased weight gain, which worsens obesity and created additional barriers to healthy behavior change. Christenson (2018) and Pont et al. (2017) concluded that children's weight shaming and stigmatization by their parents had an emotional effect on their children that lasted throughout adulthood.

## Weight Management Challenges

### Fast Food Restaurants

Fast-food consumption was prevalent in low-income minority neighborhoods, as indicated by Sanchez-Vaznaugh (2016). In research conducted by Sanchez-Vaznaugh (2016) investigated the relationship between active school transport and fast food consumption across minority groups. The author used data from the 2009 California Health Interview Survey and used logistic regression to examine this relationship between active school transport and fast food consumption. The findings of Sanchez-Vaznaugh (2016) study revealed African Americans and Hispanic children receiving

school transportation by bus or other forms of public transit were frequent consumers of fast-food restaurants after school and before arriving at home than Whites. The authors concluded that exposure to multiple fast food choices in neighborhoods was linked to excessive consumption of these foods.

Sanchez-Vaznaugh et al. (2019) found that the effects of readily available fast foods on children in low-income minority communities and obesity. Using data from 7,466 California public schools, negative binomial regression models estimated the ratios to evaluate schools in low-income communities and fast-food outlets. The researchers revealed a negative link to schools in low-income neighborhoods and fast food restaurant availability. The results showed a need for future interventions that target schools in low-income urban communities. The ready availability of fast-food restaurants impacted obesity and overweight. The researchers recommended that interventions needed to focus on educating children and their parents about fast food effects and healthier diets.

Harris et al. (2015) reported on the marketing of unhealthy foods and beverages targeting African Americans and Hispanic communities. The researchers found that the marketing of unhealthy foods and beverages targeting African American and other minority communities did contributed to health disparities. Researchers evaluated 26 restaurants, food, beverage companies, and all companies participating in the Children's Food and Beverage Advertising Initiative. The researchers revealed that advertised, fast-food restaurants often disproportionately targeted African American and Hispanic children and youth in low-income communities through television as well as print offering multiple discounts to attract consumers. Both Sanchez-Vaznaugh et al. (2019)

and Harris et al. (2015) recommend the need for improving the overall approach taken by fast-food restaurants targeting minorities.

**Lack of Public Transportation**

Another challenge to obtaining high-quality food for low-income rural and urban families is the lack of public transportation. Kumanyika et al. (2014) found in content and thematic analysis that identify the factors that impacted children's weight status and the prevention and treatment options available to fight this problem. The findings revealed that parental perceptions of the lack of adequate transportation to full-service, high-quality grocery stores led to poor food choices. The researchers concluded that food costs at neighborhood stores in low-income areas were high, and healthy food choices were limited. Therefore, there is a need to access public transportation.

She et al. (2019) found in a longitudinal analysis of county-level health and transportation data, examining 227 counties across the U.S. in 2001 and 2009. She et al. (2019) and Kumanyika et al. (2014) results indicated that in urban and rural settings, access to public transit can help reduce childhood and adult obesity and enhancing overall individual health.

Data from 367 Detroit participants examined neighborhood predictors of obesity, supplementing these data with various socioeconomic factors, including transit access, income, perceptions of neighborhood safety, and the built environment. In the least ordinal squares regressions, the researchers revealed that a lack of personal transportation and access to affordable public transportation linked to higher obesity levels among children and adults (Mohamed, 2018; She et al., 2019 & Kumanyika et al., 2014).

A lack of access to safe public transportation was of several factors that negatively influence African American low-income food choices. The researchers found in qualitative research conducted between February and April of 2010 using in-depth interviews, focus groups, and direct observation. Twenty African American youths participated in the focus groups. The authors found six thematic categories that emerged in the analysis of interview and focus group data, organized into neighborhood context, school context, family context, and peer context. The researcher's results revealed a high concentration of fast-food restaurants, convenience stores, and the lack of adequate supermarkets in predominantly African Americans living in low-income neighborhoods as well as limited use of public transportation (Christiansen et al., 2013),

Salzer and Joslin (2017) agreed with Christiansen et al. (2013); they found that transportation played a role in creating food deserts in African Americans living in low-income communities. The researchers revealed through a survey conducted that focused on access to transit and transportation disadvantage with a sample size of 30 food pantry and meal provider participants. In contrast, the spatial analysis revealed that 31 percent of food-insecure individuals in the Tampa Bay area had inadequate transportation access. The researcher recommended that the distribution of free or reduced-cost bus passes to clients respond to insufficient access to transportation and African Americans living in low-income communities.

**Limited Fresh Fruits and Vegetables**

Fresh fruits and vegetables are recognized as part of a healthy diet and foods that integrated into meals for children to prevent obesity and overweight (Wolstein et al.,

2015). Wolstein et al. (2015) found that obesity rates were higher in children and adults who lack affordable fruits and vegetables. A survey conducted on obesity in California using a California Health Interview Surveys. The author's findings revealed an increase in the prevalence of obesity among minorities in California. Still, low-income Californians were significantly more overweight or obese than middle income or high-income residents of the state.

Wolstein et al. (2015) found, along with Vedovato et al. (2016) study agreed that the lack of access to affordable fruits and vegetables in low-income African American families increased the chances of obesity. Wolstein et al. (2015) found in a cross-sectional survey of participants on obesity in children was conducted. Data obtained on issues as acquiring food, food destinations, beliefs and attitudes, food insecurity, and food choices. The researcher's findings revealed that African Americans living in neighborhoods have fewer high-quality supermarkets or grocery stores. Wolstein et al. (2015) and Vedovato et al. (2016) agreed that African American families of low-income rely on convenience stores where fruits and vegetables are in limited supply and often of poor quality.

Among 298 adult caregiver-child relationships it was found that 41.6 percent had some level of food insecurity and high BMI rates, with 37.9 percent of children experiencing this problem (Vedovato et al., 2016). The researchers concluded that food insecurity was a factor that has shaped the availability of a variety of affordable fresh fruits and vegetables (Wolstein et al., 2015 & Vedovato et al., 2016). The results revealed

that African American families of low-income were at a greater risk of experiencing food insecurity and high BMI (Vedovato, et al., 2016).

Research by Nunnery et al. (2018) found in a study that wanted to determine the effects of food security, availability of a variety of fruits and vegetables in the home along with frequency of fruit and vegetable intake. 198 pregnant women of low-income were interviewed. Findings revealed that as income decreased, food security also reduced. Nunnery et al. (2018) showed that food security status was associated with the daily intake of fruits and vegetables. Results highlighted the effects of food security, home food environment, and diet quality as contributing to obesity in pregnant women who were more likely to have overweight or obese young children (Nunnery et al., 2018, Wolstein et al., 2015 & Vedovato et al., 2016).

The effects of a school garden and the availability of fruits and vegetables in elementary school on children's homes needed assessment. Twenty-four low-income schools that included African Americans and races of children were randomly assigned to a gardening intervention project. Some assigned to a control group. The researchers revealed that fruit and vegetable availability at home measured through a questionnaire and throughout the intervention. The results showed that a garden intervention led to greater home availability of vegetables and students interested in fruits and vegetables when gardening took place in their own home (Wells et al., 2018).

**Limited Access to Grocery Stores**

Neighborhood disparities and access to healthy foods were linked to the lack of available supermarkets and grocery stores. The researchers found that low-income

neighborhoods had very few major supermarket and grocery stores options and were forced to rely on mom and pop stores and convenience stores that provided limited food choices and encouraged overreliance on unhealthy foods. The researchers also revealed that limited transportation, food insecurity and low-income status contributed to obesity among African American families of low-income (Hilmers et al., 2012). Wolstein et al. (2015) and Hilmers et al. (2012) both agreed that limited access to high-quality grocery stores was a significant factor in fostering childhood obesity.

Hamrick and Hopkins (2012) found in a survey estimating travel time to full-service grocery stores. The researcher had revealed a concentration of food deserts in low- income neighborhoods. Individuals living in low-income areas with limited supermarket access spend an average of 19.5 minutes or 4.5 minutes more in traveling to grocery stores than the national average. Additionally, Hamrick and Hopkins (2012), Salzer and Joslin (2017), as well as Christiansen et al. (2013), all agreed that residents of food deserts shop less frequently because of access issues. Hamrick and Hopkins (2012) researcher further revealed that families that live in food deserts were more than likely to bring children with them during travel to grocery stores.

Li et al. (2019) found research on the association between grocery store availability and childhood obesity. Li et al. (2019) argued that the grocery store's access had a relatively small influence on a child’s weight. Li et al. (2019) study was the opposite from Hilmers et al. (2012), Wolstein et al. (2015), Salzer and Joslin (2017) as well as Christiansen et al. (2013), revealing that limited transportation contributed to obesity among African American families of low-income.

In a pilot study that evaluated the impact of opening a new supermarket in a Philadelphia community viewed as a food desert (Cummins et al., 2014). The community consisted primarily of African American low-income families. Data were obtained through surveys, interviews, and observations of consumers shopping at this store. Results indicated that the intervention moderately improved resident's perceptions of food accessibility. Cummins et al. (2014) and Li et al. (2019) agreed that grocery store availability did not lead to significant changes in reported fruit and vegetable intake. Cummins et al. (2014) concluded that the factors that influence community receptiveness to improved food access are urgently required.

**Unsafe Neighborhoods**

Borrell et al. (2016) examined research associating neighborhood safety and overweight as well as obesity in United States children and adolescents. The survey used the age-sex adjusted growth chart, parental and child reports of weight and height data; children classified as overweight or obese based on BMI. Once the sample of African Americans and other races had been assembled the association between neighborhood safety and overweight and obesity among the children and adolescents before and after adjustments were made for selected characteristics such as physical activity and sedentary activity. The research revealed that children and adolescents living in neighborhoods perceived as unsafe had a 21 percent higher probability of being obese than their peers in safer neighborhoods. The researchers concluded African Americans and Hispanics examined the role played by the social context of the home and neighborhood environment.

Similar research by An et al. (2017) found in an international study that involved seven countries with a median sample size of 1,104 individuals per country. The researchers confirmed that living in unsafe neighborhoods had a significant gain in BMI but no change in childhood obesity risk. An et al. (2017) cautioned that this finding could partially be due to measurement problems. Future longitudinal studies should adopt validated neighborhood safety measures. Cozier et al. (2014), Borrell et al. (2016), as well as An et al. (2017) found that obesity and the impact of neighborhood safety were assessed. The researchers found the relationship between safety with an increased risk of obesity and overweight among African American females of all ages.

Violent crime and its impact on obesity was the focus of research found by Stolzenberg et al. (2019). Data collected from New York City's 2012 and 2014 Community Health Surveys using multi-level analyses of 12,645 residents of 34 New York City neighborhoods. The BMI used as a measure. The authors revealed that the data demonstrated that the violent crime rate did not directly affect obesity. Still, violent crimes influenced the relationships between minorities and obesity. Results revealed that as violent crime rates rise in predominantly African American and Hispanic neighborhoods, the probability of obese resident's increases for both individual and neighborhood. The authors suggested that violent crime and its impact on obesity was under-investigated in explaining racial and ethnic differences in obesity.

## Summary and Conclusions

Chapter II reviewed the literature on the various biological, psychological, and social factors associated with obesity and strategies and barriers related to African

American parents of low-income managing Weight-loss in young children with obesity between the ages three to ten years old. This study fills a gap by revealing essential variables that contribute to obesity in young children; however, a gap in the literature exists that does not address African American parent's experience managing weight-loss in young children with obesity. Equally important in understanding how genetics, culture, and the environment interact not only to shape parental behaviors but also to shape their children's life-long health status. The literature also emphasized childhood obesity is directly linked to a variety of life-damaging and threatening conditions that can be avoided or at least eliminated through proper nutritional intake and exercise in early childhood.

A better understanding of the biological, psychological, and social factors of this population's experiences, along with understanding the strategies and challenges faced by this population may potentially educate healthcare professionals of the experiences of this population. Chapter III addressed the research design and rationale, the researcher's role, data collection procedures, data analysis, issues of trustworthiness, and methodology of the descriptive qualitative phenomenological study. The literature review contained minimal information on the lived experiences of African American parents of low-income managing weight-loss in young children with obesity.

# Chapter 3: Research Method

## Introduction

The purpose of this qualitative descriptive phenomenological study was to understand and describe the lived experiences of African American parents of low-income managing weight-loss in their young children with obesity between the ages of three to ten. This study provided insight into the biological, psychological, social experiences, and the strategies used, and challenges faced by this population. This chapter introduces the study's purpose and describes, identified, and justifies the research design and rationale, role of the researcher, methodology, issues of trustworthiness, and concludes with a summary.

## Research Design and Rationale

### Research Question

The following research question was to understand and describe the lived experiences of African American parents of low-income managing weight-loss in their young children with obesity.

RQ: How do African American parents of low-income describe their lived experiences of managing weight-loss in young children with obesity between the ages of three to ten years old?

### Phenomenon of the Study

In this study, the phenomenon of the study was seeking to understand the lived experiences of low-income African American parents managing weight-loss in young children with obesity.

## Research Tradition

To describe, explore, and understand the lived experiences of African American parents of low-income managing weight-loss in young children with obesity a phenomenological tradition for this study was used. This descriptive phenomenological qualitative study provides descriptions through the narratives of the participant's research and research questions. Giorgi and Giorgi (2003) explained that phenomenology seeks to understand the descriptive experiences through the phenomena. Creswell and Creswell (2018) noted that a phenomenological approach allowed the researcher to explain how several participants' experiences the same phenomenon. In-depth interviewing and close observation enabled the researcher to describe the participants (King et al., 2018).

## Role of the Researcher

According to Ravitch and Carl (2019), the researcher's role was to collect and analyze the data. My part as the researcher was to interview participants, transcribe the data, interpret the results, and present their findings. As the observer-participant, I listened, asked, probed, and clarified interview questions. As the observer-participant, I was unfamiliar with the research site environment in this study. My study does not have any professional or personal relationship involved with the potential participants. My study had no relationship to obesity with a child. Ravitch and Carl (2019) explained that the researcher's role was to control any research biases. Member checking was one-way qualitative researchers used to decrease biases (Miles et al., 2014). The researcher can avoided research site biases by informing potential participants about the study, or asking

potential participants to make the researcher aware of any influences that she/he may had on the site or participants (Miles et al., 2014).

My study used member checking to decrease any potential biases. I kept hand coded notes to reflect on my feelings, thoughts, opinions, and experiences to exam and decrease biases. My study had no ethical issues associated with this qualitative phenomenological research with participants in this study. Participants in the study received a gift card of $25.00 as compensation for their participation in the research. The gift card's monetary value was reasonable and intended to thank the study participants for sharing their time and experiences. No negative impacts were foreseen due to offering a $25.00 gift card to the participants who participated in the research study.

## Methodology

### Participant Selection Logic

The target population for this qualitative phenomenological study was African American parents of low-income 18 years and older. The parents must be managing weight-loss in a young child or children with obesity in their homes. The parents must have an obese child or children between the ages of three to ten years old.

### Sampling Strategy

Ravitch and Carl (2016) explained that sampling is an important part of the qualitative research process and describes the process of deciding which participant to exclude or include in the research study. According to Ravitch and Carl (2016) qualitative studies involve purposeful sampling where the researcher's primary focus is on picking out the participants who can articulate the information requested (Shaheen &

Pradhan, 2019). Purposeful sampling involves selecting participants who understand and offer knowledge for the problem being researched (Creswell & Poth, 2018).

Purposeful sampling is consistent with phenomenological psychology studies needed for in-depth findings to explore the experiences of African American parents of low-income managing weight-loss in young children with obesity. Additionally, it is important for phenomenology research to use a homogenous population with common characteristics to find experiences and themes for that population (Creswell & Poth, 2018). Etikan and Bala (2017) explained that a purposeful snowball sampling strategy was used in qualitative research because the participants in the research were expected to have the experience and background related the research study (Etikan & Bala, (2017). African American parents of low-income who are managing weight-loss in their young children with obesity was obtained using social media through Facebook, Linkedin and community bulletin boards. A purposeful, snowball sampling strategy was used because the participants had the same experiences related to the study.

## Participant Selection Inclusion and Exclusion Criteria

An inclusion criterion was what a participant had to be included in this research study. Exclusion criteria are the factors that made a participant ineligible to take part in this research study. In exploring the lived experiences of African American parents of low-income managing weight-loss in young children with obesity between the ages of three to ten years old, and inclusion and exclusion criteria was used.

**Inclusion criteria:**

- African American parent of an obese child or children living in the home

- African American parents of obese child/children between the ages of three to ten years old
- African American parents living in a low socio-economic community/area.
- African American parents who were at least 18 years or older
- General Education Degree (GED), high School diploma, or higher
- Comprehend and speak English

**Exclusion criteria:**

- Participants who do not speak English.
- A parent that has a guardian.
- African American parent with a child that does not live in the home.
- African American parent who do not have an obese child/children

**Sample Size and Rationale**

This study's population is African American parents of low-income managing weight-loss in young children with obesity between the ages of three to ten years old. These parents live throughout the United States. According to Usher and Jackson (2019) five to 25 participants were recommended for a descriptive phenomenology study and are enough to meet saturation. Saunders et al. (2018) explained that saturation determines the sample size for most qualitative studies. My study had ten participants, which was enough to reach saturation. Nelson (2017) recommended that researchers consider no less than six participants as a starting point. The number of participants chosen for this qualitative phenomenology study was ten and continued until saturation.

### Saturation and Sample

Saunder et al. (2018) recommendation for reaching saturation for a phenomenology study was between five-to-25 participants. Participant recruitment for this study continued until the sample size of ten or saturation was reached. The population for this study was African American parents of low-income managing weight-loss in young children with obesity between the ages of three to ten years old.

## Instrumentation

### Semi-structured Interviews

Interviews lasted up to 60 minutes, and participants had the opportunity to have a second follow-up interview or communicated by phone when needed to clarify any interview information provided. In addition, an audio recorder recorded the participant's interviews and audio recordings were transcribed. Participants had the opportunity to check their interview transcript for accuracy. I used an alpha numeric code on participant's interview responses and data collected in place of using participant's names. The alpha numeric code gave me a way of keeping track of each participant data and interview responses. This study provided participants with a copy of the interview transcript after all interviews and transcriptions were completed to ensure that the participants share exactly what each participant wanted to share. The demographic questionnaire form (Appendix B), hand coded notes and typed transcripts were stored in a locked file cabinet for five years. All data was stored in a locked file cabinet and on a Word document that was on a password-protected computer. The data collected will be

destroyed after five years. Yildiz (2020) explained that storing transcripts, consent forms, and other data collected was required for qualitative research.

**Data Collection Instrument**

The collection of data from participants involved in the research study comprised of a data collection instrument used by myself (Paradis et al., 2016). In a semi-structured format for a qualitative phenomenological study a data collection instrument that was used by researchers interviewing (Clark & Veale, 2018). As reported by Paradis et al. (2016) researchers used semi-structured format for a qualitative descriptive phenomenological study to collect data, based on this research semi-structured interviewing was used. Qualitative interviewing is a conversation between the interviewer and interviewees where the interviewer gained an understanding of the issue, concept, or topic from the interviewees (King et al., 2018). Another important reason that qualitative researcher's used a semi-structured interviewing format is to get data for analysis (Roulston, 2018). For this qualitative descriptive phenomenological study, my study used in-depth interviews to collect the data from the participants.

**Researcher Instrument**

My study used an interview protocol (Appendix F) that assured each participant's consistency in the study. The interview protocol includes open-ended interview questions. The interview protocol used resources from Giorgi's Five Step Data Analysis Process (2009) to make it more appealing to the research participants. While developing the research protocol, questions that yielded a yes and no response are avoided. Open-ended interview questions that collected in-depth information from participants were

used. My goal in developing the interview guide was to understand, explore, and describe the lived experiences of African American parents of low-income managing weight-loss in young children with obesity.

## Procedures for Pilot Study

The purpose of conducting a pilot study was to determine the length of time to complete the research study and assess the research design (Malmqvist et al., 2019). The pilot study's goal was to get feedback from two participants in the research study on the interview protocol to improve the research study, which was not part of data collection and data analysis procedures to improve the research study. The research participants will receive a $25.00 gift card at the conclusion of the interview process to thank them for their participation.

The pilot study was a small scale of the research procedures that increased the validity of the research (Wray et al., 2016). The same procedure used to conduct the research study was used to conduct the pilot study. Two participants participated in the pilot study. The same research questions used to conduct the interviews for the pilot study were the same for the research study. The participants in the pilot study provided feedback. After reviewing feedback from participants in the pilot study, revisions and improvements proceed before performing the actual research study.

## Procedures for Recruitment, Participation, and Data Collection

### Procedures for Recruitment

After approval from Walden's IRB (Appendix A), the recruiting of participants started. The recruiting of African American parents of low-income managing weight-loss

in young children with obesity started with participants being recruited through social media and community bulletin boards throughout the community for this study. Flyers were posted on community bulletin boards, LinkedIn and Facebook (Appendix A) before participants were recruited. The flyers give relevant information for potential participants to make an informed decision to participate in the study. A purposeful snowball sampling strategy was also used to recruit future participants among other participants involved in the study.

**Procedures for Participation**

After approval from Walden's IRB, the recruiting of participants started. Each participant was protected by assigning participants an alpha numeric number code as identification instead of their name to ensure confidentiality. Recruitment flyers were posted on community bulletin boards, LinkedIn, and Facebook for potential participants to decrease feelings of threat or pressure for participation in the research study. The participants in the study came from low-income communities or areas throughout the United States.

Participants in the study signed an informed consent by email. Participants did not want their interviews to be audio recorded. To ensure accuracy of written data during the interview, checking of alpha numeric codes were important throughout the interviewing of each participant. The interview protocol (Appendix D) assured that participants received the same questions. The participants were given opportunities to think before responding to the questions. The interview questions were open-ended to allow for a detail response from the participant.

**Procedures for Data Collection**

The data collection instruments included a demographic questionnaire form and an interview protocol. Additionally, participant's interviews were not audio recorded. Giorgi and Giorgi (2003) explained that qualitative phenomenology researchers focused on understanding the participants' experiences in the study. My study will kept up with the study's time and focus by posing interviewing questions that answer the research questions and producing an interviewing guide. This study also asks open-ended questions that allowed each participant to describe their experience in managing weight-loss in young children with obesity (Tasker & Cisneroz, 2019).

**Procedures for Exiting the Study**

Participating in the study was voluntary, and participants were free to accept or decline involvement at any time. Participants were able to leave the research study at any time with or without any reason. Participants withdrawing from the study had the opportunity if needed to inform the researcher, but this was not required.

**Follow-up Plan**

A follow up with participants was conducted to increase the effectiveness of the study. Participants had the opportunity to check their interview transcripts for accuracy. Follow up procedures allowed participants the opportunity to communicate by phone or email to clarify any interview questions.

**Treatment of Human Participants**

Kite and Whitley (2018) explained that no harm occurred to participants involved in a research study and that confidential information only showed research findings and

analysis of the research study. According to O'Sullivan (2016) qualitative researchers made sure participants in the research study are equally treated and questioned their morals. As part of the participant selection process each participant received an explanation of the research studies' purpose and provided an informed consent form. Prior to data collection, each participant received a copy of the informed consent form. The informed consent form described the measures taken to protect each participant involved in the study that included: the research studies purpose, procedures of the research, risks involved in the participation of the study, benefits for participating in the study, confidentiality protection measures, contact information, and that the research study was voluntary.

The research participants checked interview transcripts and made clarifications and corrections to their interview. Each participant in the research was informed that they can withdraw from the research at any time before the review of transcripts. In addition, coding assured that the data from the interviews are relatable to anyone and that participants involved in the research are confidential. Each research participant was identified by an alpha numeric code instead of by name. Each participant was interviewed in a quiet area of participants choosing over the phone throughout the United States.

**Protection of Participants Rights**

Approval from Walden University Internal Review Board (IRB) was obtained before collecting any data. Participants in the research study completed a demographic questionnaire and given an alpha numeric code. The use of an assigned number on the demographic questionnaire and interview guide protected the participants' anonymity in

the study. To protect the participants' rights in the study, confidentiality of all participants involved in the research study was of importance. Informed consent from all participants involved in the research study was obtained. Participants in the research study were informed of the benefits and risks involved for their participation in the study.

**Treatment of Data**

Participant involved in the research study had an alpha numeric code assigned to them for maintain their confidentiality. Each of the participants used an alpha numeric code in place of their name as an identifier on the interview guide and when completing the demographic questionnaire. The participant's data was stored on a computer that is password protected and in a locked file cabinet store in my home.

All data was stored in a locked file cabinet in my home for at least five years. Consent forms containing the participant's names and assigned alpha numeric codes stored in a locked file cabinet. The hand coded notes and all documents used to analyze the data required protection in a lock file cabinet. All of the participant's data will be shredded after five years.

## Data Analysis Plan

After data collection and transcription, this researcher read through and verified the transcripts by reviewing the hand coded notes. After reading the hand coded noted, using a phenomenological approach to look for common themes related to the study's research questions. Giorgi (2009) descriptive phenomenological method to analyze data does not include coding, but used transformation of meaning units. Data analysis included the use of hand coded notes and the interview protocol. Additionally, the data

from hand coded notes and reviewing the data aided with identifying possible themes that resulted from the responses of the participants. The interview transcripts were typed and saved in a locked file cabinet. Giorgi (2009) suggested five steps analyze descriptive phenomenological data: The first step, make notes and read the transcript many times for understand the data and its meaning. The second step required that the researcher put aside any pre-assumptions and only describe how it was experienced and understood by the participant from his or her point of view without explaining the experience. The third step continued to focus on the expectation of the lived experience within that population then created meanings of the experiences. The fourth step, transformed the meanings into a psychologically descriptive expression of each of the participants. Step five, the general structure of the lived experiences requires systemization from the participants. I followed Giorgi (2009) five step descriptive phenomenological method to analyze the data. The interviews derived from the participants meaning units was transformed into psychological descriptive expressions of each of the participant's, than themes emerged and described how African American parents of low-income are managing weight-loss in young children with obesity. The results collected from the interviews were described in Chapter 4.

## Issues of Trustworthiness

According to Creswell and Creswell (2018) explained that there are four components of trustworthiness: credibility, transferability, dependability, and confirmability. Kyngas, Kaariainen, and Elo (2020) reported that trustworthiness is significant in qualitative research because it allowed transferability. Researchers

established credibility, transferability, dependability, and confirmability to show that their findings emerged from the data collected from the research study (Kyngas et al., 2020).

**Credibility**

Credibility required determining if the results were honest and measures, what it is meant to measure towards the validity of, the internal research (Creswell & Creswell, 2018). This study was designed to make sure that the methods used for data analysis and collection was impenetrable. The findings from this research study were truthful and correct. First, to establish credibility it was confirmed that participants meet criteria for this study through gathered information. Second, a qualitative descriptive phenomenological approach was used to ensure that my research question aligned with the research topic to guide the study. Third, the collection of data and documentation as outlined in the chapter was used to ensure credibility. Fourth, hand coded notes were kept to reflect my feelings, thoughts, opinions, and experiences to exam and decrease biases. Sixth, member checking decreased biases (Miles et al., 2014). Last, I followed ethical guidelines and Walden University's IRB Policies and Procedures.

**Transferability**

Transferability provided evidence that the findings of a qualitative research applied or transferred to other situations, settings, or populations (Connelly, 2016). This study gave the reader proof that this research's findings were similar to their situations. First, I hope that this research study's conclusions educated health care professionals about this population's experiences. Second, my goal provided an understanding of the lived experiences of African American parents of low-income managing weight-loss in

young children with obesity. Last, this researcher described the methods processes in detail. The research study was detailed and specific and the evidence from findings was transferable to populations with similar issues.

**Dependability**

Dependability is the study's reliability and consistency, allowing others to follow the same research process Hayashi et al., (2019). First, member checking assured that the interpretation, analysis, findings, and results were accurately and thoroughly reported. Second, I increased the study's dependability by ensuring that hand coded notes and records are confidential. Third, dependability was an essential element when explaining the design of my research study. Last, the dissertation committee members checked for errors in the design of this research study.

**Confirmability**

Confirmability was the researcher's ability to confirm that the study's results that originated from the research finding (Connelly, 2016). Confirmability ensured that the study's findings were the results, thoughts, and experience of the participant and not the thoughts and ideas of the researcher (Miles, Huberman, & Saldana, 2014). First, I provided research material and all data collected from the research study for transparency and proof of confirmability. Second, the findings generated from the data collected from the participant's related to their lived experiences during observations, interviews, and the pilot study. Third, the results of the study were verified and confirmed based on the data collected. Last, the data required was confirmed and verified through the collection of interviews and transcriptions.

**Ethical Procedures**

Miles, Huberman, and Saldana (2014) explained that a qualitative researcher validates their study by incorporating various strategies that establish trustworthiness and follow procedures that are ethical in the assurance of humane treatment for participants in the study. After approval from Walden's IRB, all of Walden's IRB policies and procedures were followed. Once approved, all documents were provided with Walden's IRB approval number. Additionally, once approved by Walden's IRB, participants were as recruited for the research study.

Flyers posted on community boards, LinkedIn, and Facebook for potential participants will explained the research study's purpose. Each participant received a $25.00 gift card for participating in the research. Participants had a chance before the research study to ask any questions. Before starting the research interview questions, an explanation was provided to each participant and they were informed that the study is voluntary and that they can withdraw from the study at any time. The participants were informed that the interview was audio recorded with their permission. All participants declined audio recording. Each of participants understood that the interview lasted up to 60 minutes.

Additionally, participants were provided with a copy of their interview transcript to check for accuracy after transcription. An alpha numeric code was provided and explained to participants (e.g., P1, P2, P3, etc.) to protect their identity. No other information associated with the participant's name other than the consent form had their name attached. Also, each participant was assured that no one else had access to the

participant's data other than myself and committee members. Confidentiality was provided and explained to protect the participant. No harm or risk in association with this qualitative phenomenological research for participants participating in this study. All data from the research study required was upheld for five years. The data from the study was locked in a file cabinet in the researcher's home. A password protected all data on electronic devices. The results from the research study were available to all partners and participants in the research study. This study may also educate health care professionals about the experiences of African American parents of low-income managing weight-loss in young children with obesity.

## Summary

The purpose of this phenomenological qualitative study was to gain an understanding of the lived experiences of African American parents of low-income managing weight-loss in young children with obesity. Chapter III research methods provided a detailed description of the research design and rationale, the researcher's role, pilot study, population, and sampling procedures, inclusion, and exclusion criteria for the study. Once recruiting began, a purposeful snowball sampling was used; participants participated in a semi-structured interview that addressed the research questions. Following ethical procedures was of importance. All issues related to trustworthiness, credibility, transferability, dependability, and confirmability were addressed.

Data was collected through semi-structured open-ended interviews with ten participants. A pilot study was conducted to get feedback from the two participants to improve the research study. The participants were African American parents of low-

income managing weight-loss in young children with obesity. A $25.00 gift card indicated to participants of their appreciation for participating in the research study. Numerous tools were used to organize, code, and analyze the data. The information gathered in this study came from the participants involved in the study. Confidentiality assured that participants were protected in the research study. No harm occurred to participants involved in the study were protected throughout the research study.

In relationship to the research problem, participants were recruited and selected. The data collection method and interview protocol was discussed with participants. The data collected from the study was stored in a locked file cabinet and for at least five years before being shredded. Data analysis plan, issues of trustworthiness and ethical considerations concluded Chapter III. Once the participant's interviews, data collected, and data analysis the results were provided in the results section in Chapter IV. Chapter V provides a summary of the findings with recommendations and conclusions.

# Chapter 4: Results

## Introduction

The purpose of this qualitative descriptive phenomenological study was is to understand and describe the lived experiences of African American parents of low-income managing weight-loss in their young children with obesity between the ages of three to ten years old. The following research questions guided this study:

RQI: How do African American parents of low-income describe their lived experiences of managing weight-loss children with obesity between the ages of three to ten years old?

Chapter I was comprised of eight sections. First, the pilot study contained feedback from two participants on the interview protocol to improve the research study. Second, the setting, location and conditions of the study were described. Third, the demographics data contained information on the gender, age race, education level, and socioeconomic status of the participants. Fourth, this section contained data collection methods used. Fifth, the data from the study was analyzed for themes and meaning units and were transformed into psychological descriptive expression of each of the participants. Sixth, this section contained the credibility, transferability, dependability, confirmability, and addressed the research question. Seventh, the summary contained the findings of the research and data to support the results. Eighth, a summary of the answers to the questions are reported.

## Pilot Study

A pilot study was conducted on July 6, 2021 before the actual study with two pilot study participants who met the research study criteria. The two pilot study participants had children who were obese as children. Both had obese children, one parent has one obese child, and the other parent had two obese children. The interviews took place over the phone. The two pilot study participants were asked ten interview questions to determine if the interview questions were understandable and to determine the length of time to complete the interview questions by the pilot study participants. The interview questions by the first pilot study participant lasted for one hour and 15 minutes and the second pilot study participants interview lasted for 45 minutes. The two pilot study participant's response to the interview questions helped to validate the interview questions. The pilot study helped refine the interview questions and increased validity to the research study. The information from the interview results yielded in-depth rich information about the interview questions. The two pilot study participants reported no needed changes to the interview questions. One of the pilot study participant's informed this researcher that the first research question helped her to relax and open up to the interview questions. The other individual reported that the length of time of the interview was enough time to answer the question without rushing or moving to slow. No revisions or improvement were needed for the interview.

## Setting

I conducted the research study interviews over-the-phone. The over-the-phone interviews were in a quiet, comfortable, uninterrupted setting of the participant's choice,

which enhanced trustworthiness. After receiving consent from the participants, I served as the principal researcher and conducted each of the interviews. Due to participant's work and college class schedules, it was not easy to schedule interviews. As the researcher I had to make myself flexible to meet the schedules of all interviews and make it convenient for the participants. The participants were unwilling to be audio recorded, due to feeling uncomfortable, lack of interest, or feeling that the recording would be released on Facebook. After explaining that the interviews are confidential, the participants declined audio recording. I assured each participant that their interviews would not be recorded. Each participant received a $25.00 Visa gift card by mail as a thank gift for participating in the study.

## Demographics

This qualitative descriptive phenomenological research study had ten participants. A total of ten out of 12 interested parents met the criteria and agreed to participate in the study. The ten participants were recruited based on the criteria listed below:

- African American parent of an obese child/children living in the home
- African American parent of an obese child/children between the ages of three to ten years old
- African American parent living in a low-socio-economic community/area
- African American parent at least 18 years or older
- African American parent with a General Education Degree (GED), high school diploma or higher

The median age range of the participants was 21-36 years old. Among the participants, five were women and five were men. The number of men participating in the study was surprising, which provided a balanced perspective in the study. The participants self-reported the gender of their children; eight reported their children as girls and two as boys. The participants self-reported the height, weight, and gender of their children. All ten participants self-reported living in a low-socioeconomic area, nine of the participants had high school diplomas, and one had a (GED). At the time of the interview, none of the participants were pregnant or over the age of 50. The participant's marital status, household income, or household size was not inquired for the sake of their privacy. The participant's marital status, household income, or household size was not included in the study, although it may have shed more light on the participants background, but not relevant to this study.

## Data Collection

In order to collect data, I invited parents in this study through the distribution of a flyer (Appendix A). The flyers were located on LinkedIn, Facebook and community bulletin boards. A demographic questionnaire (Appendix B) was completed before the interview. No interviews were completed until approved from Walden University Institutional Review Board (IRB) (06-28-21-0534654). There was no variation in data collection from the plan presented in Chapter III. During the data collection process, two assessment tools were used for all ten participants. The first instrument was a demographic questionnaire that asked participants for demographic information that confirmed he or she met the criteria for participating in the study. The second was an

interview guide used during the interview process, where the participants were asked to answer ten open-ended questions which helped to gain understanding of their experiences. I called participants from my home phone and put it on speaker. Each participant was interviewed within a day, after seeking their consent for their responses. Data was collected by phone interview within a five-week period. Data about the lived experience of low-income African American parents managing weight-loss in young children with obesity was collected from ten participants. The length of the interviews ranged between 50 and 60 minutes. None of the participant agreed to be audio recorded.

**Demographic Questionnaire**

A demographic questionnaire (Appendix B) was completed before the interview. Parents met low-income requirements by self-reporting of living in a low-socioeconomic area. Information regarding the parents was asked, such as education level, age, race, and relationship to the child or children. Information regarding their child or children was asked, such as the gender, age, height, and weight in order to meet requirement to participate in the study. The parent's self-reported information needed for the study on the height and the weight of their child/children; however, I was able to determine if the child or children met criteria for obesity from the CDC (2012). If the parent did not meet criteria, they were not included in this study. Of the 12 parents inquiring about the study two parents did not meet criteria for the study because the child did not live in the home with the parent.

**Interviews**

All ten interviews took place in a quiet private area of the participants choosing over the phone that prevented distractions. There were no interactions with the children and none of the children participated in the interviews. In order to gain a rich in-depth understanding of how African American parents of low-income described their lived experiences of managing weight-loss in young children with obesity. I bracketed any emotions that I may have had related to this study to avoid any biases. To ensure confidentiality the participants in the study were assigned as followed: Participant one: P1LW, Participant two: P2CJ, Participant three: P3EM, Participant four: P4JH, Participant five: P5TS, Participant six: P6AJ, Participant seven: P7CJ, Participant eight: P8AF, Participant nine: P9MG, and Participant ten: P10NM.

The interviews lasted between 50 and 60 minutes. The phone interviews were set up to be conversational to create a comfortable environment. At the beginning of each interview, I asked for permission to audio record the interview. All of the participants did not agree to be audio recorded. P2CJ stated that he did not want this interview to end up on Facebook. I assured him and all participants that they will not be recorded, because they did not want to be recorded. The interviews were semi-structured open-ended questions.

## Data Analysis

This study allowed me to use bracketing as a way to keep track of my perception of the experiences of the participants. Bracketing allowed me to put aside my assumptions to capture the authentic lived experiences of the participants and to be aware

of my personal feelings and identify any potential bias. I followed the steps by Giorgi (2009) for the data analysis process. I began data analysis by following the steps: assumed the phenomenological attitude, read entire written notes and transcripts for a sense of the whole, outlined meaning units, changed the meaning units for the participants statement of the lived meanings of the experiences, and synthesizing the psychological structure of the experience based on meaning units of the experience and composed them into categories. The original transcript from each of the participants used to complete this process. The themes were identified from the meaning units, but were anticipated from the literature review (see Chapter II). The participant's transcripts were put into meaning units and categories then formatted into an Excel spreadsheet. I then organized the meaning units grouping them into categories, moving from meaning units, categories and themes then repeating the process over and over again to summarize the meanings of the participants accurately.

## Meaning Units, Categories, and Themes from Data Analysis

### Meaning Units

The meaning units consisted of reviewing my coded journal notes, and participants transcripts. As a result of this study ten meaning units emerged:

**MUI** cooks foods or prepares cook foods high in fat consumption

**MU2** eats more than they should because they are hungry

**MU3** has weight related problems /Parent's child has no weight related medical problems

**MU4** feels okay about the types of food child eats or Parent not okay about the types of foods child eats

**MU5** feels okay about child's weight/Parent does not feel okay about child's weight/parents denied, blamed or felt guilty about their child's weight

**MU6** tried many strategies to help child to lose weight

**MU7** shopped for food at a variety of different places due to no stores in walking distance

**MU8** could not afford fresh fruits, vegetables, and healthy foods

**MU9** parent's participated in their children's weight-loss efforts

**MU10** parent received assistants for groceries/parents do not receive assistance for groceries/Parents did not qualify for food stamps

**MU11** parks prevented physical activity due to gangs and drugs

**MU12** parents held cultural traditions and beliefs about obesity and children

**Categories**

Categories analyzed consisted of reviewing the meaning units that emerged from participants transcripts. As a result of this study eight categories were revealed:

**Category 1:** Parents awareness of risks associated with childhood obesity

**Category 2:** Parents feels okay about the types of food child eats/Parent not okay about the types of foods child eats

**Category 3:** Parents feels okay about child's weight/Parent does not feel okay about child's weight

**Category 4:** Parents has tried many strategies to help child to lose weight

**Category 5:** Parent faced many challenges in managing weight-loss in their young children

**Category 6:** Parents shops for food at a variety of different places

**Category 7:** Parents transport themselves for food in a variety of different ways

**Category 8:** Parents receives assistants for groceries/Parents do not receive assistance for groceries

**Themes**

Data analysis consisted of reviewing my coded journal notes, and participants transcripts. As a result of this study ten meaning units emerged:

**Theme 1:** High Fat Food Consumption

**Theme 2:** Denial, Blaming and Guilt of Child's Obesity

**Theme 3:** Awareness of Health Risks Associated with Childhood Obesity

**Theme 4:** Consumption of Fast Foods

**Theme 5:** Awareness of Childhood Obesity

**Theme 6:** Strategies African American Parents of Low-Income used to Manage Weight-Loss in their Children with Obesity

**Theme 7:** Lack of Transportation

**Theme 8:** Cost of Healthy Foods

**Theme 9:** African American Parents of Low-Income Participation in their Children with Obesity Weight-Loss

**Theme 10:** Lack of Income

**Theme 11:** Unsafe Parks/Unsafe Communities

**Theme 12:** Culture/Traditions and Beliefs

## Evidence of Trustworthiness

### Credibility

The credibility of this study started with confirming that participants met the criteria for this study through information gathered from the demographic questionnaire. Second, a qualitative descriptive phenomenological approach was used and ensured that the research question aligned with the research topic. Third, I was able to bracketing my biases by expressing in my hand coded journal notes that reflected my feelings, thoughts, and opinions. Fourth, member checking decreased biases by allowing the participants to review the interview transcript for accuracy. Last, I followed Walden University IRB Policies and Procedure ethical guidelines to establish credibility.

### Transferability

The findings from this study provided understanding of the lived experiences of African American parents of low-income managing weight-loss in young children with obesity to educate health care professional about this population's experiences and may allow transferability to populations and settings.

### Dependability

The dependability of this study started with member checking to assure the accuracy of the interpretation, analysis, findings, and results were accurately reported. Second, the dependability was increased by ensuring that the coded journal notes, demographic questionnaire, consent form, and interview questions were confidential.

Also, dependability was established through the dissertation committee members by checking for errors in the research study design.

### Confirmability

Confirmability was established by checking data collection many times, and confirmation the accuracy of the participant's interview transcripts, and confirming that the results from the study originated from the findings. Confirmability was confirmed by ensuring that the experiences, thought, and results were the participants.

## Results

The research question for this study was: How do African American parents of low-income describe their lived experiences of managing weight-loss in young children with obesity? Once data was analyzed ten clear themes emerged from the experiences of the participants that supported the experiences of the participants.

### Themes

**Theme 1:** High Fat Food Consumption

This theme emerged from the data as a result of the participants sharing their thoughts on the foods they like to cook for their children. The following question addressed high fat food consumption: Tell me your favorite meals that you like to cook for your child? Participant P1LW said she likes to cook or buy spaghetti and meatballs for her child. Participant P2CJ stated he likes to cook or buy child pizza, chicken nuggets, fries, hot pockets, hamburgers, and hotdogs. Participant P3EM stated she likes to cook or buy fried fish, mac & cheese, meatloaf, mashed potatoes, gravy, pork chops, and fried chicken. Participant P4JH revealed he likes to cook or buy foods that are quick

and easy like fried eggs, hotdogs, bologna sandwiches, frozen pancakes, peanut butter and jelly sandwiches, burritos, and pizza. Participant P5TS explained that he likes to cook or buy spaghetti, pasta, lasagna, and pizza for his child. Participant P6AJ said he likes to cook or buy tacos, burritos, tamales, and tostadas. Participant P7CJ stated she cooks or buy soul food, Mexican food, Italian foods, and fried foods. Participant P8AF revealed she likes to cooks bacon, eggs, pancakes, fried potatoes, biscuits, toast, and grits. P9MG explained she likes foods that are easy and quick to prepare like cheese burgers, French fries, hotdogs, and can beans. Participant P10NM said he does not like to cook but he buys pizza, soda, chips for his child.

**Theme 2:** Denial, Blame and Guilt of Child's Obesity

This theme emerged from the data as a result of the participants sharing their thoughts on the causes of their children's obesity. The following question addressed parent's reason of the cause of their child's obesity: Does your child eat more than he or she should? Please explain. P1LW stated her child became obese from eating too frequently and eating large amounts of food. P4JH blamed her child's obesity on her child wanting more food to eat than she provided at meals. P3EM believed that her child is obese because she loves to eat junk food. P7CJ explained that her child is obese because she eats enough food for two people. P9MG thinks her child became obese because her child eats more than the other kids in the home and a lack of exercise.

**Theme 3:** Awareness of Health Risks Associated with Child hood Obesity

This theme emerged from the data as a result of the participants sharing their thoughts on medical problems related to their children's health. The following questions

addressed parent's awareness of health risks: Has a doctor ever told you that your child has medical problems related to his or her weight? If so, what are the problems? How do you feel about you child or children's weight? P1LW doctor informed her that she needed to help her child by cooking healthy meals and provided her with a meal plan to her child to lose weight. P2CJ feels he now knows his child is obese and he is not happy about it. P3EM believed that if she feeds her child smaller portions of food it will help her child to lose weight. P5TS thinks his child is way too big and bigger than he would like his child to be. P6AJ feels his child is a big child. P7CJ stated she does not like her child's weight and wants to help her lose weight. P10NM wants to do everything he can to help his child to lose weight so his child can be healthy.

**Theme 4:** Consumption of Fast Foods

This theme emerged from the data as a result of the participants sharing their thoughts on the fast foods their children consume. The following questions addressed Consumption of fast foods: How do you feel about the types of healthy or unhealthy foods you provide for your child or children? Can you tell me how you feel about the types of unhealthy foods you provide for your child or children? P1LW stated she feeds her child soda, donuts, fries, chicken nuggets, hotdogs, and chips. P2CJ allowed his child to eat pizza, chicken nuggets, fries, hot-pockets, hamburgers, and hotdogs. P3EM feeds her child fast foods that are fried. P4JH stated that she feeds her child frozen dinners and hotdogs all the time. P5TS allowed her child eat pizza, cookies, hot Cheetos, and soda whenever he wants. P6AJ stated that she feeds her child Mexican food a lot. P7CJ feeds her child fast foods like pizza, tacos, and burritos. P8AF allowed her child fried foods and

foods with a lot of sugar. P9MG stated her child eat cheeseburgers and hotdogs. P10NM feeds his child pizza, chicken, fries, big macs, chips, and soda.

**Theme 5:** Awareness of Childhood Obesity

This theme emerged from the data as a result of the participants sharing their thoughts on the parent's awareness of childhood obesity. The following question addressed the parent's awareness of childhood obesity: Has a doctor every told you that your child has medical problems related to his or her weight? P1LW stated "her doctor has told her that she could develop medical problems due to the weight". P2CJ explained the doctor explained that if she didn't do something about his weight now that he would become a diabetic. P3EM revealed her doctor has told that her child's weight could cause problems in the future with breathing, diabetes, or high blood pressure if she continues down this path with her weight. P4JH stated her doctor has told her that she has borderline diabetes and that she needed to limit the amount of sweets and sugar in her diet. P6AJ explained her doctor has voiced his concerns about her weight, and wants us to change her diet, and to make sure that she is eating balanced meals. P7CJ stated her doctor did talk to her about preventing medical problems from occurring by cooking healthy foods and introduction a different healthy foods and limited unhealthy until she gets use to eating healthy foods. P9MG revealed her doctor says her problems with breathing are related to her weight. P10NM stated the doctor said that her asthma is related to her weight.

**Theme 6:** Strategies African American Parents of Low-Income used to Manage Weight-Loss in their Children with Obesity

This theme emerged from the data as a result of the participants sharing their thoughts on the strategies the parent's used to manage their children's weight-loss. The following questions addressed the parent's weight management strategies: What are some of the ways you have tried to help your child or children with their weight challenge? Does any of the ways include shaming your child or children? P1LW stated that she has used exercise videos, smaller meals, cutting out fried foods, stopped bring junk food home, stopped eating junk food in front of her child, and taking her child to the park to run and play. P2CJ explained that he allows his son to play in front of the house and take walks, reduced sweets, and reduced snack. P3EM revealed that she has limited the amount of food her child eats, provided encouragement, biking riding, jumping rope, and going for walks. P4JH disclosed that he has reduced sugary foods and sweets. P5TS stated that he has increased physical activity, daily walks, added fruits, and added vegetables. P6AJ explained that he has limited overeating, added apples, carrots, celery and salads, and exercise. P7CJ has tried counting calories, exercising, portion control, increasing fruits, increasing vegetables, reduced fried foods, reduced sugary foods, and has called his child fat as a way to help her lose weight. P9MG disclosed that she has reduced chips, soda, increased walking, and water drinking. P10NM stated she has used encouragement, walking, taken way chips and soda, and has called his child lazy as a way to help her to lose weight.

**Theme 7:** Lack of Transportation

This theme emerged from the data as a result of the participants sharing their thoughts on the distance they travel or how the travel to shop for food. The following questions addressed grocery stores close to parent's home: Where are some of the places you shop for food? Can you tell me how you transport yourself to shop for food? Participant P2CJ States he shops for food that is closer to home because he does not have a car. He either rides the bus or friends and family members give him a ride to shop for food. Participant P4JH shops for food at the corner store because it is close to where he lives or in walking distance because he does not have a car.

**Theme 8:** Cost of Healthy Foods

This theme emerged from the data as a result of the participants sharing their thoughts on their lack of income to buy and prepare healthy foods. The following question addressed cost of healthy foods: Can you tell me if you receive any assistance for groceries-for example, food pantries, food banks, family members, or government assistance? If so, do you feel the assistance for groceries are enough to prepare healthy meals and snacks for your child or children? Participant P1LW states she get food from food banks because she does not have enough money to cover for the whole month. Participant P2CJ gets helps from family member for food. Participant P3EM goes to the food bank, gets food stamps to help pay for food, and help from family members. Participant P4JH struggles to keep food on the table with his full time job. He reported he has to pay bills first and whatever is left is what he has to buy food. Participant P5TS reported buying healthy food is so expensive and it is cheap and easy to buy hotdogs and

pizza. Participant P6AJ received government assistance and food stamps to pay for food. Participant P7CJ can only afford to buy a $15.00 food box from the food bank every week to help with the cost of food. Participant P8AF received food stamps every month to assistance with the cost of food. Participant P9MG works full time but wishes she could receive government assistance to help with food. P1LW stated she was not happy about the times she had to feed her child unhealthy foods based on the amount of money that she had for the week. P3EM also, stated that she had to feed her child based on the money she had after her bills were paid. P3EM reported that she needed more money to buy healthy foods for her child, however her low-income was not enough to quality her for government assistance.

**Theme 9:** African American Parents of Low-Income Participation in their Children with Obesity Weight-Loss

This theme emerged from the data as a result of the participants sharing their thoughts on their participation in their children's weight-loss. The following question addressed parent's participation in their child's weight-loss: Can you tell me has your child lost weight under your management? Participant P1LW states she is being consistent in helping her child to lose weight. Participant P2CJ encourages her child to eat healthy foods. Participant P3EM participated in her child's weight loss by helping her child to make better food choices and exercising. Participant P4JH is helping his child make changes to aid in weight-loss. Participant P5TS is making sure that every day his child eats healthy foods. Participant P8AF reports she is commented to help her child lose

weight by cooking healthy foods. Participant P10NM reported his child will get better in losing weight, because he will continue to help her.

**Theme 10:** Lack of Income

This theme emerged from the data as a result of the participants sharing their thoughts on their lack of income to make better food choice. The following question addressed parent's lack of income: Can you tell me if you receive any assistance for groceries-for example, food pantries, food banks, family members, or government assistance? If so, do you feel the assistance for groceries are enough to prepare meals and snacks for your child or children? P1LW stated she receives free food from 3 different food banks that are a big help, but not always enough to last to the end of the month, and certainly not a way to feed your family healthy foods. P2CJ explained she has gotten help with food from family members, she does the best she can do with the money she has to feed herself and her son. P3EM revealed she receives food stamps, food boxes, a monthly government, and food from family members just to have healthy food to prepare for her family. P4JH stated I work full time and still struggle to keep food on the table. P5TS explained that healthy food is expensive and it is cheap and easy to buy hotdogs, pizza and things like that. P6AJ revealed receiving food boxed from food banks, but he did not feel it was enough to prepare good meals. P7CJ stated she gets food boxes every week from the food bank and without this assistance she would not be able to have food for the whole month. P8AF explained she receives food stamps every month, but it is not enough to buy fresh fruits and vegetables on a regular basis. P9MG revealed she works, but is

managing to make ends meet and receiving some type of assistance would be a big help with better food for myself and the kids.

**Theme 11:** Unsafe Parks/Unsafe Communities

This theme emerged from the data as a result of the participants sharing their thoughts on their experience of taking their children to the park for exercise. The following question addressed unsafe parks: What are some of the ways you have tried to help your child or children with their weight challenge? Participant P1LW stated she tried to help her child to lose weight by taking her to the park so that she could run and play, but the parks near her home were full of gang members, had sharp needles from drugs use and beer can laying around. Participant P2CJ reported he would love for his child to play in the park like he did when he was a child, but the parks in his neighborhood are not safe and full of gangs and drug dealers.

**Theme 12:** Culture/Tradition/and Belief

This theme emerged from the data as a result of the participants sharing their thoughts on how they were raised as it relate to feeding their children until full. The following questions addressed culture and tradition: Does your child ever eat more than he or she should? Participant P1LW stated that she wanted her child to eat until he was full, because that was the way she was raised. P1LW also reported she feels good when her child is eating and not hungry. P1LW reported that she feels that a little weight on her child is okay. Participant P2CJ also just wanted his child to eat until full, because that was how he was raised. Participant P3EM Stated he feels that if his child is hungry or

wanted more food that he needed to feed his child until she had enough or until she was full.

## Summary

In this study, data analysis revealed twelve themes in regards to the lived experiences of African American parents of low-income managing weight-loss in young children with obesity: (1) high fat food consumption, (2) denial/ blame/ and guilt of child's obesity, (3) awareness of health risks associated with childhood obesity, (4) consumption of fast foods, (5) awareness of childhood obesity, (6) strategies African American parents of low-income used to manage weight-loss in their young children with obesity, (7) lack of transportation, (8) cost of healthy foods, (9) African American parents of low-income participation in their children with obesity weight-loss, (10) lack of income, (11) unsafe parks/unsafe communities, and (12) culture/tradition. The majority of the African American parents in this study perceived their child's body weight as baby fat, big boned, big, large, rather than obese. Some of the participants believed that their child would grow out of their weight or it was okay to be at their weight. While another participant believed that their child's weight was hereditary and passed down from other family members.

Although many of the participants were aware of healthy of eating healthy and exercising as a way of healthy lifestyle for their child, many mentioned a lack of money to purchase healthy foods, a lack of transportation to access healthy, and unsafe parks for their children to be active and play. They also identified physical exercise meant their child had to play in the park or walk and none mentioned physical exercise could be

involving their children in sports and other activities. Many of the participants considered unhealthy foods to be chips, soda, junk foods, fried foods, hotdogs, hamburgers, cookies, candy, sweets, sugary foods, and pizza. Some of the participants recognized healthy as baked meats, fruits, and vegetables. Many of the participants were aware of healthy foods, while others were unaware of healthy foods. Half of the participants in the study perceived their children's weight as big rather than obese.

Participants mentioned the cost of eating healthy frequently and the frequency of shopping for fresh fruits and vegetables as it relates to transportation. Many of the parent mentioned walking with their children as a way to help them lose weight. Additionally, one participant mentioned low-income as a factor in a weight management program for their child. Most of the participants believed that their children were healthy because they were never informed by a doctor of a medical problem related to their child's weight. However, the child's doctor had informed a few of the participants that their child medical problem was related to their weight. Therefore, many of the participants believed that since their children's doctor did not inform them of a medical problems related to their child's weight, it confirmed that their child was only large, big boned, big, will grow out of it or, it was just baby fat. The participants believed that they could manage their child weight-loss. All of the participants either enforced or participated in managing weight-loss in their children by exercising, preparing healthy meals, deceasing unhealthy foods, or increasing healthy food. Chapter five I discussed the introduction, interpretation of the findings, limitations of the study, recommendations, implications, and conclusions. I also summarized, confirmed, analyzed, and interpreted key findings from the study.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

The purpose of this qualitative descriptive phenomenological study was to understand and describe the lived experiences of African American parents of low-income managing weight-loss in their young children with obesity between the ages of thee to ten years old. The gap missing from the literature was explored by addressing the factors associated with how African American parents of low-income describe their experiences of managing weight-loss in their young children with obesity. I explored the many experiences of this population managing weight-loss in their young children with obesity. This study was significant because it provided in-depth, rich information about the experiences of this population. From the data analysis 12 themes were revealed from the experiences of the African American parents of low-income managing weight-loss in their young children with obesity. The 12 themes that emerged were convenience and time, denial/blaming and guilt of child's obesity, awareness of health risks, consumption of fast foods, awareness of childhood obesity, strategies parent's used to manage weight-loss in their children with obesity, lack of transportation, cost of health foods, parents participation in children' s weight-loss, lack of income, unsafe parks, and culture/traditions.

## Interpretation of the Findings

This study confirmed many views revealed in the literature review found in Chapter II, as well as the views in the theoretical framework. This study also revealed how the 12 themes aligned with the literature review and the theoretical framework. To

explore the relationship between how African American parents of low-income are managing weight-loss in young children with obesity the biopsychosocial model was used as the theoretical foundation. The biopsychosocial model was developed in 1977 by G. Engel. Kusamanto et al (2018) found this model useful in observing how the patient's environment contributes to their perceptions. This was revealed in the findings provided by the participants involved in the study. My interpretation of the findings supports the biopsychosocial model in that this model considered the factors of the individual's environment.

**Theme 1:** High Fat Food Consumption

The participants shared their favorite foods they like to cook or buy for their child. The participants stated that they "like to cook or buy foods like spaghetti and meatballs, pizza, chicken nuggets, fries, hot pockets, hamburgers, hotdogs fried fish, mac & cheese, meatloaf, mashed potatoes, gravy, pork chops, fried chicken, fried eggs, bologna sandwiches, frozen pancakes, burritos, lasagna, tacos, burritos, tamales, bacon, pancakes, fried potatoes, biscuits, toast, grits, and cheese burgers". Chamber et al. (2015) found that high-fat foods were prevalent in low-income African American families. Chamber et al. (2015) revealed a linked between low-income parent households, high-fat foods, and unhealthy food choices for their children. Anyoha (2015) study concluded that in other minority as well as low-income African American families high-fat food and obesity were standard in their diet. Damauding (2020) findings revealed a strong relationship between the consumption of foods high in fat, socioeconomic status, and

ethnicity. I found that all of the African American parents of low-income favorite foods that they like to cook for their child or children were foods high in fats.

**Theme 2: Denial/Blaming/Guilt of Child's Obesity**

The participants shared denial, blame, and guilt of their child's obesity. The participants stated " I feel guilty when I give her less food to eat, because I feel that if she is hungry or wants more food that I need to feed her until she has enough food or until she is full", "I feel bad about not preparing unhealthy foods for her at a young age. I feel that her weight problem is my fault because I am the parent and I gave her those unhealthy foods", "She has asthma, she has a prescription that she takes every day to help control her asthma attacks. The doctor said it is related to her weight, but I don't think it is related to her weight. I think it is heredity, because a lot of people in our family have asthma". "I feel guilty, I feel like it is my entire fault that she has gained so much weight", "I always thought he was a little big for his age, but I did not think he was obese. Now I know he is obese and I am not happy about it. I feel like him being obese is my fault", "Yes, she is big, but I just feel she is a big boned girl like most of the women in our family, I believe she will grow out of it as she gets older and lose the baby fat", "I know she is a big girl, but I love her just as she is and love her the same way as the other children". Dhoble et al. (2020) found that the lack of physical exercise, poor nutrition, and cultural beliefs about the children needing to be a little heavier as a child were prevalent in African American families. Skalat et al. (2012) found African American families were more likely than Hispanics serve children fewer fresh vegetables and fruits and reward with dessert. Porier (2016) study revealed that African American parents

tolerated overweight and obesity in their children but were concerned about their children's weight. I found it significant that all ten of the participants declined wanting to be recorded and this was identical to the pilot study of not wanting to be recorded. It is my belief that there is a relationship between denials, guilt, and blaming themselves for their child's obesity played a role in the participants not wanting to be recorded. Another thing that I found, the participants felt comfortable with me and open up about their feelings of guilt, blame, and denial with another African American as long as they were not being recorded.

**Theme 3: Awareness of Health Risks Associated with Childhood Obesity**

The participants shared their awareness of the health risks associated with childhood obesity. The participants stated " Yes, her doctor has told me that her weight could cause problems in the future with breathing, diabetes, or high blood pressure if she continues down this path with her weight", " The doctor explained that if I did not do something about his weight now, he would become a diabetic", "Her doctor had told me that she has borderline diabetes and that I needed to limit the amounts of sweets and sugar in her diet", "Yes her doctor did say that her problems with breathing are related to her weight". Alexander et al. (2018) study found that the parents acknowledge the existence of multiple challenges in relations to healthy eating behaviors and childhood obesity and were aware of childhood obesity risk factors and. Campbell-Boytal et al. (2018) survey revealed a consistent theme that African American parents did understand health risk factors associated with obesity in their children. I found that many of the

participants were aware of the risks associated with childhood obesity but failed to follow the doctor's advice.

**Theme 4: Consumption of Fast Foods**

The participants shared the consumption of fast foods that they like to eat. The participants stated " I feed my kids foods like pizza, chicken nuggets, fries, hot pockets, hamburgers, and hot dogs", "I don't like to really cook, I like foods that are quick and easy, like hogs, fried eggs, bologna sandwiches, frozen pancakes, peanut butter and jelly sandwiches, burritos, pizza, or anything that I can put into the microwave and get it done quickly", "I really don't like cooking, I do eat out a lot more than I should", Yes, he eats a lot of pizza", "Cheeseburgers and hotdogs are not the healthiest, but are very cheap", " The kids like to eat pizza, pizza, and more pizza, chicken nuggets, fries, big macs, chips, and soda". Sanchez-Yaznaugh (2016) found fast-food consumption was prevalent in low-income minority neighborhoods. Harris et al. (2015) revealed that the marketing of unhealthy foods and beverages targeting African Americans and other minority communities disproportionately contributed to healthy disparities and targeted children and youth in low-income communities through television as well as print offering multiple discounts to attract consumers. I found all of the participants consumed readily available fast foods; this fast food contributed and perpetuated obesity in African American low-income communities.

**Theme 5: Awareness of Childhood Obesity**

The participants shared their awareness of childhood obesity. The participants stated "I am embarrassed about her weight and not happy about her weight at all. At

times I see she feels sad about her weight when other kids are bullying and teasing her at school about her weight", "Of course I don't feel good at all about her weight. I want to help her to lose weight and not overeat. I feel if I can feed her smaller portions of foods and she feels full and satisfied with smaller portions of food, this will help her to lose weight and keep the weight off for the rest of her life", "I do think he is way too big. He is bigger than I would like for him to be", "I don't like it, and I know it is not good to be really big and I want to help her to lose weight. She gets made fun of at school by the other kids and comes home crying. She doesn't have friends. She just stays in her room". Beech et al. (2018) found that 42 percent of youth under the age of 16 meet the Center for Disease Control (CDC) criteria for overweight or obesity. Alexander et al. (2018) revealed that the parents were aware of childhood obesity, and acknowledged the existence of multiple challenges and its relationship to healthy eating behaviors and childhood obesity. I found that most of the participants were aware of childhood obesity but continued to feed their children food high in sugar and fat.

**Theme 6: Strategies African American Parents of Low-Income used to Manage Weight-loss in their Young Child with Obesity**

The participants shared the strategies they used to manage weight–loss in their young children with obesity. The participants stated " I used exercise videos, taking her to the park to play, smaller portions of food, cutting out fried food and junk food", "reduced sweets and snacks", encouraged her to ride bike, jumping rope, going for walks, and limiting the amount of foods she eats", "reduced the amount of sugar and sweets she eats", increased physical activity by walking every day, adding fruits and vegetables",

"chair exercises, walking, adding apples, carrot sticks, and celery sticks for snacks and salads with meals", "counting calories, exercising, portion control, increasing fruits and vegetables, reducing fried and sugary foods", "eating healthy, walking, drinking water, and adding  fruits, and vegetables", and " taking away chips and soda". Blaine et al. (2015) found African Americans and other minority groups with low-income status offered more snacks, particularly those containing high amounts of sugar and fat, while also providing standardized meals heavy in fat and salt. Kelly and Kelly (2018) revealed that exercise and nutrition interventions are essential in reducing body fat among obese and overweight children.  Chambers et al. (2015) found that high-fat foods were prevalent in low-income African American families. Briefel et al. (2013) revealed that calories with added sugars can be reduced by switching from sugar-sweetened beverages to un-sweetened and reducing snacking. I found that by reducing foods high in sugar, fats, increasing physical activity, and decreasing caloric intake for children ages three to ten years old was essential in reducing obesity.

**Theme 7: Lack of Transportation**

The participants shared their challenges with transportation and its limitation to healthy foods. The participants stated "friends and family members give me a ride to the store, because there are no store within walking distance to where we live", I ride the bus, which is very difficult trying to ride the bus and bring lots of bags from Walmart on the bus". The bus is often crowed and sometimes it is standing room only", and "most of the time there is no room to put the grocery bags", the grocery store is so far away, I have to buy food that is convenient and close to our apartment", we shop at fast food restaurants

like McDonalds and Burger King because they are close to home", and "we go to Little Caesars Pizza, because pizza is only $5.00". Kumanyika et al. (2014) found that parental perceptions of the lack of adequate transportation to full-service, high-quality grocery stores led to poor food choices. She et al. (2019) revealed that access to public transit can help reduce childhood and adult obesity and enhance the overall health of the individual. Christiansen et al. (2013) found a high concentration of fast-food restaurants, convenience stores, and a lack of adequate supermarkets in predominantly African Americans living in low-income neighborhoods as well as limited use of public transportation. I found that a lack of access to public transportation is necessary to obtain quality health foods for weight-loss in African American families with young children.

**Theme 8: Cost of Healthy Foods**

The participants shared the cost of purchasing healthy foods. The participants stated "I feed my child according to the money that I had that week or that month", "I get a monthly check from the government, but it is not enough to cook and prepare healthy foods", "Healthy foods are so expensive and it is easier to buy fast food", "Healthy foods you have to have money to shop for food several times a week for fresh fruits and vegetables, and the food stamps I get every month is not enough to buy healthy foods". Wolstein et al. (2015) found that obesity rate were higher in children and adults who lack affordable fruits and vegetables. Vedovato et al. (2016) found that the lack of access to affordable fruits and vegetables in low-income African American families increased the chances of obesity. I found that fresh fruits and vegetables play an essential part of a healthy diet and should be included in meals for children to prevent obesity.

**Theme 9: African American Parents of Low-income Participation in their Children with Obesity Weight-Loss**

The participants shared their participation in their children with obesity weight-loss. The participants stated " I encourage my child to eat healthy, "I ride bike, jump rope, and walk with my child", "I am reducing sweets to help my child to lose weight", "I am adding more fruits and lean meats to help my child", "I praise my child for the hard work she has done to lose weight, I take walks with my child", "I take my child to the park to play when it is safe", "I am reducing and limiting the unhealthy snacks she eats", "I play exercise videos and exercise with her to help her to lose weight", "I am reducing sweets and snacks", "I limit the amount of food she eats", "We are no longer eating fast foods, and increasing physical activity", "I added fruits and vegetables", "I increased physical exercise by walking with him every day", "I put a limit on unhealthy foods, and I now give her more foods like apples, carrots, and salads". Olvera et al. (2013) found in an intervention study conducted with 99 African American girls and other youth under the age of 14 participated along with their mothers. The girls attended daily exercise, nutrition, education, and counseling sessions. The study revealed that the girls exhibited significant reductions in bodily fat and aerobic endurance. Kelley and Kelley (2018) revealed that exercise alone was not enough to reduce body fat but combined with nutrition and physical activity to improve weight status. I found that when parents participate in their child's weight-loss by exercising, encouraging, incorporating healthy foods, and limiting unhealthy foods contributes in the reduction of obesity in young children.

**Theme 10: Lack of Income**

The participants shared their lack of income. The participants stated " I shop for food according to how much money I have", I shop at food banks because of a lack of money", "Family members give her food and money", "I get food from food banks a couple of times a month", "I go to Little Caesars Pizza because the pizza is only $5.00", "I go to fast food restaurants because the food is cheap"," I mainly shop at Walmart because it is affordable", "I do the best I can to feed my family with the little money I have, and without food boxes from the food bank I would go without food". Campbell-Boytal et al (2018) found that young girls in low-income minority families were likely to be at a higher risk of developing obesity at a young age. Chambers et al. (2015) revealed a link between high-fat foods and parents in low-income households and the relationship to food choices for their children. Anyoha et al. (2015) study concluded that limiting high-fat foods was made more complicated by low-income status. I found that low income play a major role in the development of obesity in African American children based on the inability for the participants to afford to purchase fresh fruits and vegetables.

**Theme 11: Unsafe Parks**

The participants shared vital information on unsafe parks in their communities. The participants stated "I have tried to help her to lose weight by taking her to the park so that she can run and play, but the parks near our home are full of gang members, sharp needles from drugs use and beer cans", and "I would love to send him to the park to play, like I did when I was a child but with gangs and drug dealers hanging out at the park it is not a safe place". Borrell et al. (2016) examined research associating neighborhood

safety and overweight as well as obesity. Borrell et al. (2016) found that children and adolescents living in neighborhoods perceived as unsafe has a 21 percent higher probability of being obese than their peers in safer neighborhoods. An et al. (2017) found a relationship between obesity and neighborhood obesity safety. An et al. (2017) revealed an increased risk of overweight and obesity among African American families of all ages living in unsafe neighborhoods. I found that some of the participants and their children wanted to run and play in the parks in their community for exercise but were limited due to unsafe parks in their communities.

**Theme 12: Culture/Traditions**

The participants shared their culture and traditions. The participants stated "I like soul foods like fried fish, mac & cheese, meatloaf, mashed potatoes, gravy, fried pork chops, and fried chicken", "I feel that the foods they eat are okay", I feel okay about it, and I am just feeding my kids. I am more concerned about making sure they get enough food to eat", "I feel children should eat until they are full". "I always thought he was a little big for his age, but I did not think he was obese", "Yea, she is big, but I just feel like she is a big boned girl like most of the women in our family", "I feel okay, she is big and so am I", and "She don't have to be as thin as a rail". Skala et al. (2021) found that African American parents showed love and care through food. Skala et al. (2021) further noted that foods were prepared high in fat, sugar, and salt in many African American families. Also, Porier (2016) study revealed that the diets of was heavy in fat, sugar, and salt which all were associated with obesity. I found that African American culture played an essential role in determining attitudes towards obesity.

## Limitations of the Study

This descriptive qualitative phenomenological study was limited to African American parents of low-income managing weight-loss in young children with obesity between the ages of three to ten years old. This study included limitations related to method, design and data collection. Another limitation of the study was that the interview responses represented only the parent's experiences that participated in this study. It is further limited by a small sample size of ten participants. Because of the limited sample size of participants to represent the participant's experiences the outcome may not represent the experiences of all African American parents of low-income managing weight-loss in young children. This study was also limited by the honesty of the participant's responses about how they describe their experiences in how they are managing weight-loss in young children with obesity. Another limitation in this study, participant's responses may have been influenced by their bias prior to the interview process influencing their responses to the interview questions. I had no known biases that identified with the participants. I was able to bracket my biases by expressing my feelings, thoughts, and opinions reflected in my coded journal notes on the topic. The interview protocol was created before the interviewed of the participants. In order to avoid the possibility of personal influences with the interview process, all participants received the same interviewing questions verbatim. Lastly, all phone interviews occurred in a protected and private area that was agreeable for the participants to share their lived experiences. Another limitation for this study was the failure to see non-verbal communication of the participants. As per Walden University IRB guidelines, because of

the COVID-19 corona virus, the interviews were over the phone. As for the limitations of phone interviews, I affirmed the precision of the data collected by member checking. Part of member checking is utilized by researchers to decide the validity of the data collected through the completion of the information received from the participants and to ensure accuracy (Creswell and Creswell, 2018). Member checking was conducted by sending the transcribed interviews to the participants to review and check for accuracy. While conducting this study, I found no issues with confirmability, dependability, transferability, credibility, or trustworthiness.

## Recommendations

This study was conducted to understand and describe the lived experiences of low-income African American parent's managing weight-loss in young children with obesity. Recommendations for future research are needed to examine the experiences of this population in each state individually. I recommend adding a question asking the participants how they manage their weight/weight-loss; this will provide insight into how they are managing the child/children's weight/weight-loss. I also, recommend adding a question asking the participants about their weight or weight-loss, this will allow the participants to talk about their weight/weight-loss and provided insight into how they are managing their weight/weight-loss and maybe this is how they are managing their child/children's weight/weight-loss. I recommend affordable intervention and prevention programs within low-income communities of African American parent's to assist with managing weight-loss in young child with obesity. I recommend program based on a sliding scale for intervention and prevention programs within low-income communities

for African American parents to educate them on the risks of childhood obesity, healthy meal planning and healthy food choices. I recommend safe exercise facilities in low-income communities for African American parents based on a sliding scale for young children with obesity to exercise in a safe environment. I also recommend community gardens that grow fresh fruits and vegetables in low-income community for African American parents that do not have access to grocery stores or transportation to healthy foods. I recommend this study be expanded to not only African American parents with children between the ages of three to ten years old but include all children and adolescent. I also recommend not just the potential to educate health-care professionals but include educating school districts professionals such as intervention specialist, prevention specialist, family specialist, school nurse, school psychologist, and social workers on the experiences of this population. Future research studies need to be conducted to provide more in-depth understanding as to why African American parents of low-income are not successful in managing weight-loss in young children with obesity.

## Implications

This research study promoted positive social change as it described and created an understanding as to how African American parents of low-income are managing weight-loss in their young children with obesity. The results of this study can be used to potentially educate health-care professionals and educating school districts professionals such as intervention specialist, prevention specialist, family specialist, school nurse, school psychologist, and social workers on the experiences of this population. This study may be used to incorporate affordable intervention and prevention programs within low-

income communities of African American parent's to assist with managing weight-loss in young child with obesity. The results of the study may also be used to incorporate intervention and prevention program based on a sliding scale in low-income African American communities to educate them on the risks of childhood obesity, healthy meal planning and healthy food choices. This study could also incorporate safe exercise facilities in low-income communities with African American parents based on a sliding scale for young children with obesity to exercise in a safe environment. The results promote community gardens that grow fresh fruits and vegetables in low-income community with African American parents that do not have access to grocery stores or transportation to healthy foods.

## Conclusion

The purpose of this qualitative phenomenological study was to describe and to gain an understanding of the lived experiences of African American parents of low-income managing weight-loss in young children with obesity. African American parents of low-income managing weight-loss in young children with obesity need affordable intervention programs and prevention programs based on a sliding scale and within their communities. African American parents of low-income managing weight-loss in young children with obesity need to education on the risks of childhood obesity, healthy meal planning and healthy food choices. Many African American women did not adhere to the managing weight-loss in their young children with obesity due the lack of safe places for physical activity for their children, a lack of grocery stores within walking distance to where they live, and a lack of transportation to healthy foods. Community gardens that

grow fresh fruits and vegetables and a safe affordable exercise facility based on a sliding scale would be helpful to African American parents of low-income managing weight-loss in young children with obesity by allowing access to healthy affordable foods and a safe environment for physical activity. Also, it is important for African American parents of low-income managing weight-loss in young children with obesity to understand the risks associated with childhood obesity. African American parents of low-income managing weight-loss in young children are concerned about their children safe environments for physical activity for their children, having access to grocery stores within walking distance to their home and transportation to shop for healthy foods. Health-care professionals, intervention specialist, prevention specialist, family specialist, school nurse, school psychologist, and social workers who come in contact with African American parents of low-income managing weight-loss in young children can provide referrals to affordable intervention programs and prevention programs based on a sliding scale and within their communities. They can also educate this population on the risks associated with childhood obesity, and healthy meal planning and healthy food choices. When health-care professionals, intervention specialist, prevention specialist, family specialist, school nurse, school psychologist, and social workers can identify and address this population, African American parents of low-income can manage weight-loss in young children with obesity.

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Appendix B: Demographic Questionnaire Form

**Demographic Questionnaire Form**

**Title:** Low Income African American Parents Experiences Managing Obese Young Children Weight Loss

**Researcher:** Angela Berry
**Location: _____**
**Research Date: _____**
**Research Start Time: _____**
**Research End Time: _____**
**Participant Number: _____**

**Demographics**

**Place answer individual response to each question**

1. Gender: Male: _____ Female: _____

2. Childs Gender: Male: _____ Female: _____

3. Child's age: _____ Child's weight: _____ Child's height: _____

4. Your relationship to the child: Mother: _____ Father: _____ Other: _____

5. Participant's age: _____

6. Participant's race: _____

7. Participant's education Level: _____

8. Do you live in a low-social economic area or community: Yes _____ No _____

Appendix D: Interview Guide

**Interview Guide**

**Researcher:** Angela Berry
**Location: _____**
**Research Date: _____**
**Research Start Time: _____**
**Research End Time: _____**
**Participant Number: _____**

Target Audience: African American parents of low-income managing young children with obesity

**Ice Breaker:** How did you find out about this research study?

**INSTRUCTIONS**
My name is Angela Berry. Thank you for coming. I am a graduate student at Walden University conducting my study in partial fulfillment of the requirements for the degree of Doctor of Philosophy: Health Psychology. This interview involves two parts. The first part is completing a demographic questionnaire form, in which I will ask you to complete to confirm that you meet the criteria to participate in the study. The second part I will ask you ten questions about your experiences of managing obesity in your child. The purpose of this study is to gain an understanding of your experiences in managing weight-loss in your child or children with obesity. There is no right or wrong answer, so please be as honest as you can in helping me to understand your experiences of managing weight-loss in your child or children with obesity. I want you to feel comfortable with sharing your experiences with me.

**AUDIO RECORDING INSTRUCTIONS**

If it okay with you, I will be audio recording our interview. The purpose of audio recording this interview is so that I can get all of the details and be able to hold a conversation with you. All of your responses will be confidential.

**CONSENT FORM INSTRUCTIONS**
Before we get started, take a few minutes to read and sign the consent form. At this time I would like to confirm that you have read and signed the informed consent form, that you understand that your participation in this study is entirely voluntary. You will receive a copy of this interview after transcription and I will maintain a copy in a locked file cabinet separate from your responses to the interview questions.

Your participation in this study is voluntary, if at any time you would like to stop or need a break, please let me know. You may withdraw your participation from the study at any time with no consequences. Do you have any questions or concerns before we start the interview? Do you have any questions before we start the interview? With your permission we will start the interview.

**Biological**

1. Tell me about your favorite meals that you like to cook for child?

2. Does your child ever eat more than he or she should? Please explain

3. Has a doctor every told you that your child has medical problems related to his or her weight? If so, what are the medical problems?

**Psychological**

4**.** How do you feel about the types of healthy or unhealthy foods you provide for your child or children? Can you tell me more about the types of unhealthy foods you provide for your child or children?

5. How do you feel about your child or children's weight?

6. What are some of the ways you have tried to help your child or children to lose weight? Does any of the ways include shaming your child or children about their weight?

7. Can you tell me has your child or children lost weight under your management?

**Social**

8. Where are some of the places you shop for food?

9. Can you me how you transport yourself to shop for food?

**THIS IS OUR LAST INTERVIEW QUESTION**

10. Can you tell me if you receive any assistance for groceries-for example, food pantries, food banks, family members, or government assistance? If so, do you feel the assistance for groceries are enough to prepare healthy meals and snacks for your child or children?

**END OF INTERVIEW INSTRUCTIONS**

Is it ok if I read your responses from the interview for accuracy of information?

Is there anything else that you would like to share that we have not already talked about?

A written report of the interview will be transcribed and provided to you for your review. This process helps to ensure that I understand your responses to the interview questions.

I appreciate the time you took for this interview, Thank you.